HOME HEALTH AIDE CARE PLAN *(PLAN DE CUIDADO DE LA AYUDANTE DE ENFERMERA)*

Patient Address: _____ **Telephone No.** _____

Directions to Home: _____

☐ Patient oriented with Care Plan ☐ Reviewed with Home Health Aide/CNA

Care Manager: _____ **Phone No.** _____

Frequency/Duration: _____

Supervisory visits: ☐ every 14 days ☐ every 30 ☐ every 60 ☐ Other _____

Patient problem: _____

_____ **DNR:** ☐ Yes ☐ No

PARAMETERS TO NOTIFY CARE MANAGER / PARAMETROS A NOTIFICAR

T° _____ BP _____

P _____ R _____

Urine _____

☑ changes in skin condition

Other (pain) _____

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply. Circle the appropriate item if separated by slash.

- ☐ Lives alone/Vive solo
- ☐ Lives with other/Vive con otros
- ☐ Alone during the day/Solo durante el día
- ☐ Bed bound/Confinado a la cama
- ☐ Bed rest/BRPs/Descanso en la cama
  - ☐ Up as tolerated/Se levanta hasta donde puede
- ☐ Amputee (specify)/Amputación: _____
- ☐ Partial weight bearing/Soporte de peso parcial: ☐ R ☐ L

- ☐ Non weight bearing/No soporte de peso: ☐ R ☐ L
- ☐ Fall precautions/Prevención de caidas
- ☐ Special equipment/equipos especiales: _____
- ☐ Speech/Communication deficit/Habla deficiente
- ☐ Vision deficit/Visión def: ☐ Glasses/Espejuelos
  - ☐ Contacts/Lentes de contacto
  - ☐ Other/Otro: _____
- ☐ Hearing deficit/Def.Auditiva: ☐ Hearing aid/Ayuda para oir

- ☐ Dentures/Dentaduras: ☐ Upper/Sup. ☐ Lower/baja ☐ Partial/Parcial
- ☐ Oriented/Orientado x 3 ☐ Alert/Alerta
- ☐ Forgetful/Confused-Olvidadiso/Confuso
- ☐ Urinary catheter/Cateter urinario
- ☐ Prosthesis/Protesis (specify): _____
- ☐ Allergies/Alergias (specify): _____

- ☐ Diabetic/Diabetico ☐ Do not cut nails/No cortar uñas
  - ☐ Diet/Dieta: _____
- ☐ Seizure precaution/Precauciones con convulsiones
- ☐ Watch (observar por) for hyper/hypoglycemia
- ☐ Bleeding precautions/Prec. sangreamientos
- ☐ Prone to fractures/Posible fracturas
- ☐ Other (specify)/Otro (especificar): _____
- ☐ _____
- ☐ _____

Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc as needed beside the appropriate item

	ASSIGNMENT-TAREAS	Every visit	Weekly	Multi-Visits a day only 1	2	3	4	Other - Otro Comments/Instructions Comentarios/Instrucciones
VITALS / VITALES	Temperature/Temperatura	☐	☐	☐	☐	☐	☐	
	Pulse/Pulso	☐	☐	☐	☐	☐	☐	
	Respirations/Respiración	☐	☐	☐	☐	☐	☐	
	Blood Pressure/Presión	☐	☐	☐	☐	☐	☐	
	Weight/Peso	☐	☐	☐	☐	☐	☐	
	Pain Rating (0-10 scale)/Dolor	☐	☐	☐	☐	☐	☐	
BATH / BAÑO	Tub/Shower-Bañera/Ducha	☐	☐	☐	☐	☐	☐	
	Bath: Bed/Sponge - Baño:Cama/Sponja Partial/Complete-Parcial/Completo	☐	☐	☐	☐	☐	☐	
	Assist Bath-Chair - Asistir baño en silla	☐	☐	☐	☐	☐	☐	
HYGIENE /GROOMING / HIGIENE	Personal Care/Cuidado Personal	☐	☐	☐	☐	☐	☐	
	Assist with Dressing/Asistir vestirse	☐	☐	☐	☐	☐	☐	
	Hair Care/Cuidado del cabello	☐	☐	☐	☐	☐	☐	
	Hair shampooing in sink, tub, bed	☐	☐	☐	☐	☐	☐	
	Skin Care/Cuidado de la piel	☐	☐	☐	☐	☐	☐	
	Foot Care/Cuidado de los pies	☐	☐	☐	☐	☐	☐	
	Check Pressure Areas/Ulceras de presión	☐	☐	☐	☐	☐	☐	
	Nail Care/Cuidado de las uñas	☐	☐	☐	☐	☐	☐	
	Oral Care/Cuidado oral	☐	☐	☐	☐	☐	☐	
	Clean Dentures/Limpiar dentaduras	☐	☐	☐	☐	☐	☐	
	Shave/Afeitar	☐	☐	☐	☐	☐	☐	
	Other/Otro: _____	☐	☐	☐	☐	☐	☐	
PROCEDURES / PROCEDIMIENTOS	Assist with Elimination/Asistir eliminación	☐	☐	☐	☐	☐	☐	
	Catheter Care/Cuidado de catetes	☐	☐	☐	☐	☐	☐	
	Ostomy Care/Cuidar ostomia	☐	☐	☐	☐	☐	☐	
	Record Intake/Output-Registro tomar/salida	☐	☐	☐	☐	☐	☐	
	Inspect/ Reinforce/Inspeccionar Dressing/Vendas (see specifics in comment section/ver comentarios)	☐	☐	☐	☐	☐	☐	
	Medication Reminder/Recordar medicinas	☐	☐	☐	☐	☐	☐	
	Other (specify)/Otro (especificar): _____	☐	☐	☐	☐	☐	☐	

	ASSIGNMENT-TAREAS	Every visit	Weekly	Multi-Visits a day only 1	2	3	4	Other - Otro Comments/Instructions Comentarios/Instrucciones
ACTIVITY / ACTIVIDADES	Assist with - Asistir con Ambulation/Ambulación W/C/Walker/Cane - Silla Rueda/Andador/Baston	☐	☐	☐	☐	☐	☐	
	Assist with Mobility/assistir con mibilidad Chair/Bed/Dangle-Silla/Cama/Oscilar Commode/Cuña-Pato Shower/Tub=Ducha/Bañera	☐	☐	☐	☐	☐	☐	
	ROM Active/Passive-Rango de Mov.Activo/Pasivo Arm R/L (Brazos D/I) Leg R/L (Pies D/I)	☐	☐	☐	☐	☐	☐	
	Positioning-Encourage / Cambio de Posiciones Assist/assistir _____ hrs	☐	☐	☐	☐	☐	☐	
	Exercise Per - Ejercicios por PT / OT / SLP Care Plan/Plan de cuidado	☐	☐	☐	☐	☐	☐	
	Other (specify)/Otro (especificar):	☐	☐	☐	☐	☐	☐	
NUTRITION / NUTRICION	Meal Preparation/Prep. de comida	☐	☐	☐	☐	☐	☐	
	Assist with Feeding/Asistir alimentar	☐	☐	☐	☐	☐	☐	
	Limit/Encourage-Limitar/Exigir Fluid/Fluidoss	☐	☐	☐	☐	☐	☐	
	Grocery Shopping/Comprar comida	☐	☐	☐	☐	☐	☐	
	Other (specify)/Otro (especificar):	☐	☐	☐	☐	☐	☐	
OTHER / OTRO	Wash Clothes/Lavar ropa	☐	☐	☐	☐	☐	☐	
	Light Housekeeping/Ligera limpieza Bedroom / Baño Bathroom/Cuarto / Kitchen /Cocina Change Bed Linen/Cambiar sábanas	☐	☐	☐	☐	☐	☐	
	Equipment Care/Cuidado de equipos	☐	☐	☐	☐	☐	☐	
	Other (specify)/Otro (especificar):	☐	☐	☐	☐	☐	☐	

Signature/Title: _____ Date: _____ Review and/or revise at least every 60 days

SIGNATURE/TITLE	DATE	SIGNATURE/TITLE	DATE

PART 1 - Clinical Record **PART 2 - Patient Home Folder**

PATIENT NAME - Last, First, Middle Initial	ID#

As Nurse Aide you are an important member of the home care team. It is important that you check your Aide Care Plan before initializing care. Perform only the tasks assigned on the patient's Care Plan. If there are tasks being performed that are not on the patient care plan, notify your supervisor for approval before the changes are made.

