Trilogy-Admission Observation and Data Collection 3.16.20

Observation

Resident Name:_____ **MR#:**_____ **U/R/B:** _____

OBSERVATION INFORMATION

Creator:

Observation Date: **Date Recorded:**

Completed Date: **Completed By:**

DESCRIPTION

OBSERVATION DETAIL

General Admission Information

Assessment Reference Date

Enter Date of Admission

Method of Admission Transportation

- ○ Private vehicle
- ○ Ambulance
- ○ Transport service
- ○ Other, describe

Mode of Transfer

- ○ Ambulatory
- ○ Stretcher
- ○ Wheelchair
- ○ Other, describe

Transfer Activity

- ○ No assistance needed for transfer
- ○ Stand pivot from stretcher
- ○ Mechanical lift
- ○ Stand pivot from wheelchair
- ○ Manual lift from stretcher

Staff Assist with Transfer

- ☐ 1 person facility staff physical assist
- ☐ 2 person facility staff physicial assist
- ☐ Transferred by ambulance staff
- ☐ No assistance needed, transferred self

Admission Vital signs obtained to include Height and Weight

Are the Admission vitals (BP, HR, Resp, Height, Weight) recorded under the Vitals Tab

- ○ Yes
- ○ No, Please explain why

History Information Obtained From

- ☐ Resident
- ☐ Authorized surrogate
- ☐ Family/Support person
- ☐ Medical record
- ☐ Other, describe

Primary Language Spoken

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ French
- ☐ Italian
- ☐ Portuguese
- ☐ German
- ☐ Greek
- ☐ Russian
- ☐ Polish
- ☐ Hindi
- ☐ Other

Communication Devices

- ☐ None
- ☐ Yes: Lip reading
- ☐ Yes: Type-To-Talk
- ☐ Yes: Communication board
- ☐ Yes: Voice synthesizer
- ☐ Yes: Other:

Diagnosis Inquiry

Check all that apply

- ☐ HIV/AIDS
- ☐ Multiple Sclerosis
- ☐ Opportunistic Infection
- ☐ COPD/Asthma/Chronic Lung Disease
- ☐
- ☐ Myelodysplastic Syndromes/Myelofibrosis
- ☐ Systemic Lupus Erythematosus, Other Connective Tissue Disorders, Inflammatory Spondylopathies
- ☐ Diabetic Retinopathy (Except Proliferative Diabetic Retinopathy and Vitreous Hemorrhage)
- ☐ Severe Skin Burn or Condition
- ☐ Intractable Epilepsy

Bone/Joint/Muscle Infections/Necrosis

- ☐ Chronic Myeloid Leukemia
- ☐ Diabetes Mellitus
- ☐ Endocarditis
- ☐ Immune Disorders
- ☐ End Stage Liver Disease
- ☐ Narcolepsy/Cataplexy
- ☐ Cystic Fibrosis
- ☐ Hereditary Metabolic/Immune Diseases
- ☐ Morbid Obesity
- ☐ Psoriatic Arthropathy/Systemic Sclerosis
- ☐ Chronic Pancreatitis
- ☐ Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
- ☐ Complications of Specified Implanted Device/Graft
- ☐ Inflammatory Bowel Disease
- ☐ Aseptic Necrosis of Bone
- ☐ Cardio-Respiratory Failure and Shock
- ☐ Malnutrition Code
- ☐ Disorders of Immunity
- ☐ Cirrhosis of Liver
- ☐ Respiratory Arrest
- ☐ Pulmonary Fibrosis and Chronic Lung Disorders
- ☐ Septicemia
- ☐ Quadriplegia
- ☐ Cerebral Palsy
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Hemiplegia/Hemiparesis
- ☐ CVA/TIA/Stroke
- ☐ Traumatic Brain Injury
- ☐ ALS (Amyotrophic Lateral Sclerosis)
- ☐ Resident has none of the above conditions

Prior Surgical History

- ☐ Lung Transplant
- ☐ Major Organ Transplant
- ☐ Prior surgeries in last 100 days, describe
- ☐ No surgery in last 100 days

