

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Medical Care Policy Administration

ADULT DAY CARE ASSESSMENT AND PLANNING SYSTEM

11/84; 8/88; Revised 8/98; Revised 2-25-09

ADULT DAY CARE ASSESSMENT AND PLANNING SYSTEM

1998 WORKING GROUP MEMBERS

Barbara Kawczynski	The Support Center, Inc.
Marilyn Kirby	Winter Growth, Inc.
Adrienne Johnson	Waxter Adult Day Care Center
Carolyn Johnson	Crescent Cities Adult Day Care
Kathy Boyd Mansfield	Daybreak Adult Day Care, Inc.
Christina Peach	Eldersburg Eldercare
Jan Pennington	Senior Connections, Inc.
Connie Roby	Stoneleigh Adult Day Care
Brenda Russell	Elder Health, Kirk Ave.
Marge Turner	Pikesville Adult Day Treatment

Local Health Department Representative

Virginia Griffin, R.N.,	Baltimore County Health Department
-------------------------	------------------------------------

INTRODUCTION TO THE ADULT DAY CARE ASSESSMENT AND PLANNING SYSTEM

	Page
I. ASSESSMENT	
A. The Process	4
B. Schedule of Completion	4
C. Coding	5
D. Comments	5
E. Assessment Categories	6
F. Progress Notes	9
II. CARE PLANNING	
A. The Process	9
B. Participant - Focused Care Plans	10
C. Identifying Problems	10
D. Goal Setting	11
E. Selecting Approaches	11
F. Responsible Staff	12
III. EVALUATION	
A. Assessing Outcomes	12
B. Updating the Care Plan	12
IV. Addendum:	13
The Care Plan with Instructions	a
Optional Physical Assessment Guide	b

INTRODUCTION TO THE ADULT DAY CARE ASSESSMENT AND PLANNING SYSTEM

The primary purpose of the Adult Day Care Assessment and Planning System is to provide a standardized format for participant assessment and care planning. It is a working document to be used by all members of the adult day care team.

This system enables staff to assess the participant's strengths as well as problems and needs on a regular, on-going basis, so that improvement and/or deterioration in every area becomes evident.

Through the care planning process, measurable goals and specific approaches are defined. The use of numerical codes provides an objective evaluation of the participant's progress in achieving goals and an evaluation of the appropriateness and effectiveness of the approaches.

I. ASSESSMENT

A. The Process

A comprehensive assessment of a participant's strengths, needs, and abilities is the first step to providing quality care. By evaluating the participant's functional status, it is possible to begin to define the nature of the services which will be needed to assist that individual in achieving or maintaining the optimal level of functioning possible.

In the Adult Day Care Assessment and Planning System, there are 12 categories of assessment to enable each participant to be assessed under the same terms and at regular intervals. It is designed so that each specific discipline (nursing, social work, therapeutic activity, etc.) may utilize their expertise for that specific part of the assessment related to their area of training.

B. Schedule of Completion

The entire assessment is to be completed during the first month of enrollment and quarterly thereafter. The number codes may remain the same unless there is a change noted. If the code represents a static condition, there is no need to document the number code monthly. If, however, this is a condition which requires intervention, indicate the code but there is no need to

comment unless there is a change. A comment needs to be made at the time of change. In the event that it has been unable to evaluate a participant in a particular month, record "A" at the top of the first page in the space designated for DATE and record the reason for absence or unavailability (such as hospitalization, vacation, etc.) in the progress note section.. Care must be taken that in the succeeding months, the space is then left blank or inability to evaluate noted.

C. Coding

The coding system is provided specifically for each assessment section. During each assessment a code is selected to reflect the participant's status or ability. Often there is an "Other" code provided so that information not provided can be noted. When this occurs, note the code for "Other" in the code space and give the details in the comment section with the appropriate date. It is also possible that more than one code will apply. Several codes may be entered in one "box" as necessary to fully describe the participant's status. **NOTE THAT A CODE SHOULD BE ENTERED EVERY MONTH WHEN INTERVENTIONS ARE INDICATED.** Enter a zero (0) if no problems are assessed or if stated findings do not apply in that particular area.