REMEMBER TO RESPECT PATIENT'S PRIVACY/PROPERTY pnsystem.com 305.777.5580 (855)PNSystem

HOME HEALTH/HOME CARE
AIDE ASSIGNMENT SHEET

Care Manager _____ Phone No. _____
Frequency/Duration: Aide visits _____ Super. visits _____
Patient/Client problem: _____

Goals for care: ☐ Effective and safe personal care ☐ Patient/Client clean, comfortable
☐ Other (specify) _____

PARAMETERS TO NOTIFY CARE MANAGER

T _____ BP _____
P _____ R _____
Urine _____
Other (pain) _____

PRECAUTIONARY AND OTHER PERTINENT INFORMATION-Check all that apply. Circle the appropriate item if separated by slash.

Patient/Client Address: _____ Telephone No. _____
Directions to Home" _____

☐ Lives alone
☐ Lives, with other
☐ Alone during the day
☐ Bed bound
☐ Bed rest/BRPs
☐ Up as tolerated
☐ Amputee (Specify) _____
☐ Partial weight bearing ☐ Right ☐ Left
☐ Non weight bearing ☐ Right ☐ Left
☐ Hip precautions
☐ Special equipment _____

☐ Speech/Communication deficit
☐ Vision deficit: ☐ Glasses
☐ Contacts ☐ Other _____
☐ Hearing deficit: ☐ Hearing aid
☐ Dentures ☐ Upper ☐ Lower ☐ Partial
☐ Oriented x 3 ☐ Alert
☐ Forgetful/Confused
☐ Urinary catheter
☐ Prosthesis (specify) _____
☐ Allergies (specify) _____

☐ Diabetic ☐ Do not cut nails.
☐ Diet _____
☐ Seizure precaution
☐ DNR
☐ Watch for hyper/hypoglycemia
☐ Bleeding Precautions
☐ Prone to fractures
☐ Other (specify) _____
☐ _____
☐ _____

ASSIGNMENT-Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc, as needed bedside the appropriate item.

BATH	☐	Bath - Tub/Shower (F1)	ACTIVITY	☐ Ambulation Assist (F8) WC/Walker/Cane
	☐	Bed Bath - Partial/Complete (F2)		☐ Mobility Assist - Chair/Bed/Dangle/Commode/Shower/Tub
	☐	Assist Bath - Chair		☐ ROM - Active/Passive Arm R/L; Leg R/L
	☐			☐ Positioning - Encourage/Assist to Turn q Hrs
HYGIENE/GROOMING	☐	Personal Care (F4)		☐ Exercise - Per PT/OT/SLP Care Plan (F10)
	☐	Assist with Dressing		☐
	☐	Hair Care - Brush/Sharnpoo/Other	NUTRITION	☐ Diet Order
	☐	Skin Care/Foot Care (Hygiene)		☐ Food Allergies:
	☐	Check Pressure Areas		☐ Meal Preparation (F11)
	☐	Shave/Groorn/Deodorant		☐ Assist with Feeding
	☐	Nail Hygiene - Clean/File/Report		☐ Limit/Encourage Fluids
	☐	Oral Care - Brush/Swab/Dentures		☐ Grocery Shopping (F12)
	☐	Elimination Assist		☐
	☐		OTHER	☐ Wash Clothes (F13)
PROCEDURES	☐	Catheter Care (F6)		☐ Light Housekeeping (14)
	☐	Ostorny care		Bedroom/Bathroom/Kitchen/Change Bed Linen
	☐	Record output		☐ Equipment Care
	☐	Inspect/Reinforce Dressing (see specifics below)		☐ Pain Management
	☐	Assist with Medications (see specifics below)		☐
	☐			☐

VITALS	☐ T - 0/A/R - Record _____ /week - Report	☐ R - Record _____ /week	☐ Weight - Record _____ /Week - Report
	☐ P - Wrist/Pedal, R/L - Record _____ /week - Report	☐ BP - Record _____ /week	☐ Other (specify) _____

Wound Care - Inspect/Reinforce Dressing: _____

Assist with Meds (describe): _____

Special Instructions/Safety Measures: _____

SIGNATURES

INITIAL ASSIGNMENT: Signature/Title: _____ Date: ___/___/___

THIS ASSIGNMENT SHEET MUST BE REVIEWED AND/OR REVISED AT LEAST EVERY 60 DAYS.

REVIEWED/REVISED- Signature/Title: _____ Date ___/___/___
REVIEWED/REVISED- Signature/Title: _____ Date ___/___/___
REVIEWED/REVISED- Signature/Title: _____ Date ___/___/___

PART 1 - Clinical Record **PART 2 - Patient/Client**

PATIENT/CLIENT NAME - Last, First, Middle Initial: | ID#:

LOVABLE HOME HEALTH SERVICES, CORP.

CNA/HOME HEALTH AIDE ASSIGNMENT

Patient Address: _____ **Telephone No.** _____

Directions to Home: _____

Goals for care: ❑ Effective and safe personal care. ❑ Patient/Client clean and comfortable.
❑ Other (specify): _____

Frequency/Duration: _____

Supervisory visits: ❑ q 14 days ❑ q 60 days ❑ Other _____

Patient problem: _____

PARAMETERS TO NOTIFY CARE MANAGER

T° > 99.8 BP < 100/60 > 146/96
P <60 or >110 R <16 or > 22
Urine Foul odor, cloudy, blood tinged
Other (pain) Severe without relief
DNR: ☐ Yes ❑ No ❑ N/A

PRECAUTIONARY AND OTHER PERTINENT INFORMATION - Check all that apply. Circle the appropriate item if separated by slash.

❑ Lives alone
☐ Lives with other
❑ Alone during the day
❑ Bed bound
❑ Bed rest/BRPs
❑ Up as tolerated
☐ Amputee (specify): _____
☐ Partial weight bearing: ❑ R ☐ L

❑ Non weight bearing: ❑ R ☐ L
❑ Fall precautions
❑ Special equipment: _____
☐ Speech/Communication deficit
❑ Vision deficit: ❑ Glasses
❑ Contacts
❑ Other: _____
❑ Hearing deficit: ❑ Hearing aid

❑ Dentures: ❑ Upper ❑ Lower
❑ Partial
❑ Oriented x 3 ❑ Alert
❑ Forgetful/Confused
❑ Urinary catheter
☐ Prosthesis (specify): _____
❑ Allergies (specify): _____

❑ Diabetic ❑ Do not cut nails
❑ Diet: _____
❑ Seizure precaution
☐ Watch for hyper/hypoglycemia
❑ Bleeding precautions
❑ Prone to fractures
❑ Other (specify): _____
❑ _____

Check all applicable tasks. Specify by circling the applicable activity for those items separated by slashes. Write additional precautions, instructions, etc as needed beside the appropriate item.