Cardiac Support Devices

- ☐ None
- ☐ Pacemaker
- ☐ Automatic implantable cardioverter defibrillator (AICD)
- ☐ Life Vest
- ☐ Other, describe

Mental/Neuro

Orientation

Check all that apply

- ☐ Oriented to person
- ☐ Oriented to place
- ☐ Oriented to time
- ☐ Oriented to situation
- ☐ Unable to determine

Level of Consciousness

- ☐ Alert
- ☐ Lethargic/Drowsy
- ☐ Stupor/Difficult to arouse
- ☐ Unresponsive/Comatose
- ☐ Other, describe

Responsiveness

- ○ Responds to commands
- ○ Responds to pain only
- ○ Unresponsive

Speech

- ☐ Speech clear
- ☐ Speech unclear
- ☐ Speech slurred
- ☐ Able to make needs known
- ☐ Expressive communication difficulty
- ☐ Other, describe

Dominate hand

- ○ Right
- ○ Left

Tremors

Upper extremity tremors noted

- ○ No
- ○ Yes, describe

Left Eye- Pupil Size, Shape, and Response

- ☐ 1mm
- ☐ 2mm
- ☐ 3mm
- ☐ 4mm
- ☐ 5mm
- ☐ 6mm
- ☐ 7mm
- ☐ Round/Brisk
- ☐ Round/Sluggish
- ☐ Round/Non-Reactive
- ☐ Misshapen/Brisk
- ☐ Misshapen/Sluggish
- ☐ Misshapen/Non-Reactive

Left Eye - Accommodates

- ○ No
- ○ Yes

Right Eye- Pupil Size, Shape, and Response

- ☐ 1mm
- ☐ 2mm
- ☐ 3mm
- ☐ 4mm
- ☐ 5mm
- ☐ 6mm
- ☐ 7mm
- ☐ Round/Brisk
- ☐ Round/Sluggish
- ☐ Round/Non-Reactive
- ☐ Misshapen/Brisk
- ☐ Misshapen/Sluggish
- ☐ Misshapen/Non-Reactive

Right Eye - Accommodates

- ○ No
- ○ Yes

Pupils are Equal

- ○ No
- ○ Yes

Hand Grasp Strength

- ○ Strong bilaterally
- ○ Weak bilaterally
- ○ One side stronger than other side
- ○ Unable to assess

Foot Press Strength

- ○ Strong bilaterally
- ○ Weak bilaterally
- ○ Right side stronger than left
- ○ Left side stronger than right
- ○ Unable to assess

Seizure Activity

- ○ No
- ○ Yes, answer next question

Describe Seizure Activity

Facial Droop

- ○ No
- ○ Yes

Comments:

Eyes, Ears, Nose and Throat

Visual Disturbances

- ☐ None
- ☐ Blind
- ☐ Halos
- ☐ Light flashes
- ☐ Rings
- ☐ Other, describe
- ☐ Unable to determine

Eyesight Devices

- ☐ None
- ☐ Reading glasses
- ☐ Glasses
- ☐ Contacts
- ☐ Magnifying glass
- ☐ Other, describe

Hearing Aides

Check all that apply

- ☐ None
- ☐ Both ears
- ☐ Left ear
- ☐ Right ear
- ☐ Have but do not use

Notes abnormalities to eyes, sclera, conjunctiva

Nares Patency

- ○ Both nares patent
- ○ Left blocked
- ○ Right blocked
- ○ Both nares blocked

Oral Cavity

Check all that apply

- ☐ No ulcers, lesions, halitosis, dry membranes or bleeding gums
- ☐ Bleeding gums
- ☐ Halitosis
- ☐ Inflamed gums
- ☐ Lesions
- ☐ Membranes dry
- ☐ Mouth pain
- ☐ Ulcers
- ☐ Unable to assess

Dentures

Check all that apply

- ☐ None
- ☐ All natural teeth
- ☐ Full Dentures (upper and lower)
- ☐ Upper Dentures
- ☐ Upper Partial
- ☐ Lower Dentures
- ☐ Lower Partial
- ☐ Broken or missing teeth
- ☐ Edentulous (no natural teeth)
- ☐ Other

