# APD Care Plan Version

# ACHP Classification Level Worksheet for Adult Care Home Operators

**See MCAR’S 023-800-400 through 023-080-425:** Operators shall complete this worksheet as part of the Care Plan once the resident has been in the home for up to 14 days. (Initial class worksheet is completed as part of the screening). Care Plans rewritten annually.

**Resident Name:** **DOB:**  **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Definition**  **Independent Assist Full Assist**

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| **Eating**  Feeding and eating; may include using assistive devices | Needs no assistance  Considered independent even if set-up, cutting up food, or special diet needed. | Requires another person to be immediately available and within sight. Requires hands-on feeding or assistance with special utensils, cueing while eating, or monitoring to prevent choking or aspiration | Requires one-on-one assist for direct feeding, constant cueing, or to prevent choking or aspiration. Includes nutritional IV or feeding tube set-up by another person*. Needs assistance through all phases, every time.* |
| **Dressing and Grooming**  Dressing and undressing; grooming includes nail care, brushing and combing hair. | Needs no assistance | Needs assist in dressing, or full assist in grooming (cannot perform any task of grooming without the assistance of another person.) | Needs full assist in dressing. (cannot perform any task of dressing without the assistance of another person.) |
| **Bathing/Personal Hygiene**  Bathing includes washing hair, and getting in and out of tub or shower. Personal hygiene includes shaving, and caring for the mouth. | Needs no assistance | Requires assist in bathing, **or** full assist in hygiene. (needs hands-on assist through all phases of hygiene, every time, even with assistive devices.) | Requires full assistance in bathing. (needs hands-on assist through all phases of bathing, every time, even with assistive devices.) |

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| **Mobility** Includes ambulation and transfer. Does NOT include getting to/from toilet or in/out of shower/tub or motor vehicle. | Needs no assistance | Must require assistance of another person with ambulation, **or** with transfers, **or** with both. | Must need full assist with ambulation **or** with transfers **or** both. Unable to ambulate or transfer without the assistance of another person throughout the activity, every time, even with assistive devices. |
| **Elimination**  Toileting, bowel & bladder management includes getting on/off toilet, cleansing after elimination, and clothing adjustment; catheter and ostomy care, toileting schedule, changing incontinence supplies, digital stimulation. | Needs no assistance. Continent, or manages own incontinence | Requires assist with bladder care **or** bowel care **or** toileting. Even with assistive devices, the individual is unable to accomplish some tasks of bladder care, bowel care, or toileting without the assistance of another person. | Requires full assist with bladder care **or** bowel care **or** toileting. Full assist means that the individual is unable to accomplish any part of the task and assistance of another person is required throughout the activity, every time. |
| **Cognition/Behavior**  **8 components**: Functions of the brain (5) : **adaptation, awareness, judgment/ decision-making, memory, orientation.**  Behavioral symptoms (3): **demands on others, danger to self, wandering** | Needs no assistance | Needs assist in at least 3 of the 8 components of cognition and behavior.  Assist implies that the need is less than daily, or if daily, impairment is not severe. | Needs full assist in at least 3 of the 8 components of cognition and behavior.  Full assist implies that the need is ongoing and daily. The level of impairment is severe. |

**Independent** **Assist Full Assist**

**Total:**

**Class Level: ­­­­­**\_\_\_\_\_\_\_

**Class I** = Assist with 4 or fewer ADL and not full assist in any ADL

**Class II** = Assist with all ADL, full assist in no more than 3.

**Class III** = Full assist (dependent) with 4 or more ADL.

**Name of RN or Physician responsible for monitoring client care in the home:**

**Phone: Frequency of visits:**

APD Adult Care Home Care Plan

Resident Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of annual plan: \_\_\_\_\_\_\_\_\_\_\_\_\_ Update: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Operator Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Eating**  **Special diet:**    **General appetite:**  **Allergies:**  **Special equipment:**  **Preferences:** | **What resident does:** | **What caregiver does/when:** |

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| **Dressing**  **Equipment:**    **Day preferences:**  **Night preferences:**  **Other:** | **What resident does:** | **What caregiver does/when:** |
| **Grooming**  **Nail care**   * **Fingernails:** * **Toenails:**   **Brushing/combing hair**    **Preferences:**  **Other:** |  |  |

**Residential Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Bathing**  **Frequency:**  **Schedule:**  **Time Required:**  **Equipment:**    **Transfer:**  **Preferences:** | **What resident does:** | **What caregiver does/when:** |
| **Personal Hygiene**  **Shaving**  **Frequency:**  **Schedule:**    **Caring for the mouth**  **Frequency:**  **Dentures:**  **Schedule:**  **Preferences:** |  |  |

**Residents Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| **Mobility**  **Ambulation**  **Equipment :**  **Transfer**  **Equipment:**    **Preferences:**  **Special Transportation Needs:** | **What resident does:** | **What caregiver does/when:** |
| **Elimination**  **Toileting:**    **Transfer:**  **Other assist:**    **Bladder management:**  **Bowel management:**    **Equipment/supplies:**  **Schedule:** |  |  |

**Residents Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Cognition**  **Adaptation:**    **Awareness:**  **Judgment/decision making:**  **Memory:**  **Orientation:** | **What resident does:** | **Interventions:**  **What caregiver does/when:** |
| **Behavior (describe)**  **Demands on others:**    **Danger to self:** |  |  |

**Residents initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| **Night Needs**  **Toileting/Incontinence care:**  **RN consultation:**    **Medication:**  **Equipment:**  **Other needs:**  **Resident’s preferred bedtime:**  **Other preferences:** | **What resident does:** | **What caregiver does/when:** |
| **Communication Needs**  **Glasses:**  **Hearing Aids:**  **Interpreter:**  **Other:** |  |  |

**Residents Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Medical Concerns**  **Health Issues to Monitor:**      **Treatment/Therapies/Procedures:**  **RN Consultation:**  **RN Delegation:**  **Physical Restraints:**  **Allergies:**  **Other:** |

**Residents initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- |
| **Social/Spiritual/Emotional**  **Activity Needs:**  **Church affiliation:**  **Clubs:**    **Social Contacts:**  **Activities Preferred:** | **What resident does:** | **What caregiver and/or**  **significant others do:** |
| **Exiting in an Emergency**  **Equipment needed:** |  |  |

**Residents Initials:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

APD Care Plan Signature Page

**Name of Resident:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of annual Plan:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signatures: Dates:**

Operator Annual Plan 6 month review change of condition

Resident Annual Plan 6 month review change of condition

Resident’s Representative Annual Plan 6 month review change of condition

**Signature: Dates:**

Caregiver Annual Plan 6 month review change of condition

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