	ASSIGNMENT	Every visit	Weekly	Other - Comments/Instructions
VITALS	Temperature	❑	❑	
	Pulse	❑	❑	
	Respirations	❑	❑	
	Blood Pressure	❑	❑	
	Weight	❑	❑	
	Other (specify): _____	❑	❑	
BATH	Tub/Shower	❑	❑	
	Bed Bath - Partial/Complete	❑	❑	
	Assist Bath - Chair	❑	❑	
HYGIENE /GROOMING	Personal Care	❑	❑	
	Assist with Dressing	❑	❑	
	Hair Care	❑	❑	
	Shampoo	❑	❑	
	Skin Care	❑	❑	
	Foot Care	❑	❑	
	Check Pressure Areas	❑	❑	
	Nail Care	❑	❑	
	Oral Care	❑	❑	
	Clean Dentures	❑	❑	
	Other (specify): _____	❑	❑	
PROCEDURES	Assist with Elimination	❑	❑	
	Catheter Care	❑	❑	
	Ostomy Care	❑	❑	
	Record Intake/Output	❑	❑	
	Inspect/ Reinforce Dressing (see specifics in comment section)	❑	❑	
	Medication Reminder	❑	❑	
	Other (specify): _____	❑	❑	

	ASSIGNMENT	Every visit	Weekly	Other - Comments/Instructions
ACTIVITY	Assist with Ambulation W/C / Walker / Cane	☐	❑	
	Assist with Mobility Chair / Bed / Dangle Dangle / Commode Shower / Tub	❑	❑	
	ROM Active / Passive Arm R/L Leg R/L	❑	❑	
	Positioning - Encourage Assist _____ hrs	❑	❑	
	Exercise - Per PT / OT / SLP Care Plan	❑	❑	
	Other (specify): _____	❑	❑	
NUTRITION	Meal Preparation	❑	❑	
	Assist with Feeding	❑	❑	
	Limit/Encourage Fluids	❑	❑	
	Grocery Shopping	❑	❑	
	Other (specify):	❑	❑	
OTHER	Wash Clothes	❑	❑	
	Light Housekeeping Bedroom / Bathroom / Kitchen / Change Bed Linen	❑	❑	
	Equipment Care	❑	❑	
	Other (specify):	❑	❑	

RN Signature/Title: _____ Date: _____ Review and/or revise at least every 60 days

Review/Revise SIGNATURE/TITLE	DATE	Review/Revise SIGNATURE/TITLE	DATE

PART 1 - Clinical Record **PART 2 - Patient**

PATIENT NAME - Last, First, Middle Initial | MR #

NON SKILLED

AIDE/PERSONAL CARE SERVICES PLAN

Employee Name _____

Employee ID _____

Patient/Client Name	ID#	Patient Address / Phone:

	Every Visit	Weekly	1	2	3	4 *(visit/hours)*
PERSONAL CARE (PC)						
BATH - TUB/SHOWER/BED/ASSIST						
HAIR CARE BRUSH/SHAMPOO						
ORAL CARE - BRUSH/SWAB/DENTURES						
DRESS/UNDRESS						
SKIN CARE/FOOTCARE/(HYGIENE)						
SHAVE/GROOM/DEODORANT						
NAIL HYGIENE - CLEAN/FILE/REPORT						
AMBULATION ASSIST - WC/WALKER/CANE						
TRANSFER ACTIVITY						
CHANGE POSITION						
INCONTINENCE CARE						
TOILETING ASSIT						
COMODE/BED PAN ASSIST						
MEAL PREP						
ASSIST WITH FEEDING						
MAKE BED / CHANGE LINEN						
LIMIT/ENCOURAGE FLUIDS						
EMOTIONAL SUPPORT						
FOLLOW UNIVERSAL PREC						
SAFETY						
INFECTION CONTROL						
HOMEMAKER (HMK)						
LAUNDRY						
CLEAN BATHROOM						
CLEAN BEDROOM						
CLEAN KITCHEN / REFRIGERATOR						
CLEAN LIVING ROOM						
MEAL PREP						
EMPTY TRASH						
VACUUM/SWEEP/ DUST						
WASH DISHES						
FOLLOW UNIVERSAL PREC						
SAFETY						
INFECTION CONTROL						
OTHER						
COMPANION						
RESPITE CARE						
ATTENDANT CARE						
CHORES						
ESCORT						
SHOPPING						
FOLLOW UNIVERSAL PRECAUTIONS, SAFETY MEASURES						

Frequency of Services, ADDITTIONAL INSTRUCTIONS:

_____

_____

_____

_____

_____

Expected client/patient outcomes/goals:

_____

_____

_____

_____

☐ FAIR RETURN TO PREVIOUS LEVEL OF ADLS INDEPENDENTLY by: _____.

☐ WILL NOT BE ABLE TO CARRY OUT ADLS WITHOUT MAXIMUM SUPPORT by: _____.

☐ BE SAFE IN SELF CARE By: _____.

_____

_____

_____

_____

_____

Additional Instructions/orders:

_____
_____
_____
_____
_____

☑ Report Significant finding to Agency. ☑ patient/client participate in planning of his/her care

_____ _____

Staff Preparing Plan Signature/Title Date

ABSOLUTE
HOME CARE INC

HHA / HOMEMAKER CARE PLAN

☐ Home Health Aide ☐ Homemaker

Patient Name	Patient #	Date ot First Visit

Supervisor	HHA Frequency	Caregiver Name

Diagnosis/Patient Problems

Address	Phone	Date ot Birth

Directions

ASSIGNMENTS: Specify QVisit, frequency with day of week, at patient request or PRN.

VITAL SIGNS	FREQUENCY
Temperature	
BP	
Pulse	
Respiration	

BATH	TOTAL SUPPORT	ASSIST	SELF CARE	FREQUENCY
Bed/Tub/Shower	☐	☐	☐	
Bed- Partial/Complete	☐	☐	☐	
Assist Bath-Chair	☐	☐	☐	
Shampoo Hair	☐	☐	☐	
Comb Hair	☐	☐	☐	
Mouth Care	☐	☐	☐	
Shave ☐ Electr. ☐ Straight	☐	☐	☐	
Assist with Dressing	☐	☐	☐	
HAND / FOOT CARE				
Clean/File Nails	☐	☐	☐	
Soak Feet	☐	☐	☐	
ELIMINATION				
Perineal Care	☐	☐	☐	
External Cath Care	☐	☐	☐	
Measure Cath Output	☐	☐	☐	
Empty Drainage Bag	☐	☐	☐	

	TOTAL SUPPORT	ASSIST	SELF CARE	FREQUENCY
SKIN CARE				
Moisture Skin	☐	☐	☐	
ACTIVITY				
Ambulation Assist	☐	☐	☐	
Walker/Wheelchair	☐	☐	☐	
Mobility Assist	☐	☐	☐	
Chair/Bed	☐	☐	☐	
Dangle/Commode	☐	☐	☐	
Exercise per PT/OT CP	☐	☐	☐	
Reposition Patient	☐	☐	☐	
MEALS				
Prepare	☐	☐	☐	
Feed	☐	☐	☐	
Setup	☐	☐	☐	
Offer Oral Supplement	☐	☐	☐	
HOUSEKEEPING				
Change Bed Linens	☐	☐	☐	
Make Bed	☐	☐	☐	
Straighten Room	☐	☐	☐	
Laundry	☐	☐	☐	
Shopping	☐	☐	☐	

☐ DO CPR ☐ DO NOT DO CPR

PERTINENT INFORMATION

- ☐ Lives Alone
- ☐ Lives with other: _____
- ☐ Alone during the day
- ☐ Bed Bound ☐ Bed Rest/BRP's
  - ☐ Up us tolerated
- ☐ Amputee (specify) _____
- ☐ Partial weight bearing:
  - ☐ Right ☐ Left
- ☐ Non-weight bearing:
  - ☐ Right ☐ Left
- ☐ Hip precautions
- ☐ Prone to fractures
- ☐ Prosthesis (specify): _____
- ☐ Special Equipment: _____
- ☐ Speech/Communication deficit
- ☐ Vision deficit Glasses
- ☐ Contacts ☐ Other _____
- ☐ Hearing deficit ☐ Hearing Aid
- ☐ Dentures:
  - ☐ Upper ☐ Lower ☐ Partial
- ☐ Oriented x 3 ☐ Alert
- ☐ Forgetful/Contused
- ☐ Diabetic
- ☐ Diet _____
- ☐ Seizure precautions
- ☐ Bleeding precaution
- ☐ Pain Medication
- ☐ O2
- ☐ Allergies (specity) _____

SAFETY

- ☐ Fall Precautions
- ☐ 24* Supervision
- ☐ Emergency Call System
- ☐ Other: _____

Other (specify):

_____

_____

_____

Special Instructions:

_____

_____

_____

Parameters, or Special Conditions, to Report to Nurse:

Review Date / Initials	Review Date / Initials	Review Date / Initials	Review Date / Initials

Nurse's /Therapist's Signature	Date

goldencare
Home Health Agency Inc.