Comments

Respiratory

Respiratory Function

- ☐ Regular/unlabored
- ☐ Labored/accessory muscles used
- ☐ Shortness of breath or trouble breathing when lying flat
- ☐ Shortness of breath with exertion
- ☐ Shortness of breath without exertion
- ☐ Other, describe

Onset of Shortness of Breath

- ○ No Shortness of breath
- ○ New
- ○ Chronic

Lung Sounds- Left Side

Check all that apply

- ☐ Clear
- ☐ Crackles/Rales
- ☐ Diminished
- ☐ Rhonchi
- ☐ Wheezes
- ☐ Absent
- ☐ Other, describe

Lung Sounds- Right Side

Check all that apply

- ☐ Clear
- ☐ Crackles/Rales
- ☐ Diminished
- ☐ Rhonchi
- ☐ Wheezes
- ☐ Absent
- ☐ Other, describe

Tracheostomy

- ○ No
- ○ Yes, answer next question

Tracheostomy Details

Check all that apply, refer to physician order for trach size and type

- ☐ Trach midline
- ☐ Without sign/symptoms of infection
- ☐ Signs and symptoms of infections, describe
- ☐ Capped
- ☐ Other, describe

Chest Tube

- ☐ No chest tube
- ☐ Chest tube present, decribe
- ☐ Recent history of chest tube (within last 30 days)
- ☐ If drainage, describe

CPAP, Bi-PAP, Trilogy Vent

- ○ No
- ○ Yes, see physician orders for settings

Uses Oxygen

- ○ No
- ○ Yes, refer to physician orders for liter flow and delivery method

Restlessness Present

- ○ No
- ○ Yes

Anxiety Present

- ○ No
- ○ Yes

Fatigue Present

- ○ No
- ○ Yes

Cough Present

- ○ No
- ○ Yes, answer next question

Sputum Production

Check all that apply

- ☐ None, dry cough
- ☐ Small
- ☐ Moderate
- ☐ Copious
- ☐ Green
- ☐ Yellow
- ☐ Clear
- ☐ Blood-tinged/streaked
- ☐ Frothy
- ☐ Thin
- ☐ Thick
- ☐ Other, describe

Comments:

Cardiovascular

Heart Tones

- ☐ Regular
- ☐ Irregular
- ☐ Murmur present
- ☐ Other, describe

Chest pain

- ○ No
- ○ Yes, answer next two questions

Chest Pain is Exacerbated with Activity

- ○ No
- ○ Yes, describe if necessary

Chest Pain is Relived With

- ☐ Rest
- ☐ Oxygen
- ☐ Medication
- ☐ Other, describe

Capillary Refill

- ○ Less than 3 seconds
- ○ Greater than 3 seconds

Radial Pulses

- ○ Present Bilateral
- ○ Absent Bilateral
- ○ Absent Left
- ○ Absent Right
- ○ Other, describe
- ○ Unable to check pulses, describe

Pedal Pulses

- ○ Present Bilateral
- ○ Absent Bilateral
- ○ Absent Left
- ○ Absent Right
- ○ Other, describe
- ○ Unable to check pulses, describe

Left Lower Leg Edema

- ☐ No edema present
- ☐ Non-pitting
- ☐ Pitting +1
- ☐ Pitting +2
- ☐ Pitting +3
- ☐ Pitting +4
- ☐ Other, describe

Right Lower Leg Edema

- ☐ No edema present
- ☐ Non-pitting
- ☐ Pitting +1
- ☐ Pitting +2
- ☐ Pitting +3
- ☐ Pitting +4
- ☐ Other, describe

Left Upper Extremity Edema

- ☐ No edema present
- ☐ Non-pitting
- ☐ Pitting +1
- ☐ Pitting +2
- ☐ Pitting +3
- ☐ Pitting +4
- ☐ Other, describe

Right Upper Extremity Edema

- ☐ No edema present
- ☐ Non-pitting
- ☐ Pitting +1
- ☐ Pitting +2
- ☐ Pitting +3
- ☐ Pitting +4
- ☐ Other, describe