An "Unknown" will periodically be listed as an option. Occasionally, not all areas can be assessed at a given point in time, due to the nature of the participant's limitations, caregiving situations, or other variables.

A column should be dated for each month at the top of the page, so that it is readily apparent that monthly assessment has taken place. Note that the date is only entered once on each page in the box provided at the top of the page. The other boxes are for codes. Evaluators should initial the bottom of the designated columns after each section which he/she has assessed. The last page of the assessment is designated for staff members, representing specific disciplines, to enter their initials, signature and discipline.

D. Comments

Comments are used to provide individual detail to the coded information provided on the form. Codes cannot be infinitely descriptive, therefore comments are to be written by the staff to relate specifics about the participant. Every time a code changes within an assessment section, a comment should be written describing the nature of the change.

Comments should be brief and to the point. Remember that progress notes should be used to expound on short term acute problems that develop and to detail how staff handle them. Comments may begin and end on any line, therefore precede each

comment with a date. If staff need more space for comments, a sheet of paper may be added to the assessment.

Comments are necessary to give a clear and up to date picture of the participant. When the various areas are re-assessed each month, comments are necessary only to describe significant change(s). Comments are not to be used to duplicate or to take the place of a progress note or to be repetitive.

Following is an example of a completed assessment area.

ADL	Date	Code	Comments
Toileting Independent Independent, but requires reminding/cueing Supervision (Some) physical assistance required Dependent	1/5/98	3	Needs STAFF to
	2/5/98	3	observe Her in Bathroom
	3/6/98	3	provide cues, esp. with clothing
	4/5/98	4	4/5/98 Note
	5/6/98	4	CONFUSED ABOUT Her clothing AND Needs ASSISTANCE IN ARRANGING HerSELF After toileting. 5/6/98 IS
	6/2/98		SOMETIMES MILDLY RESISTANT TO ASSISTANCE

E. Assessment Categories: Definitions

There are 12 categories of assessment with the suggested discipline evaluators as follows. The disciplines listed are not required to perform the assessments but are rather offered as possible sources. This is a participant focused assessment, for example, in the section Communication Patterns, indicate the status of the participant's ability to hear, etc.

I. Physical Assessment:

The Health Assessment section is designed to be used in conjunction with the physician's report and orders and other pertinent data. Information from the caregiver and observations by the various disciplines should also be incorporated. The areas addressed will allow for ease in identifying health problems which may need special attention while at the adult day

care center. Further, the health problems may indicate a need for special program plans, adaptations, or referrals to meet individual needs.

Each assessment area is specific. Select the numerical code (or codes) which best describes the participant's status and record in the corresponding space. Comments are always necessary when changes occur with re-evaluations. Comments are not restricted to specific lines but all comments must be preceded by a date.

Most areas have "Other" listed as a choice. Document the finding in the comment section with the date. If there are no changes at the time of evaluation, and the codes are not changing, no comment is necessary.

II. Functional Assessment:

This section focuses on communication abilities and continence status. Select the numerical code (or codes) which best demonstrates the status of the individual participant. It is not necessary to repeat information previously stated unless there is change to report. Document changes as appropriate. In the section, Communication Patterns, "hears in special situations only", reference is made to placement in groups, etc.

III. Mobility Assessment:

This section focuses on the strengths/limitations affecting the mobility status of the participant. Comment if changes occur or if additional information is necessary to give a clear picture of the participant.

IV. ADL Assessment:

This area will give a picture of the participant's abilities to perform the ADL's of grooming, dressing, bathing, toileting and the eating/feeding status.

V. Medication Management:

Allergies should be documented in this section. Focus on issues of the participant's abilities to appropriately self medicate or the appropriate management of the medications. Assistive devices, such as "pill boxes" may be documented in this section.

VI. Therapies:

Additional therapies should be documented in this section.