HOME HEALTH AIDE CARE PLAN

PATIENT NAME (Last, First)	PATIENT #	SOC / RI DATE	TYPE OF DIAGNOSIS

PERTINENT PATIENT INFORMATION/SPECIAL INSTRUCTIONS

DO NOT RESUCITATE ORDER [ ]

CAREGIVER(S) _____

ALLERGIES: _____

DIET: _____

PERSONAL CARE
[ ] Bed Bath
[ ] Shower Sit/ Stand
[ ] Bath Supervision
[ ] Hair Care / Shampoo
[ ] Oral care
[ ] Nail Care (Do Not Cut)
[ ] Pen Care
[ ] Skin Care
[ ] Shave
[ ] Dress
[ ] Teds/Ace Application
[ ] Assist w/ Toileting
[ ] **Feeding**
[ ] **Linen Change**
[ ] **Assist in Ambulation**
[ ] **Transfer Bed-Chair**
[ ] **Foley Catheter (cc)**

HOMEMAKER
[ ] Light Cleaning
[ ] Laundry
[ ] Shopping / Errands
[ ] Meal Preparation
[ ] Wash Dishes

COMPANIONSHIP
[ ] Companionship

RESPITE
[ ] Respite

MONITOR VITAL SIGNS
[ ] **Temperature**
[ ] **Pulse**
[ ] Respiration

PROBLEM
SELF CARE DEFICIT RELATED TO:
[ ] Genetal weakness
[ ] Paralysis
[ ] Amputation
[ ] Recent surgery
[ ] Debilitating disease
[ ] Confusion
[ ] Immobility
[ ] Bedridden
[ ] Cast
[ ] Assistive device(s)
[ ] Wheelchair
[ ] Walker
[ ] Cane
[ ] **Quadcane**
[ ] **Braces**
[ ] Sensory Deficit
[ ] **Blind/poor vision**
[ ] **Deaf/HOH**

PROGNOSIS
[ ] Excellent
[ ] Good
[ ] Fair
[ ] Poor
[ ] Guarded

COPING
[ ] Unable to Perform Self Task
[ ] Able to Assist
[ ] Other

PRECAUTIONS

[ ] **Seizures** **[ ] Oxygen**

[ ] Safety _____

[ ] **Weight Bearing Limitation** _____

[ ] **Fluid Restrication** _____

[ ] **Activities Not Permitted** _____

SIGNATURE OF NURSE	DATE

NON SKILLED

HOME HEALTH AIDE CARE PLAN

Patient Name: MR #

Patient Address: Telephone: _____

☐ Patient oriented with Care Plan ☐ Reviewed with the HHA/CNA

Case Manager: Phone No.

Frequency/Duration: _____

_____

Supervisory Visits: ☐ 90 days ☐ Other _____

Patient problems: _____

Parameters to Notify Case Manger

Urine: Cloudy, Bloody

DNR: ☐ Yes ☐ NO

Precautionary and other pertinent information – Check all that apply.

- ☐ Lives alone/*Vive solo*
- ☐ Live with other /*Vive con otros*
- ☐ Alone during the day/ *Solo durante del día*
- ☐ Bed Bound /*Confiado a la cama*
- ☐ Bed rest/BRPs/ *Descanso en la cama*
- ☐ Up as Tolerated / *Se levanta hasta done puede*
- ☐ Amputee (specify)/*Amputación* _____
- ☐ Partial weight bearing / *Soporte de peso parcial* ☐ R ☐ L
- ☐ No weight bearing / *No soporte de peso* ☐ R ☐ L
- ☐ Fall precautions/ *Prevención de caidas*
- ☐ Special Equipment/ *equipos especiales:*
- ☐ Speech/Communication deficit/ *Habla deficiente*
- ☐ Vision deficit / *Visión def:*
- ☐ Glasses/ *Espejuelos*
- ☐ Contacts / *Lentes de contacto*
- ☐ Other / *Otro:* _____
- ☐ Hearing deficit / *Def. Auditiva*
- ☐ Hearing Aid */ Ayuda para oir*
- ☐ Oxygen Precautions / *Precuaciones de Oxígeno*
- ☐ Dentures/ *Dentaduras*
- ☐ Upper / *Sup.*
- ☐ Lower/ *Baja*
- ☐ Partial/ *Parcial*
- ☐ Oriented / *Orientado* x 3
- ☐ Alert / *Alerta*
- ☐ Forgetful/*Olvidadiso*
- ☐ Confused/ *Confuso*
- ☐ Urinary catheter / *Cateter urinario*
- ☐ Prosthesis / *Protesis (specify)* _____
- ☐ Allergies / *Alergias (specify):* _____ _____
- ☐ Diabetic / *Diabetico*
- ☐ Do not cut nails / *No cortar uñas*
- ☐ Diet / *Dieta* _____
- ☐ Seizure precautions / *Precauciones con convulsions*
- ☐ Watch (*observer por)* for
  - ☐ Hyperglycemia
  - ☐ Hypoglycemia
- ☐ Bleeding precautions/ *Prec. Sangremientos*
- ☐ Prone to fractures / *Posible fracturas*
- ☐ Other / *Otro* _____

Every Visit **(EV)** Weekly **(W)** Other **(O)**

		EV	W	O
BATH	☐ Assist patient with Bath	☐	☐	
	☐ Bath Chair	☐	☐	
	☐ Bed Bath	☐	☐	
PERSONAL CARE	☐ Assist with Dressing	☐	☐	
	☐ Grooming	☐	☐	
	☐ Skin Care	☐	☐	
	☐ Shave	☐	☐	
	☐ Check Pressure Areas	☐	☐	
	☐ Nail Care	☐	☐	
	☐ Oral Care	☐	☐	
	☐ Assist with Elimination	☐	☐	
	☐ Medication Reminder	☐	☐	
	☐ Ambulation Assist	☐	☐	
	☐ Mobility Assist	☐	☐	

		EV	W	O
HOMEMAKER	☐ Meal Preparation	☐	☐	
	☐ Assist with Feeding	☐	☐	
	☐ Light Housekeeping	☐	☐	
	☐ Wash Clothes	☐	☐	
	☐ Groceries	☐	☐	
OTHER	☐ Respite	☐	☐	
	☐ Adult Companion	☐	☐	
	☐ Chore	☐	☐	