Periorbital Edema

- ○ No edema present
- ○ Resident able to open eyes wide
- ○ Resident only able to open eyes small amount
- ○ Resident uable to open eyes
- ○ Other, describe

Other Edema Present

- ○ No
- ○ Yes, describe

Comments

Gastrointestinal (GI)

Changes in Bowel Movements

- ☐ None
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incontinence, answer next question

Bowel Incontinence

- ○ No
- ○ Yes

Date of Last BM

Abdomen

Check all that apply

- ☐ Soft
- ☐ Distended
- ☐ Guarded
- ☐ Rigid
- ☐ Tender
- ☐ Other, describe

Bowel Sounds

- ○ Active x
- ○ Hyperactive
- ○ Hypoactive
- ○ Absent

Emesis Present

- ○ No
- ○ Yes, answer next question

Emesis Description

- ☐ Coffee ground
- ☐ Bloody
- ☐ Other, describe

Appliances

- ○ None
- ○ Colostomy
- ○ Ileostomy
- ○ Other, describe

Comments

Genitourinary (GU)

Bladder Continence

- ☐ Continent
- ☐ Incontinent
- ☐ Complaints of frequent urination
- ☐ Complaints of difficulty urinating
- ☐ Change in urine color or odor, describe
- ☐ Other, describe

Incontinence Pattern

- ☐ Unable to recognize need to void
- ☐ Unable to sit on toilet or BSC
- ☐ Unable to communicate need to void
- ☐ Urinates with sneezing/coughing
- ☐ Dribbling/leaking small amount of urine
- ☐ Urgency, unable to get to bathroom
- ☐ None

Indwelling Catheter Present

- ○ No
- ○ Yes, risk and benefits of use have been explained to resident/representative. Refer to physician order for size.

Type of Catheter

Refer to physician order for size of catheter

- ☐ None
- ☐ Intermittent catheterization
- ☐ External (condom)
- ☐ Indwelling
- ☐ Suprapubic

Urine Characteristics

- ☐ Clear
- ☐ Cloudy
- ☐ Sediment present
- ☐ Mucous present
- ☐ Hematuria
- ☐ Other, describe
- ☐ Unable to assess

Urinary Diversion

- ○ None
- ○ Urostomy
- ○ Nephrostomy
- ○ Suprapubic

Location of Urinary Diversion

- ☐ Right
- ☐ Left
- ☐ Bilateral

Dialysis

- ○ No
- ○ Yes, answer next questions

Type of Dialysis

- ○ Hemodialysis, use order set
- ○ CAPD (Continuous Ambulatory Peritoneal Dialysis)
- ○ Other, describe

Thrill/Bruit

If has AV fistula or AV graft

- ☐ Thrill felt
- ☐ Thrill not felt
- ☐ Able to hear bruit
- ☐ Not able to hear bruit
- ☐ Other, describe

AV Fistula or AV Graft

- ☐ Warm
- ☐ Cool
- ☐ Hot to Touch
- ☐ Pink/Flesh Tone
- ☐ Cyanotic
- ☐ Reddened
- ☐ Bleeding (Dressing reinforced or changed)
- ☐ Other, describe

Type and Location of Dialysis Access

Answer if has dialysis port or dialysis catheter

Comments

Musculoskeletal

Numbness or Tingling

- ○ No
- ○ Yes, answer next question

Location of Numbness or Tingling

- ☐ All extremities
- ☐ Left upper extremity
- ☐ Right upper extremity
- ☐ Left lower extremity
- ☐ Right lower extremity
- ☐ Other, describe

Extremity Weakness

- ☐ None
- ☐ All extremities
- ☐ Left Upper extremity
- ☐ Left Lower extremity
- ☐ Right Upper extremity
- ☐ Right Lower extremity

Contractures

- ☐ None
- ☐ All extremities
- ☐ Left upper extremity, location
- ☐ Right upper extremity, location
- ☐ Left lower extremity, location
- ☐ Right lower extremity, location