VII. Nutritional Assessment:

Document diet, restrictions and/or special needs for the individual. Poorly fitting dentures would be addressed as Other in the Mouth/Oral Health section.

VIII. Aspiration Pneumonia Risk Assessment:

An OPTIONAL section entitled "Aspiration Pneumonia Risk Assessment" has been added. It is recommended that this be completed when there is a concern about a participant's swallowing ability. If a score of 5 points or more is found, then it is recommended that a referral be made to the primary health care provider.

IX. Home Management Assessment:

This section is designed for assessment of an individual's current activities in home management and to provide a picture of the amount of assistance available to the participant.

This section is to be completed to the degree possible within the first thirty (30) days. Due to the fact that this information rarely changes for some participants, re-assessments may be completed on an annual basis. It should be completed regularly for participants whose abilities are changing fairly regularly.

X. Mental/Behavioral Assessment:

This section provides a mechanism for the evaluation of the level of orientation, cognition, thought processes, decision making abilities and judgement. Document any assessments in the comments section. For acute problems document in more detail in progress notes.

Clinical Depression Assessment: Optional

Although this area is OPTIONAL, many participants would benefit from this evaluation. If more than 3 behaviors can be identified as occurring consistently, it is recommended that the findings be discussed at the next interdisciplinary team meeting and a referral for mental health follow-up be considered and discussed with the caregiver(s). If any of the behaviors are noted, document the specific findings in the comment section.

XI. Psychosocial Assessment:

This section addresses the participant's support system, need for and use of community resources and caregivers'

concerns. If discharge is anticipated, address this in the appropriate section, such as Adjusted to Present Residence, and a discharge plan should be initiated indicating steps taken, such as, education, referrals, planned follow-up, etc.

Utilization of Community Resources should indicate issues related to medical health insurance, Adult Protective Services involvement, Advance Directives, etc.

XIII. Activities Assessment:

A change in a participant's level of abilities, attention or motivation levels needs to be documented in this section. Additional information such as an activities profile with past and current interests should be included elsewhere in the record. Issues and concerns should be added to the plan of care.

F. Progress Notes

A progress note is necessary to supplement the monthly assessments when there is significant change or an incident involving the participant. They are not required to be used to record ordinary observations or to replace the assessment in identifying on-going problems. Progress notes should not take the place of an Incident Report which is reviewed by the director.

If there has been a significant change or an unusual episode, progress notes should be written, describing the concern or issue, actions taken by the staff and the participant's responses. When it is time again for the monthly re-assessment, any changes which have occurred need to be recorded in the appropriate section of the assessment. If one is reporting an isolated incident which is quickly resolved, it will probably not require incorporation into the assessment and care plan but should be documented with an appropriate progress note.

II. CARE PLANNING

A. The Process

Use of a team approach to care planning is one of the keys to providing quality care. The entire staff's knowledge, expertise and efforts with a participant can be coordinated and focused. The care plan must incorporate the input of all staff, not just that of one discipline.

The selection of a team leader can greatly facilitate the assessment/care planning process. The primary function of

the team leader is to coordinate the efforts of all staff involved in direct care to assure they are knowledgeable and accountable to their tasks, and to lead regularly scheduled care planning meetings.

The care plan must be evaluated and updated at least once every 6 months. The Medical Assistance program requires that the care plan be updated every 3 months for Medical Assistance recipients.

B. Participant Focused Care Plans

The care planning process can be much enhanced by seeking the participant's interest and involvement. It is very difficult for a participant to benefit as much as possible from the team's effort if he does not know what is to be done on his behalf and for what reasons.

Of course, the extent to which a participant can be involved in this process is going to vary with the capacity that the individual has to understand and make use of the information. However, the majority of participants will likely benefit from the sharing of at least information about the intended plan of care.

Family or caregivers should also be involved in the care planning process to the extent possible. Their ability and willingness to assist in follow through activities at home and to provide staff with valuable information is dependent on their knowledge of the plans developed for the participant.

Again, for many reasons not all family or non-related caregivers can be highly involved in the planning process. It is also very important to keep in mind that the participant has a right to privacy. What is communicated to family/caregivers should always be weighed against this consideration.