Clinician's Name/Title: _____ Signature: _____ Date: _____ Time: _____

UPDATES

Clinician's Name/Title: _____ Signature: _____ Date: _____

Aide Care Plan: ☐ No Change ☐ Updated ☐ Frequency Change; Effective Date: _____

☐ New Frequency: Time: _____

Clinician's Name/Title: _____ Signature: _____ Date: _____

Aide Care Plan: ☐ No Change ☐ Updated ☐ Frequency Change; Effective Date: _____

☐ New Frequency: Time: _____

Clinician's Name/Title: _____ Signature: _____ Date: _____

Aide Care Plan: ☐ No Change ☐ Updated ☐ Frequency Change; Effective Date: _____

☐ New Frequency: Time: _____

AIDE CARE PLAN

PATIENTS NAME: _____ **MR #:** _____

TELEPHONE NO: _____ **DATE:** _____

[ ] PT ORIENTED TO AIDE CARE PLAN [ ] CAREPLAN REVIEWED WITH HHA/C.N.A

CASE MANAGER: _____ **PHONE NO:** _____

FREQUENCY/DURATION: _____

SUPERVISORY VISITS: EVERY [ ] 14 DAYS[ ] 60 DAYS [ ] OTHER **DNR:** [ ] YES [ ] NO

PRECAUTIONARY AND PARAMETERS TO REPORT TO AGENCY - CHECK ALL THAT APPLY. CIRCLE THE APPROPRIATE ITEM IF SEPARATED BY SLASH

[ ] LIVES ALONE/VIVE SOLO	[ ] DENTURE/DENTURAS: [ ] UPPER/SUP. [ ] LOWER/BAJA [ ] PARTIAL
[ ] LIVES WITH OTHER/VIVE CON OTROS	[ ] ORIENTED/ORIENTADO [ ] ALERT/ALERTA
[ ] ALONE DURING THE DAY/SOLO DURANTE EL DIA	[ ] FORGETFUL/CONFUSED-OLVIDADISO/CONFUSO
[ ] BED BOUND/CONFINADO A LA CAMA	[ ] DIABETIC/DIABETICO [ ] URINARY CATHETER/CATETER URINARIO
[ ] CHAIRBOUND/CONFINADO A LA SILLA	[ ] FALL PRECAUTIONS/PREVENCIÓN DE CAIDAS [ ] PAIN/DOLOR:
[ ] UP AS TOLERATED/LEVANTARSE SEGUN LO TOLERE	[ ] PROSTHESIS/PROTESIS (SPECIFY):
[ ] AMPUTEE/AMPUTACION (SPECIFY/ESPECIFICAR):	[ ] ALLERGIES/ ALLERGIAS: _____
[ ] PARTIAL WEIGHT BEARING/SOPORTE DE PESO PARCIAL: [ ] R [ ] L	[ ] BLEEDING PRECAUTIONS/PRECAUCIONES DE SANGRAMIENTO
[ ] NON WEIGHT BEARING/NO SOPORTE DE PESO: [ ] R [ ] L	[ ] DO NOT CUT NAILS/NO CORTAR UÑAS
[ ] SPECIAL EQUIPMENT/EQUIPOS ESPECIALES: [ ] HOSP BED [ ] HOYER LIFT	[ ] PRONE TO FRACTURES/PROPENSO A FRACTURAS
[ ] WALKER [ ] CANE [ ] WHEELCHAIR [ ] OXYGEN [ ] GRABBARS	[ ] DIET/DIETA: _____
[ ] SHOWER CHAIR [ ] OTHER: _____	[ ] SEIZURE PRECAUTION/PRECUACIONES CON CONVULSIONES
[ ] VISION DEFICIT/VISIÓN DEF: [ ] GLASSES/ESPEJUELOS [ ] CONTACTS	[ ] WATCH (OBSERVAR POR) FOR HYPER/HYPOGLYCEMIA
[ ] BLIND/LEGALLY BLIND [ ] CIEGO/LEGALMENTE CIEGO	[ ] REPORT CHANGES IN SKIN CONDITION, INCLUDING PRESSURE ULCERS
[ ] SPEECH/COMMUNICATION DEFICIT/IMPEDIMENTO DEL HABLA	**VITAL SIGNS: Temp: _____ BP: _____ P: _____ R: _____**
[ ] VISION DEFICIT/VISIÓN DEF: [ ] GLASSES/ESPEJUELOS [ ] CONTACTS	VITAL SIGNS/SIGNOS VITALES: [ ] **T** each visit/cada visita [ ] ones a day/una vez día
[ ] HEARING DEFICIT/DEFICIENCIA AUDITIVA/HEARING AID/AYUDA PARA OIR	[ ]**BP** each visit/cada visita [ ]ones a day/una vez día [ ]**R** each visit/cada visita [ ] ones a day/una vez día
[ ] OTHER/OTRO:	[ ] **P** each visit/cada visita [ ]ones a day/una vez día [ ]Other / Otro:

PERSONAL CARE	1	2	3	WEEKLY
BATH: [ ] COMPLETE BED BATH [ ] CHAIR BATH				
[ ] TUB BATH [ ] PARTIAL BED BATH				
SHOWER: [ ] WITH SHOWER CHAIR				
SKIN CARE: [ ] CHECK FOR PRESSURE AREAS				
COMB/BRUSH HAIR				
HAIR SHAMPOO (in sink, tub, bed)				
ASSIST WITH DRESSING				
ORAL HYGIENE				
SHAVE				
NAIL CARE (DO NOT CUT NAILS)				
FEED PATIENT (BY MOUTH ONLY)				
TURN/CHANGE POSITION IN BED				
ASSIST WITH TRANSFERS: (SPECIFY)				
[ ] BED [ ] CHAIR [ ] HOYER LIFT				
ASSIST WITH AMBULATION: (SPECIFY)				
[ ] CANE [ ] WALKER [ ] WHEELCHAIR				
ASSIST WITH ELIMINATION				
[ ] DIAPER CHANGE				
[ ] EMPTY DRAINAGE BAG				
[ ] URINARY CATHETER CHANGE				

HOMEMAKER/CHORES	1	2	3	WEEKLY
GROCERY SHOPPING				
LIGHT MEAL PREPARATION				
CHANGE LINENS				
MAKE BED				
CLEAN BEDROOM				
CLEAN BATHROOM				
CLEAN KITCHEN				
WASH DISHES				
LAUNDRY				
DISHASHER CLEAN/Limpiar lavador de platos				
OORGANIZE, CLEAN CLOSETS/Organizar closes				
OTHER: _____				
RESPITE/COMPANION	**1**	**2**	**3**	**WEEKLY**
RESPITE				
COMPANION				

AIDE NAME: _____ TITLE: _____

AIDE SIGNATURE: _____

Comments/Clarification: _____

_____

RN SIGNATURE: _____ **DATE:** _____

CARE PLAN UPDATE: _____

_____

_____

RN SIGNATURE: _____ **DATE:** _____

Personal Care Aide Care Plan

Plan completed by (Name/Title): _____ Signature: _____ Date: _____

Reviews:
Signature/Title:_____ Date: ____
Signature/Title:_____ Date: ____

Patient Name_____ Med. Record #: _____	
Directions to Home:_____ Telephone: _____ Patient Concern(s): _____	Patient Oriented with Care Plan ____ Reviewed with Home Health Aide___
Care Manager: Phone Number:	**Parameters to Notify Care Manager**
Frequency/ Duration: DNR ___Yes ___No	Temp: BP:
Supervisory Visits: __every 14 days __every 30 __every 60 ___ other	Pulse: Rate:

Precautionary and Other Pertinent Information - Check all that Apply. Circle the appropriate item if separated by a slash.