Lower Extremities Equal in Length

- ○ No, answer next question
- ○ Yes

Description

- ○ Left leg shorter than right
- ○ Right leg shorter than left

Assistive Device

- ☐ None
- ☐ Cane
- ☐ Walker
- ☐ Wheelchair
- ☐ Electrical Wheelchair
- ☐ Splint, location
- ☐ Brace, location
- ☐ Prosthesis, location
- ☐ Other, describe

Weight Bearing

- ☐ Full
- ☐ Partial
- ☐ TTWB
- ☐ Non (Right, Left, Bilateral)

Activity Level

- ○ No Limitations
- ○ Bed Rest
- ○ As tolerated
- ○ Wheelchair
- ○ Other, describe

Pain

Does Resident complain of Pain or display other indicators of Pain

- ○ No
- ○ Yes, answer next questions and open pain event

If able to verbalize, ask to rate pain on scale 1-10

If unable to verbalize, skip to non-verbal signs

1
2
3
4
5
6
7
8
9
10

Pain description, if able to verbalize

Check all that apply

- ☐ Sharp
- ☐ Dull
- ☐ Throbbing
- ☐ Aching
- ☐ Stabbing
- ☐ Burning
- ☐ Radiating
- ☐ Cramping
- ☐ Other, describe

If resident unable to verbalize, describe non-verbal signs

- ☐ Facial Grimaces/Winces- Furrowed brow, narrowed eyes, clenched teeth, tightened lips, jaw drop,distorted expressions
- ☐ Bracing-clutching holding onto furniture
- ☐ Restlessness- constant intermittent shifting of position, rocking, intermittent or constant hand motions, inability to keep still
- ☐ Rubbing- massaging affected area
- ☐ Nondescript words- cursing during movement, exclamations of protest "stop, that's enough"
- ☐ Other, describe

Describe pain location/site

What brings on pain or increases pain

Describe,

What alleviates pain?

Check all that apply,

- ☐ Medication
- ☐ Eating
- ☐ Exercise
- ☐ Heat
- ☐ Massage
- ☐ Cold
- ☐ Rest
- ☐ Positioning/Repositioning
- ☐ Other, describe

Describe pain further if necessary

Skin

Skin Color

- ☐ Normal
- ☐ Pale
- ☐ Dusky
- ☐ Flushed
- ☐ Cyanotic
- ☐ Jaundice
- ☐ Other, describe

Skin Temperature

- ☐ Warm
- ☐ Cool
- ☐ Clammy
- ☐ Dry
- ☐ Moist
- ☐ Other, describe

Skin Turgor

- ○ Normal
- ○ Slow to return to normal position
- ○ Tenting

Skin Impairment

Skin event selection- Bruise, Burn, Incision, Pressure/Stasis/Diabetic, Rash/Lesion, Skin Tear/Laceration

- ☐ None
- ☐ Yes, complete appropriate Wound Event for further assessment

Unable to visualize skin integrity due to non-removable dressing, hardware, or cast

- ○ No
- ○ Yes, describe

IV

- ☐ None
- ☐ Peripheral
- ☐ Peripherally Inserted Central Catheter (PICC)
- ☐ Port
- ☐ Central line, subclavian or jugular
- ☐ Midline
- ☐ Other, describe

IV Dressing Intact and Dry

- ○ Yes
- ○ No

Braden Scale for pressure ulcer predictability

Sensory Perception: Resident's ability to respond meaningfully to pressure-related discomfort:

- ○ 1. Completely limited - Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation. OR Limited ability to feel pain over most of body surface. (1 point)
- ○ 2. Very Limited - Responds only to painful stimuli. Can't communicate discomfort except by moaning, or restlessness. OR Has sensory impairment that limits ability to feel pain/discomfort over half of body. (2 points)
- ○ 3. Slightly Limited - Responds to verbal commands but can't always communicate discomfort or need to be turned. OR Has some sensory impairment that limits ability to feel pain/discomfort in 1 or 2 extremities. (3 points)
- ○ 4. No Impairment - Responds to verbal commands. No sensory deficit limiting ability to feel or voice discomfort/pain. (4 points)