C. Identifying Problems

During the assessment process, strengths as well as problems will begin to be identified. Sources of information will include the physician(s) report and orders, the home assessment, staff observations, and information from the participants, the family or caregiver(s). The strengths and problems which are identified should provide the foundation of a comprehensive guide to working with the participant. Documentation should be descriptive and to the point. Medical diagnoses for example, should not be listed as problems. Instead, the symptoms of the medical problem which interfere with functioning should be highlighted. That is, merely stating the fact that someone has had a stroke is not helpful in indicating

what special care and services are needed. What is useful is the specific information about the limitations caused by the stroke, which can then be translated into the need for assistance or re-training in dressing, toileting, ambulation, rehabilitation therapies, etc.

D. Goal Setting

Goals state the desired outcomes of the care provided to the participant. They must be practical and reflect an outcome which can be realistically attained. Long term goals are developed to indicate desired outcomes for a future point in time. Conversely, short term goals identify the desired outcomes to be achieved within a one month to six month period.

Examples of long and short term goals are as follows:

Long Term Goal: "Provide creative arts therapies to reduce isolation, depression and to improve overall quality of life."

Short Term Goal: "Orient to new surroundings and introduce to other participants within the first week of attendance."

One of the key factors in establishing goals is including meaningful measurements so that progress toward achievement can be determined. That is, goals should be measurable in time and degree whenever possible. For example, if the problem being addressed is "dependency in maintaining personal hygiene" the goal may be: "To increase independence, participant will assist with grooming by washing/drying face and hands within one month". In this example, degree is specified by detailing exactly what the participant will do - washing and drying face and hands. The goal is also measured in time - one month.

E. Selecting approaches

It is often easy to confuse goals and approaches. It is helpful to keep in mind that approaches are the instructions to staff about what care or services need to be provided, how often and by whom. These care instructions outline the steps to be carried out for goal achievement. Approaches should be specific and in enough detail to give a clear picture of the care needed by the participant. For example, using the short term goal listed above, the following approaches may be appropriate:

Short Term Goals

1. Participant will wash face and hands independently or with cuing only within one month.

Approaches

1. Provide participant with a wash cloth after lunch and provide cuing as needed

F. Responsible Staff

Those assigned with primary responsibility for a given intervention should be identified by discipline, for example, nursing, social work, activity therapy, etc.

G. Sample Forms

A sample Plan of Care form is included in the Addendum as well as a Guide for Adult Physical Assessment. These are meant to be utilized as guides for the assessment process.

III. EVALUATION

A. Assessing Outcomes

The success and appropriateness of the goals and approaches which were chosen must be assessed. At this time, the staff decides what needs have been met and where further attention should be directed. The evaluations and comments which are documented at least every 6 months, gauge the success of the plan of care and indicate what changes are needed in the goal statements or approaches. Are the goals that were set realistic? Should the approaches be continued or modified in some way?

The "Goals Met" area of the care plan provides a way to numerically "rate" the level of goal achieved. While somewhat subjective, continued use of the ratings should lead to consistency by staff.

B. Updating the Care Plan

Care plans must be updated with regularity, according to the timetable established in the goals or at least every 6 months (every 3 months for Medical Assistance recipients). The updating process includes more than an assessment and re-thinking of the current plan. During this review, any new problems should be documented and appropriate goals and approaches selected. At the same time, problems which no longer exist can be deleted from the plan. The date that the problem was resolved should be noted beside or in the comment section.

The importance of assessing and re-thinking the care plan on a regular basis can not be over emphasized. During this

process, staff must evaluate the appropriateness of the day care program in meeting the participant's needs. The continued need for adult day care services must be closely examined. Does the participant need a higher level of care or is discharge to a lower level of care appropriate? Discharge planning should involve all staff and be incorporated into the participant's plan of care.

IV. Addendum:

Sample forms are included.

The Plan of Care form is also found in the MCPA Quality Assurance Manual and is to be used as directed at a minimum of every 6 months (every 3 months for Medical Assistance funded participants).