Lives Alone ___ with other___	Non Weight Bearing___	Dentures___	Diabetic___ Seizures___
Alone during the Day ___	Fall Precautions___	Oriented___ Forgetful___	Hyper/ Hypoglycemia___
Bed Bound____	Special Equipment___	Prone to Falls___	Bleeding Precautions___
Bed Rest/ BRP's___ Up as tolerated___	Speech/ Communication Deficiency__ Vision Deficiency___ Contacts__	Urinary Catheter___ Prosthesis___	Partial Weight Bearing___ R or L
Amputee___ Where:	Hearing Deficiency___ Aid____	Allergies:	Other:

Assignment	Every Visit	Weekly	Specific days	Comments
Bathing: Tub Bed Bath Chair Bath Shower				
Shampooing				
Brush Hair				
Lotion Application				
Nail Filing				
Shaving Electric Only				
Dental Care				
Assistance to Toilet				
Empty Bed Pan or Urinal				
Cleaning of Eye Glasses				
Cleaning of Hearing Aids				
Light Cleaning of Wheelchair __ Walker __				
Light Cleaning of Cane/Crutch				
Assistance with Dressing				
Making Meals				
Feeding /Assistance with				
Washing Cloths				
Bed Making/ Change Linen				
Assistance with ambulation				
Transferring __ Positioning __ Turning__				
Restock Bathroom Supplies				
Wash Dishes				
Restock Refrigerator Supplies				
Clean Refrigerator____ Clean Oven ___				
Clean Windows___ Dust ___ Mop ___				
Vacuum				
Take out Trash				
Water Plants ____ Check Mail ____				
Shopping for House				
Accompany to Medical Appointments				
Assist with Phone Calls __ Mail __ Emails __				
Monitor ADLs				
Accompany on Walks				
Converse/ Socialize				
Read to Client				
Observe While Sleeping				

SOC date:

Med. Record #

Home Health Aide Care Plan (long term plans)

PLAN DE CUIDADO DE LA AYUDANTE DE ENFERMERA

CLIENTS NAME:	

☐ **Patient oriented with Care Plan** ☐ **Limitations explained to aide staff** **DNR** ☐ **Yes** ☐ **No** *(copy available if yes)*

Limitations/Limitaciones

- ☐ Lives Alone/Vive solo
- ☐ Lives w/others, alone daytime/Vive con otro
- ☐ Bed bound/Confinado a la cama
- ☐ Bed rest/Reposo de cama
- ☐ Up as Tolerated/Subir según tolera
- ☐ Amputee/Amputado
- ☐ Medical Equip/Equipo médico
- ☐ Partial Weight Barring/Ganandoal peso
- ☐ Non-weight bearing/Sin soporte de peso
- ☐ Speech Deficit/Déficit del habla
- ☐ Vision Deficit/Déficit de visión
- ☐ Hearing Deficit/Déficit auditivo
- ☐ Dentures/Dentadura postiza
- ☐ Oriented/Orientado x ____
- ☐ Forgetful/Olvidadizo
- ☐ Confused/Confuso
- ☐ Urinary Catheter/Catéter urinario
- ☐ Other/Otro: _____
- ☐ Prothesis/Protesis

Safety Measures/Precauciones

- ☐ Falls/Caidas
- ☐ Diabetic/Diabético
- ☐ Don't cut nails/No cortar uñas
- ☐ Seizures/Convulsiones
- ☐ Bleeding/sangreamietos
- ☐ Fractures/Fracturas
- ☐ Allergies/Alergias:_____
- ☐ Emergency Plan/Plan emergencia

☒Report changes to skin conditions/*Informar cambios en la piel* ☒ Report Pain, and significant finding/Informar dolor, algo significativo

TASK/TAREA ***(each duties must be explained to aide staff/cada tarea explicada a la ayudante)***

PERSONAL CARE/CUIDADO PERSONAL	S	M	T	W	T	F	S
☐ Bed Bath/Cama ☐ Shower/Ducha							
☐ Tub Bath/Baño en la Bañera							
Incontinence Care/Cuidado incontinencia							
PERI-Skin Care/Cuidado de la piel							
Hair Care/Cuidado del cabello							
Foot Care/Cuidado de los pies							
Skin Care/Cuidado de la piel							
Assist Dressing/Ayudar a vestirse							
Oral Hygiene/ Higiene oral							
Shave/Afeitalo							
Prepare Meals/Preparar comidas							
Feed Patient/Alimentar al Paciente							
Ambulation/Ambulación							
Change Position/ cambier posición							
Transfer Pt/Transferir paciente							
Use Hoyer Lift/Uso de Hoyer							
Toileting assistance/Ayudar en el aseo							
Commode, Bed pan asst/acomodo							
ROM Exercise/Ejercicio movimiento							
PERSONAL CARE HOURS							
RESPITE SERVICE HOURS							

HOMEMAKER-CHORE/TAREAS EN CASA	S	M	T	W	T	F	S
Make Bed/Hacer la cama							
Change Linens/Cambiar sábanas							
Clean Bedroom/Limpiar Dormitorio							
Laundry/Lavandería							
Clean Living Area/Limpiar Sala							
Clean Kitchen/Limpiar Cocina							
Prepare Meals/Preparar comidas							
Wash Dishes/ Lavar los platos							
Iron Clothing/ Plancha la ropa							
Mop Floors /Fregar los pisos							
Vacuum or Sweep/Aspirar-Barrer							
Reduce Dust/Reducir el polvo							
Appliances cleaning/Limpieza equipos							
Shopping/Compras							
HOMEMAKER/CHORE HOURS							
COMPANIONSHIP/ACOMPAÑAR	**S**	**M**	**T**	**W**	**T**	**F**	**S**
Emotional Support/Soporte emocional							
Socialize/Socializar (help with social sites)							
Med Reminder/Recordar Meds							
Accompanying for a walk outside/caminar							
COMPANIONSHIP HOURS							
ESCORT SERVICE HOURS							

Follow Universal Precautions: ☒ Infection Control/Control de infección ☒ Report issues of confidentiality, distress, abuse signs.

_____

Plan prepared by (Staff name/title)

_____ _____

Staff Signature **Date**

Reviewed/Updated Plan:
Date: _____ by: _____
Signature: _____
Date: _____ by: _____
Signature: _____

SUNSHINE GOOD CARE, LLC

HOME HEALTH AIDE ASSIGNMENT SHEET/ CARE PLAN

PATIENT NAME: _____ MED. REC. # _____ DATE: _____

DX: _____ FREQUENCY: _____

DIRECTIONS / SPECIAL ARRANGEMENTS: _____

PERSONAL ASSISTANCE REQUIRED

FIRST VISIT	SECOND VISIT	THIRD VISIT	FOURTH VISIT
Tub Both [ ] total [ ] assist	Tub Bath [ ] total [ ] assist	Tub Bath [ ] total [ ] assist	Tub Bath [ ] total [ ] assist
Shower [ ] total [ ] assist	Shower [ ] total [ ] assist	Shower [ ] total [ ] assist	Shower [ ] total [ ] assist
Sponge bath [ ] total [ ] assist	Sponge bath [ ] total [ ] assist	Sponge bath [ ] total [ ] assist	Sponge bath [ ] total [ ] assist
Bed Bath [ ] complete [ ] partial	Bed Bath [ ] complete [ ] partial	Bed Bath [ ] complete [ ] partial	Bed Bath [ ] complete [ ] partial
Shampoo, prn [ ] total [ ] assist	Nail Care, prn	Nail Care, prn	Nail Care, prn
Hair Care	Skin Care, prn	Skin Care, prn	Skin Care, prn
Shave, prn	Foot Cart, prn	Foot Care, prn	Foot Care, prn
Nail Care, prn	Perineal Care, prn	Perineal Care. prn	Perineal Care, prn
Skin Care, prn	Check Pressure Areas	Check Pressure Areas	Check Pressure Areas
Foot Care, prn	Dentures Care	Dentures Care	Mouth Care: [ ] Oral [ ] Dentures
Perineal Care, prn	Assist with Toileting	Assist with Toileting	Assist with Toileting
Check Pressure Areas	Foley Care: [ ] Empty [ ] Change	Foley Care: [ ] Empty [ ] Change	Foley Care: [ ] Empty [ ] Change
Mouth Care: [ ] Oral [ ] Dentures	Ostomy Care	Ostomy Care	Ostomy Care
Assist with Dressing	Diaper Change, prn	Diaper Change, prn	Diaper Change, prn
Assist with Toileting	Medication Reminder, prn	Medication Reminder, prn	Medication Reminder, prn
Foley Care: [ ] Empty [ ] Change	Assist with Ambulation	Assist with Ambulation	Assist with Ambulation
Ostomy Care	Assist with Transfers	Assist with Transfers	Assist with Transfers
Diaper Change, prn	Transfer Bed/Chair, pro	Transfer Bed/Chair, prn	Transfer Bed/Chair, prn
Medication Reminder, prn	Repositioning [ ] Q2 hrs [ ] Prn	Repositioning [ ] Q2 hrs [ ] Prn	Repositioning [ ] Q2 hrs [ ] Prn
T.P.R.	R.O.M. [ ] Active [ ] Passive	R.O.M. [ ] Active [ ] Passive	R.O.M. [ ] Active [ ] Passive
Assist w/ [ ] Ambulation [ ] Transfers	Assist with Feeding	Assist with Feeding	Assist with Feeding
Transfer Bed/Chair, prn	Meal Preparation	Meal Preparation	Meal Preparation
Repositioning [ ] Q2 hrs [ ] Prn	Light Shopping, prn	Light Shopping, prn	Light Shopping, prn
R.O.M. [ ] Active [ ] Passive	Light Personal Laundry, prn	Light Personal Laundry, prn	Light Personal Laundry, prn
Assist with Feeding	Tidy up Bedroom	Tidy up Bedroom	Tidy up Bedroom
Meal Preparation	Tidy up Bathroom	Tidy up Bathroom	Tidy up Bathroom
Light Shopping, prn	Tidy up Kitchen	Tidy up Kitchen	Tidy up Kitchen
Light Personal Laundry, prn	Tidy up Bathroom	Tidy up Bathroom	Tidy up Bathroom
Tidy up Bedroom	Make Bed	Make Bed	Make Bed
Tidy up Bathroom	Change Linens, prn	Change Linens, pro	Change Linens, prn
Tidy up Kitchen			
Make Bed			
Change Linens, prn			