Moisture: Degree to which resident's skin is exposed to moisture:

- ○ 1. Constantly Moist - Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time resident is moved or turned. (1 point)
- ○ 2. Very Moist - Skin is often but not always moist. Linen must be changed at least once a shift. (2 points)
- ○ 3. Occasionally Moist - Skin is occasionally moist, requiring an extra linen change approximately once per day. (3 points)
- ○ 4. Rarely Moist - Skin is usually dry; linen only requires changing at routine intervals. (4 points)

Activity: Degree of resident's physical activity:

- ○ 1. Bedfast - Confined to bed. (1 point)
- ○ 2. Chairfast - Ability to walk severely limited or nonexistent. Can't bear own weight and/or must be assisted into chair or wheelchair. (2 points)
- ○ 3. Walks Occasionally - Walks occasionally during day but for very short distances, with/without assist. Spends majority of each shift in bed or chair. (3 points)
- ○ 4. Walks Frequently - Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours. (4 points)

Mobility: Resident's ability to change and control body position:

- 1. Completely Immobile - Does not make even slight changes in body or extremity position without assist. (1 point)
- 2. Very Limited - Make occasional slight changes in body or extremity position, but unable to make frequent or significant changes independently. (2 points)
- 3. Slightly Limited - Makes frequent, though slight, changes in body or extremity position independently. (3 points)
- 4. No Limitations - Makes major and frequent changes in position without assist. (4 points)

Nutrition: Resident's usual food intake pattern. (NPO - Nothing by mouth, IV = Intravenous, TPN =Total Parental Nutrition):

- 1. Very Poor - Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy) per day. Takes fluids poorly. Doesn't take liquid dietary supplement. OR Is NPO and/or maintained on clear liquids or IV's for more than 5 days. (1 point)
- 2. Probably Inadequate - Rarely eats a complete meal and generally eats only about 1/2 of food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement when offered. OR Receives less than optimum amount of liquid diet or tube feeding. (2 points)
- 3. Adequate - Eats over half of most meals. Eats a total of 4 servings of protein (meat and dairy products) each day. Occasionally will refuse a meal, but will usually take a supplement when offered. OR Is on a tube feeding or TPN regimen that probably meets most nutritional needs. (3 points)
- 4. Excellent - Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation. (4 points)

Friction and Shear: Describe any problems related to friction and shear:

- 1. Problem - Requires moderate to maximum assist in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assist. Spasticity, contractures, or agitation leads to almost constant friction. (1 point)
- 2. Potential Problem - Moves feebly or requires minimum assist. During a move, skin probably slides to some extent, against sheets, chair, restraints or other device. Maintains relatively good position in chair or bed most of time but occasionally slides down. (2 points)
- 3. No Apparent Problem - Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times. (3 points)

Braden Scale Score Braden Scale

Acuity Score:
Acuity Level:

Initial Skin Plan of Care- Braden Scale 12 or less is high to very high risk, 13-18 is low to moderate risk.

Braden Score 12 or less- High to Very High Pressure Ulcer Risk

Resident will not develop a pressure ulcer, or if a pressure ulcer present it will not worsen.

- ☐ **IF THE BRADEN SCALE SCORE IS 13-18, check box and go to next question**
- ☐ Turn and reposition for comfort with care
- ☐ Elevate heels
- ☐ Use lift sheet to reposition in bed
- ☐ Provide pressure relieving device chair
- ☐ Explain consequences of refusal of treatments and/or prevention interventions
- ☐ Ensure resident is clean and dry
- ☐ Provide padding for casts, splints, devices, etc.
- ☐ Ensure adequate hydration
- ☐ Observe labs (e.g., albumin, H&H)
- ☐ Observe nutritional intake
- ☐ Provide vitamins and supplements per physician order
- ☐ Check edema, circulation for cast, splint, and devices
- ☐ Dietician consult
- ☐ For bedfast resident elevate HOB 30 degrees or less for short periods.
- ☐ Other, describe

Braden Score 13-18 - Low to Moderate Risk

Resident will not develop a pressure ulcer, or if a pressure ulcer present it will not worsen.