Adult Physical Assessment Guide is meant to be utilized as a guide in the assessment process as needed.

ADDENDUM

Guidelines for completing the PLAN OF CARE

- A. Identification:** Name of participant and some identification number - e.g. MHRPC #, Center Identification #, Social Security #, etc.
- B. Problem(s):** These are presenting problems or issues that should be addressed in the plan of care.
- C. Long Term Goals:** These represent the goals for the participant which will be addressed over the long term. They may include the following:
- (1) Prevention of avoidable deterioration
 - (2) Maintenance of functional level of participants
 - (3) Opportunities for growth and development or to improve general health status
 - (4) Activities to reduce isolation or improve overall quality of life
 - (5) Relief for caregivers
 - (6) Restoration/rehabilitation
- D. Date:** The date that the expected outcome/short term goal is formulated by the Team.
- E. Expected Outcomes/Short Term Goals w/Time Frames:** These represent the objectives or measurable outcomes that can be anticipated if the planned services are carried out and if the participant and his/her caregiver(s) cooperate generally with the plan.
- F. Services, Approaches, Interventions:** These should be as specific as possible. They are the particular program activities or specific interventions which will be carried out. They should detail staff responsibilities and actions to achieve the desired outcomes.
- G. Responsible Staff:** Those assigned with primary responsibility for a given activity or intervention. They could include any of the following:
- | | |
|-----------------------|------------------------------------|
| Nursing | Other therapists (incl. physician) |
| Social Work | Transportation |
| Recreation/Activities | Other |
| Dietary/Nutrition | |
- H. Review Date:** The date upon which the Team reviews the plan to monitor progress, update documentation and conduct QA reviews.
- I. Services rendered and accepted:** This refers to both the Center's actual activity on behalf of this participant, as well as his/her cooperation and involvement in the plan of care. It essentially begins the process of addressing the question, "What has occurred" and impacts directly on outcomes.
- J. Goals met:** This provides a way to "rate" the level of goal achievement, using the explanation given on the Form itself. While admittedly subjective, continued use of these ratings by staff should lead to fairly useable consensus.
- K. Comments:** Comments should serve to explain the entries in the Reviews columns and relate to the Health Care Audit/Utilization Review Form.

ADULT PHYSICAL ASSESSMENT GUIDE

1. GENERAL APPEARANCE ASSESSMENT

Techniques: Inspection

- apparent state of health
- cleanliness
- nutritional status
- level of distress
- ability to make/maintain eye contact
- facial expression
- affect
- gait
- ability to maneuver environment.
- body symmetry
- body build in relationship to height and weight
- speech

2. MENTAL STATUS ASSESSMENT

Technique: Inspection

- orientation
- attention/concentration
- judgment
- memory-remote/recent (long term/short term)
- thought content/processes
- mood/ affect
- differentiate delirium, dementia, depression

3. VITAL SIGNS

4. SKIN ASSESSMENT

Techniques: Inspection and Palpation

Skin

- condition
- color
- moisture
- texture
- temperature
- turgor
- hygiene
- lesions
- tenderness/burning/itch/irritations
- skin over bony prominence
- presence of pressure sores

Hair

color
distribution
texture
scalp lesions

Nails

surface
color
shape
consistency
lesions
clubbing
capillary refill

5. HEAD AND NECK ASSESSMENT

Techniques: Inspection, Palpation, Percussion, and Auscultation

Skull

size/shape/proportion
symmetry
depressions/indentations

Skull

color, texture
lesions, scaling
"creepy crawlers"
tenderness/pain

Hair (see under skin)

Face

shape
color
symmetry
proportion
drooping
involuntary movements
facial expression
temporal/cranial arteritis evaluation
pulse volume assessment, comparison r/l
presence of bruits/thrills
tenderness on palpation
swelling/nodularity
heat
redness
c/o headache, local tenderness, visual deficits