EQUIPMENT USE

☐ WHEELCHAIR ☐ HOSP. BED ☐ SHOWER CHAIR ☐ WALKER ☐ CANE
☐ HOYER LIFT ☐ OTHER _____

FUNCTIONAL LIMITATIONS

☐ VISION (GLASSES. ETC..) ☐ LEGALLY BLIND ☐ PARALYSIS ☐ HARD OF HEARING
☐ SPEECH ☐ BOWEL INCONTINENCE ☐ BLADDER INCONTINENCE ☐ AMBULATION
☐ DYSPNEA W/MIN EXERTION ☐ ENDURANCE ☐ CONTRACTURE ☐ AMPUTATION

PARAMETERS FOR CARE MANAGER NOTIFICATION

VITAL SIGN RANGES

TEMP _____ PULSE _____ RESP _____ WEIGHT _____

SIGNS/SYMPTOMS TO REPORT TO RN _____

SPECIAL PRECAUTIONS _____

SAFETY PRECAUTIONS ☐ Universal ☐ Cardio/Pulmonary ☐ Respiratory ☐ Wound ☐ Skin Breakdown ☐ Oxygen
☐ Aspiration ☐ Diabetic ☐ Bleeding ☐ Seizure ☐ Fall ☐ Infection Control ☐ Catheter ☐ 911 Protocol

NURSE SIGNATURE: _____ DATE _____

PATIENT SIGNATURE: _____ DATE _____

WHITE: AGENCY YELLOW: PATIENT FOLDER

Fatima Home Care, Inc.

Name:_____ Pt. #:_____ Dx:_____

	Personal Care		Nutrition		Elimination		Activity
	Bed Bath		Diet		Check BM each visit & chart		Complete bed rest
	Complete		Fluids		Bedpan		OOB in wheelchair
	Partial		Limit		Bedside commode,		OOB whit assist
	Tub Bath		Force		Bathroom		Walking
	Shower,		Prepare meal		I&O		Turns & position
	Shave		Serve meal		Empty drain bag		Side rails
	Shampoo		Feed patient		Chart amount		Range of motion
	Comb Hair		Wash dishes		S & A (urine)		Assist with walker
	Oral Hygiene				Ass't pt. to test urine		Crutches
	Nails (do not cut toenails)				Catheter care		
	TPR (Each visit)				Peri-Care		
	Check oral meds & freq.						

Other _____

_____

Chart any change in ADL status daily. Notify SN of any changes

_____

_____

_____

_____

_____

_____

RN Signature _____ Date: _____

Print Name _____ Print Title: _____

Legend: I = Independent A = Assist

Chinny Nurses Registry

HOME HEALTH AIDE CARE PLAN

Client Name: _____ **M.R. #:** _____ **Date:** _____
Address: _____ **Phone:** _____
Diagnosis: _____ **Diet:** _____ **Allergies:** _____

Functional status: ☐ alert ☐ forgetful ☐ disoriented ☐ depressed ☐ agitated ☐ blind ☐ vision impaired ☐ HOH ☐ deaf
☐ Speech/language ☐ unsteady gait ☐ fall risk ☐ seizures ☐ Diabetes ☐ Cardiac ☐ Oxygen ☐ other: _____

Safety measures: ✓ universal precautions ✓ maintain safe environment ✓ other: _____

Problems / needs: ☐ Mobility ☐ Environment ☐ Nutrition/Hydration ☐ Housekeeping ☐ Safety ☐ Personal Care ☐ ADL
☐ Skin Integrity ☐ Incontinent Bladder ☐ Incontinent Bowel ☐ Other: _____

Goals:
- Client's personal care/ADL needs will be met.
- Client's safe environment will be maintained
- Client/S.O. will be independent in personal care/ADL
- Client's nutrition/hydration needs will be met
- Client's skin integrity will be maintained
- Client will avoid accidents/injury.

Action/Task	Check (all that apply)	Action/Task	Check (all that apply)
Take and record TPR		Note client voiding	
Bed sponge bath		Note BM	
Shower		Catheter/Ostomy care	
Shave		Assist with Ambulation	
Skin care / Back rub		Assistive devices	
Oral Hygiene		☐ W/C ☐ cane ☐ Walker	
Comb / style hair		Assist with Transfers	
Shampoo hair		☐ Hoyer ☐ belt ☐ stand-by	
Dress client		Turn and Position every 2 hours	
Assist client dressing		Make bed/Care of sick room	
Feed client		Change lines weekly and PRN	
Assist with meal		Light housekeeping	
Encourage fluids		Grocery shopping	
Assist to bathroom/BSC		Client's laundry	
Offer bedpan / urinal		Prepare meals	

Notify SN of the following:
T above _____ bellow_____
P above _____ below _____
R above _____ below _____

Elimination: pain, discomfort or blood in stool Urine: cloudy, concentrated, visible sediment, difficult urination, catheter: clogged or leaking
Skin: reddened, dry, cracked, bruised, itching, discharge or bleeding.
Nutrition: change in appetite, fluid intake, Non-compliance with diet/fluid orders.

Activity: change in client's level of ability, weakness, unsteady gait, of any falls.
Environmental: frayed wires, scatter rugs, inadequate lighting, no phone, lack or malfunction of necessary equipment.
Psychosocial: change in behavior, level of orientation of emotional status.

R.N. Signature	Date	RN Signature	Date

Goldencare Home Health Agency Inc.

