presbyterian homes & services

Individual Service Agreement/ Functional Assessment/Plan of Care

Resident Name:_____DOB:_____Sex:_____Date:_____

Physician:_____Diagnosis:_____

Bathing

____ Independent

____ Shower (one person assist): service should not exceed 30 min. Includes trimming of nails only if able to be clipped with a regular nail
____ clipper. Not available for diabetics or those taking blood thinning medications. Includes assist with washing back, hair, feet, difficult to reach areas and drying off.

____ Whirlpool/Sponge (one person assist): service should not exceed 30 min. Includes trimming of nails only if able to be clipped with a
____ regular nail clipper. Not available for diabetics or those taking blood thinning medications. Includes assist with getting in and out of whirlpool, set-up of supplies, washing/drying back, hair, feet and difficult to reach areas.

Grooming/Dressing

____ Independent: Can wash hands and face, comb hair, brush teeth or dentures, shave, and use deodorant without help. Able to put on, fasten and remove all clothing without any help.

____ Ted Hose/Ace Wrap/Velcro Leg Wrap Assistance: Assistance putting on or taking off ted hose, ace wraps, or Velcro leg wraps. After removing wash and hang to dry. Do not use metal fasteners on ace bandages.

____ Standard Assist AM: Up to 15 min. Assist with dressing, grooming and toileting to prepare for the day. Brushing teeth and washing face, putting in dentures. This is minimal assistance of staff with cueing, setting out items/clothes, etc., resident actively participates.

____ Standard Assist PM: Up to 15 min. Assist with dressing, grooming and toileting to prepare for bed. Brushing teeth and washing face, removing dentures. This is minimal assistance of staff with cueing, setting out items/clothes, etc., resident actively participates.

Resident's preferred time to get up and go to bed: _____

Physical Assistance

____ Independent: Ambulates without assistance or uses cane, walker or wheelchair independently.

____ Exercise Walking: Up to 15 minutes. See exercise instructions provided by nurse or PT.

Toileting Assist

____ Independent

____ Catheter Assist: Includes physical assistance with catheter care. Type of Device: _____

Safety Checks

____ Independent

____ Commons Reassurance Checks 1-3x/day: This is a scheduled check time. Check resident for safety

Medication Management

____ Independent

____ Medication Monitoring/Management: Nurse to assist with ordering, storage and set-up of medication. This includes all oral, topical, inhalation, eye, ear, rectal, and as needed medications. Weekly monitoring includes medication compliance, PRN usage, checking for needed refills and medication expiration dates.

____ Medication Administration: Resident Assistant to administer meds. May include the following routes (oral, topical, inhalation, or eye/ear). This does not include administration of injections-see diabetes management for insulin injection options.

____ Special Medication Administration: This includes-crushing medications, checking blood pressure, pulse or weight prior to giving medications.

____ Nebulizer: Includes set up only, no supervision. This includes rinsing out the unit after use.

____ CPAP: Includes assistance with CPAP. This includes wiping after use and filling with water.

____ Oxygen Management: Includes making sure portable oxygen tank is full, checking to make sure accurate flow rate is set. changing

____ tubing monthly, and filling humidity bubblers. Need MD order for monitoring and no parameters.

Liters required _____

Diabetes Management

____ Independent

____ Blood Sugar 1x-2x/day or less: MD order will be obtained for parameters for when to notify for high or low blood sugar. Staff will be made aware of this parameter.

____ Insulin Administration and Blood Sugar check 1-2x/day: MD order will be obtained for parameters for when to notify for high or low blood sugar. Staff will be made aware of this parameter. Includes the staff administering the insulin to resident. Insulin site rotation needed. Medication management fee is required.

Dining Room Assistance

____ Independent

____ Assist with meal ordering

____ Light Breakfast (10 min): Resident requests a light breakfast or a light snack to be prepared in their apartment. A light breakfast might consist of toast, juice, instant hot cereal or cold cereal and coffee. Food and utensils provided by resident.

Diet:_____

Wellness and Treatments

____ Vital Monitoring: Includes staff checking pulse, blood pressure, weight and/or pulse oximeter (if not addressed under special medications).

____ Sensory/Communication 2x/day: Hearing impaired, needs reminders to use hearing aid (adjust volume, change battery, needs assist in ordering hearing aid batteries, etc.). Needs reminders to wear glasses. Staff time required due to difficulty speaking. Locking up hearing aides in medication cabinet in PM and taking out in AM.

____ Wound Care 1-2x/day: Includes simple dressing changes or wound or skin treatments per physician orders (for Resident Assistant to complete).

____ Treatments 1-2x/day: Includes any physician ordered treatment-ice packs, Tens Unit, ear care, incentive spirometry. etc.

***See Grooming/Dressing section for Ted Hose, Ace Wraps and Velcro Leg Wraps*

Health Maintenance

____ Homemaking 1x/day up to 15 min: Includes daily bed making, washing dishes, making coffee, taking garbage out, etc.

☐ **Level 1: $945/month** Includes **30 minutes per day** of personal care by the Resident Assistant with Registered Nurse oversight.

☐ **Level 2: $1,225/month** Includes 30 minutes per day of personal care by the Resident Assistant with Registered Nurse oversight. Also includes **one meal per day** and **housekeeping twice monthly**.

☐ **Level 3: $1,505/month** Includes 30 minutes per day of personal care by the Resident Assistant with Registered Nurse oversight. Also includes **two meals per day** and **housekeeping weekly**.

If the care provided exceeds 30 minutes per day, there will be a $21 charge for every additional 15 minutes.

Services recommended but declined:

_____
_____
_____

____ Education provided to resident/responsible party regarding benefit/need for services
____ Risk reviewed with resident/responsible party
____ Assessment updated to reflect decline of service
____ Nursing note completed

Services being provided by family/responsible party:

_____
_____
_____

Services being provided by Outside Agency:

_____
_____
_____

Monthly Fee: _____

**** Complete a new functional assessment with changes in care and sign new service agreement.****

Ancillary Fees for Unscheduled Visits: Nurse = $37.00 per 15 minutes Resident Assistant = $21.00 per 15 minutes

Resident/Responsible Party Signature or Verbal consent given by: _____ **Date** _____

RN Signature: _____ **Date** _____