Eyes

Eyes, eyelids and brows (perform gross exam then detailed)

size, shape, protrusion

color

hair distribution of brows and lashes

blinking

drooping

= closure of lids

lesions

extraocular movements (EOMs)

eyeball mobility

periorbital edema

swelling or inflammation

Iris, pupil, sclera, conjunctiva, cornea

color

inflammation

pupillary reaction

corneal opacity

extra ocular muscle function

Ears

location/symmetry

color

tenderness

lesions

drainage

auditory function

Nose

size

color

swelling

displacement/deformities

tenderness

nares =?

flaring

septum tilting

drainage/crusting

sniff test (to detect symmetrically open passageways)

sinus tenderness

smell test (to detect loss of sense of smell)

Mouth (examine outside then in)

lips-symmetry, color, cracks, fissures, ulcerations, lesions, swelling, breathing pattern
gums-color, inflammation
oral mucosa-color, moisture, lesions
teeth-color, presence/absence, broken, inflammation
tongue-color, moisture, position, ability to move, coating, ulcerations, scarring, lesions,
hard and soft palate-color, lesions
uvula-color, mobility
tonsils-color, size, inflammation

Neck

size/length and width
shape
symmetry
hypertrophied neck muscles
curvature
involuntary muscle movements
presence of masses
range of motion
tracheal deviation
thyroid enlargement/masses
jugular venous distension
carotid pulse evaluation
bruits
thrills
=pulse amplitude
enlarged nodes

6. CHEST ASSESSMENT: Respiratory

Techniques : Inspection, Auscultation, Percussion, Palpation

breathing position
chest cavity(note front and back)
size
shape
symmetry
curvatures/deformities
AP: Transverse measurement
excursion
retraction/bulges
respiration rate, rhythm, depth
sputum(presence, color consistency, odor)
cough

breath sounds

anterior/posterior/lateral comparison

R to L: comparison

present/ absent/ diminished

normal/abnormal

normal sounds heard in right location

bronchial -over trachea

bronchovesicular-over main stem bronchus

vesicular-lung periphery

adventitious sounds (abnormal sounds)

rales (crackles)

rhonchi

wheezes

pleural friction rub

sound classification

intensity: mild moderate or severe

frequency: continuous or discontinuous

quality: fine, medium or course

place in respiratory cycle (inspiration/expiration)

chest palpation

areas of tenderness

respiratory symmetry of expansion

chest percussion

areas of suspected consolidation

Advanced Respiratory Assessment Techniques

palpation for tactile fremitus

auscultation for voice sounds

Cardiac

Techniques: Inspection, Palpation prn, and Auscultation

Chest Wall Inspection

pulsations

exaggerated lifts/heaves

Chest Wall Palpation

areas of visible pulsations, lifts, heaves

Heart Sound Auscultation

S1 and S2)

rate, rhythm (regular/irregular)

Advanced Cardiac Assessment

Auscultation

S3 and S4

murmurs and friction rubs

7. ABDOMINAL ASSESSMENT

Techniques: Inspection, Auscultation, Palpation, and Percussion

Abdominal Inspection

- size
- shape
- contour
- symmetry
- masses, bulges, distension
- lesions/scars/striae/superficial veins
- status/position/color of umbilicus
- respiratory movement
- peristaltic waves
- abdominal aortic pulsation

Bowel Sound Auscultation (all four quadrants)

- present/absent
- hypoactive/hyperactive

Vascular Sound Auscultation (over abdominal pulse sites)

- bruits (if present, palpate for thrill once auscultation is completed)
- venous hums
- friction rubs

Abdominal Percussion

- dullness/tympany
- bladder distension
- areas of suspicion (where bowel sounds not heard)

Abdominal Palpation

- pain/tenderness
- guarding
- masses
 - location
 - consistency
 - size
 - pain
- thrills over pulse sites