Home Health Aide Care Plan

TYPE OF BATH:	AM	PM
☐ Partial PRN		
☐ Complete PRN		
METHOD OF BATH:		
☐ Shower ☐ Tub Bath		
☐ Bed Bath ☐ Sponge Bath		
☐ Per Patient Preference (√ at least 2)		
PERSONAL CARE:		
☐ Oral Care ☐ Patient preference PRN		
☐ Skin/Back Care ☐ Patient preference PRN		
☐ Peri-Care ☐ Patient preference PRN		
☐ Shave ☐ Patient preference PRN		
☐ Shampoo ☐ Patient preference PRN		
☐ Foot Soak ☐ Patient preference PRN		
☐ Nail Care ☐ Patient preference PRN		
☐ Dress/Undress ☐ Patient preference PRN		
☐ Incontinence care PRN		
ELIMINATION Record Date of last BM		
OSTOMY CARE PRN		
☐ Empty ☐ Assist with Change		
CATHETER CARE PRN		
☐ Empty bag ☐ Record Output		
☐ Change Drainage bag(s) Q:		
☐ Apply bedside/leg drainage bag PRN		
☐ Apply/Remove external catheter PRN		
TED HOSE		
☐ Apply in AM ☐ Remove in PM		
AMBULATE PATIENT PRN		
☐ w/SBA ☐ w/Contact ☐ Using Gait Belt		
☐ w/Device:_____		
☐ Transport patient per Wheelchair		
ASSIST PATIENT TO TRANSFER PRN:		
☐ w/SBA ☐ w/Contact ☐ Using Gait Belt		
☐ Using Hoyer Lift ☐ With Maximum Assist		
☐ REMIND PATIENT TO TAKE MEDICATIONS		

ASSIST WITH EXERCISES:	AM	PM
☐ Perform PROM to: _____		
☐ Prompt patient to do AROM		
☐ Prompt patient to deep breath x _____ Reps		
☐ Reposition bed bound patient		
☐**ASSIST WITH NUTRITION:**		
☐ Diet:_____		
☐ Fluid Restrictions:		
☐ Prepare meals PRN		
☐ Feed patient PRN		
☐ Offer Fluids		
OTHER:		
☐ Grocery shop PRN		
☐ Change linen PRN ☐ Tidy bath PRN		
☐ Wash clothes PRN ☐ Tidy kitchen PRN		
VITAL SIGNS QVS Su M T W Th F Sa		
☐ Temp ☐ Pulse ☐ Respirations ☐ Weight		
REPORT V/S TO SUPERVISOR IMMEDIATELY		
If: Oral Temperature > 99		
Pulse Rate >100 or 60		
Respirations > 30 or < 12		
MENTAL STATUS:		
☐ Oriented ☐ Comatose ☐ Forgetful		
☐ Depressed ☐ Disoriented ☐ Lethargic		
☐ Agitated ☐ Other:_____		

Date	SPECIFIC CARE INSTRUCTIONS
	OBSERVE SAFETY PRECAUTIONS:
	☐ Fall ☐ Bleeding ☐ Seizure

Diagnosis: _____ Allergies: _____
Certification Period: From: _____ To: _____ HHA Frequency: _____
Certification Period: From: _____ To: _____ HHA Frequency: _____
Certification Period: From: _____ To: _____ HHA Frequency: _____

Date(s) Initiated, Reviewed/Revised

Date:	Date:	Date:	Date:
☐No change CM_____	☐No change CM_____	☐No change CM_____	☐No change CM_____

Patient Name: _____ MR #_____

Professional Signature:_____

Preferred Home Health Agency, Inc.

AIDE ASSIGNMENT/*TAREAS DE LA ASSISTENTE DE ENFERMERA*

PATIENT NAME (Last, First) *Nombre del Paciente*	MR#	SOC DATE/*Fecha de Inicio*	TYPE OF DIAGNOSIS/Diagnóstico

Vive solo, sordo, ciego, olvidadiso, *Lado débil, Dieta*
Lives alone, deaf, blind, forgetful, _____ sided weakness, Diet _____
Pl. Care Supervisor _____, Care Team Nurse, PT, ST, OT, Social Worker, Dietician
Supervisor

PRECAUCIONES:
PRECAUTIONS
Convulsiones
☐ Seizure
☐ Oxygen *Oxigeno*
Limitaciones de Peso
☐ Weight bearing limitations _____
☐ Activities not permitted _____ *Actividades no permitidas*
Retención de Fluido
☐ Fluid restriction _____
☐ Safety _____ *Seguridad*

OBSERVE, RECORD and REPORT CHANGES *OBSERVE y REPORTE CAMBIOS*

- ☐ Temperature/Temperatura
- ☐ pulse/pulso
- ☐ Respiration/Respiración
- ☐ Appetite/Apetito
- ☐ Skin Condition/Condición de la piel
- ☐ Mood/Attitude/TemperamentoActitud
- ☐ Pain/Dolor
- ☐ SwellingSudoración
- ☐ Last BM/Ultima vez al baño
- ☐ Intake and Output/Liquidos Tomados y Salidas
- ☐ Urine in bag-amount and color/Orine en bolsa, cantidad y color
- ☐ Ostomy bag contents-amount and type/Bolsa de Ostomia

PERSONAL CARE *CUIDADO PERSONA*

- ☐ Bed bath/Baño en cama
- ☐ Commode bath/Baño con asistencia
- ☐ Tub bath with seat/Baño con silla
- ☐ Shower with assist/Ducha con asistencia
- ☐ Shampoo
- ☐ Brush/comb hair/Cuidado del pelo
- ☐ Oral care/Cuidado bucal
- ☐ Clean dentures/Limpiar dentaduras
- ☐ Clean, file nails/cuidar uñas(no cortar)
- ☐ Shave/Afeitar
- ☐ Skin care with lotion/Cuidado de la piel con loción
- ☐ Back rub with lotion/Masaje espalda con loción
- ☐ Foot care-clean, dry, inspect/cuidado de los pies. inspeción
- ☐ Perineal care/Cuidado area perianal
- ☐ Catheter care/Cuidado de las sondas

ELIMINATION *ELIMINACION*

Assist with Asistir con:
- ☐ Bed pan/cuña
- ☐ Bedside commode/Silla comodín
- ☐ House bathroom/Baño de la casa

Empty/*Vaciar*
- ☐ Urine bag/Bolsa de Orine
- ☐ Commode bucket/Recipiente del Comodín
- ☐ Ostomy bag/Bolsa de Ostomia

Change/Cambiar
- ☐ Urine night or leg bag/Bolsa del pie de Orine
- ☐ Diapers/Pampers
- ☐ Underpad/Ropa interior

ACTIVITY *ACTIVIDADES*

- ☐ Bedrest/Descanso en cama
- ☐ Turn/reposition in bed/Mover-posicion en cama
- ☐ Side rails up/Agarraderas
- ☐ Dangle
- ☐ Passive ROM/movimientos pasivos
- ☐ Exercises as Therapist taught/Ejercicios
- ☐ Trasfer to chair/Transferirse a la silla
- ☐ 1 person assist/Asistencia de 1 persona
- ☐ 2 person assist/asistencia de 2 personas
- ☐ Hoyer lift/Grua
- ☐ Walk independent with standby/Camina independiente
- ☐ Walk with assist/Camina con asistencia
- ☐ Walker/Burrito
- ☐ Cane/Bastón
- ☐ 1 person/persona
- ☐ 2 persons/personas

ADL

- ☐ Dress patient/Vestir al paciente
- ☐ Assist Dress patient/Ayudar a vestir
- ☐ Bedside commode/Silla comodín
- ☐ **Clean and Straighten/Limpiar**
- ☐ Bedroom/Cuartos
- ☐ Bath area/Baños
- ☐ Kitchen if used/Cocina si es usada
- ☐ Change bed each visit/Cambiar cama cada visita
- ☐ Change bed PRN/Cambias cama si es necesario
- ☐ Shopping/Compras
- ☐ **Laundry/Lavar ropa**

NUTRITION

- ☐ Encourage fluids/Reenforzar líquidos
- ☐ Check foods available/Chequear comida disponible
- ☐ Prepare and serve meal PRN/Preparar comida
- ☐ Assist with feeding as needed PRN/Alimentar

Additional information:
Información Adicional: _____

SIGNATURE/*FIRMA* OF RN ORIGINATOR: _____

DATE/Fecha	CHANGES / REVIEWED PLAN/Cambios	SIGNATURE/Firma