8. EXTREMITIES ASSESSMENT

Techniques: Inspection and Palpation: Consider bone, muscle, joints, attached skin, innervation and sensation

gait evaluation

normal/abnormal ambulation

type of abnormality (hemiparetic, parkinsonian, ataxic, steppage)

posture

balance

coordination

smoothness

ability to get up and sit down

utilization of assistive devices to enable ambulation

extremity assessment (arms, hands, fingers, legs, feet, toes)

size

shape

symmetry

alignment

atrophy/deformities/amputations

knotted muscles

joint swelling

enlarged bony prominences

contractures

color

temperature

inflammation

tenderness

lesions

varicosities

changes in sensation

pins and needles

numbness

tingling

irregular/uncoordinated movement : tremors, tics, spasms, fasciculations

swelling

joint range of motion

local crepitus

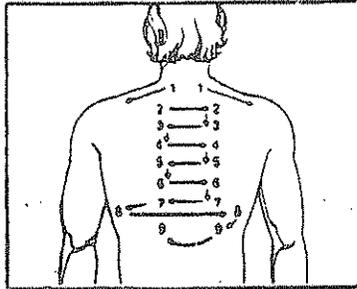
muscle strength from side to side

weakness

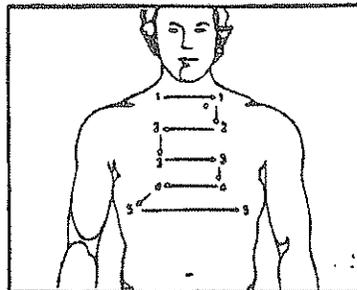
paralysis

breath sounds

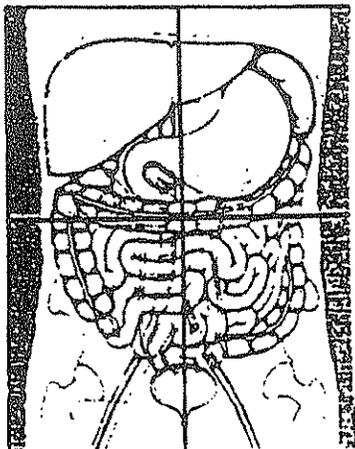
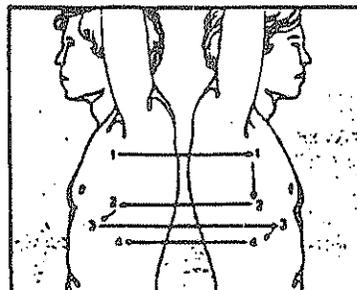
Posterior sequence



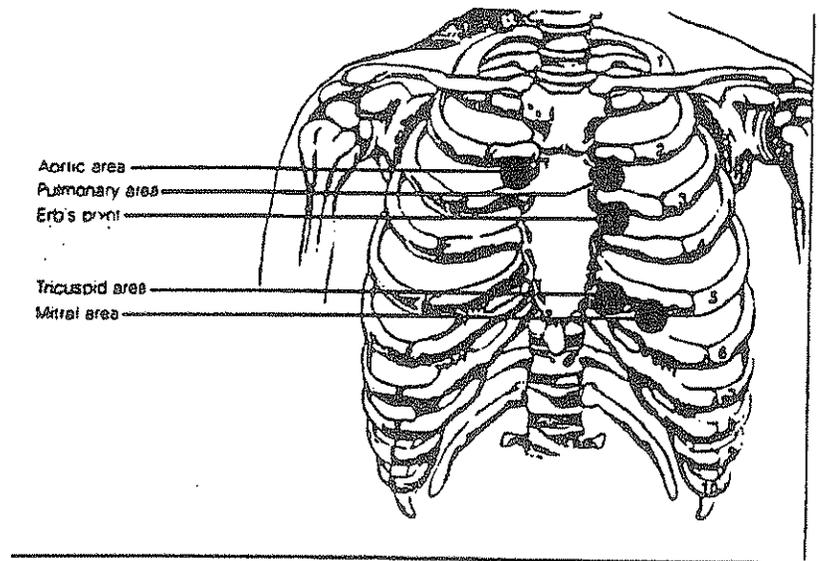
Anterior sequence



Lateral sequence



heart sounds



bowel and abdominal vascular sounds