- ☐ **IF BRADEN SCALE SCORE IS <12, check box and go to next question**
- ☐ Turn and reposition for comfort with care.
- ☐ Use devices to optimize independent repositioning and transfers.
- ☐ Explain consequences of refusal of treatments and/or prevention interventions
- ☐ Monitor fluid and nutritional intake
- ☐ Inspect skin when repositioning, toileting and assisting with ADL's.
- ☐ Provide routine skin care per current order.
- ☐ Other, describe

Infectious Disease

Current Infections

- ○ No
- ○ Yes, complete appropriate Infection event form

Type of Current Infection(s)

- ☐ None
- ☐ Blood
- ☐ Ear
- ☐ Eye
- ☐ Gastrointestinal
- ☐ Respiratory
- ☐ Skin
- ☐ Urinary (UTI)
- ☐ Other, describe

Isolation

If resident in isolation, obtain order

- ○ No
- ○ Yes, indicate contact or droplet

Enter Immunization History in Preventative Health Care

Safety

Falls Review

Did the resident have a fall in the last month prior to admission?

- ○ Yes
- ○ No

Potential for fall risk

Check all that apply

- ☐ History of falling within the past year
- ☐ Orthostatic hypotension
- ☐ Impaired mobility or gait
- ☐ Altered mental status
- ☐ Incontinence
- ☐ Medications associated with falls, such as sedative-hypnotics and blood pressure drugs
- ☐ Use of assistive devices
- ☐ None of the above

Needs to Maintain Safety

- ☐ 1/4 bed rail x
- ☐ 1/8 bed rail x
- ☐ Grab bars x
- ☐ Assist bars x
- ☐ Mobility bars x
- ☐ Exit seeking alarm bracelet (e.g., wander guard, and secure care)
- ☐ Lap buddy
- ☐ Wedge cushion
- ☐ Walker
- ☐ Wheelchair
- ☐ Low Bed
- ☐ Define Parameter Mattress
- ☐ Floor mat
- ☐ Mechanical Lift
- ☐ Reclining Chair (describe)
- ☐ Special care unit
- ☐ Hospice services
- ☐ Other-describe
- ☐ No safety devices needed

Did the resident have a fall in the last 2-6 months prior to admission?

- ○ Yes
- ○ No
- ○ Unable to assess

Exit/Elopement Review

Risk for Elopement Reviewed

- ○ Yes
- ○ No

Does resident have an elopement risk

Check all that apply

- ☐ History of exit seeking
- ☐ Voices statements of leaving
- ☐ Exhibit periods of pacing, agitation or wandering toward and exit
- ☐ Resident has eloped within the last 3 months
- ☐ Resident has eloped within the last 6 months
- ☐ Does resident demonstrate confusion and has the ability to exit campus
- ☐ Other, describe
- ☐ None of the above

Wandering device needed

Should apply wandering device if any box checked to prior question except 'None of the above'

- ○ Wander device applied (utilize wandering order set)
- ○ No device required

Nutrition

Diagnosis Inquiry

Check all that apply

- ☐ Laryngeal Cancer
- ☐ Apraxia
- ☐ Dysphagia
- ☐ Oral Cancers
- ☐ Speech/Language
- ☐ Dementia
- ☐ Alzheimer's
- ☐ Intellectual Disability
- ☐ Other Cognitive Impairment
- ☐ Aphasia
- ☐ None of the above

Significant Weight Change in the Last 30 days

- ○ No
- ○ Not enough information to determine
- ○ Yes, describe below

Describe Weight Change

Swallowing Problems

- ☐ None
- ☐ Loss of liquids/solids from mouth
- ☐ Holds food in mouth/cheeks (pocketing)
- ☐ Coughing or choking during meal or med pass
- ☐ c/o difficulty or pain with swallowing
- ☐ Residual food in mouth after meals

Tube Feeding

- ○ No
- ○ Yes, answer next question

Tube Feeding Site

- ☐ Gastrostomy
- ☐ Jejunostomy
- ☐ Nasogastric
- ☐ Other, describe

Evaluation for Assistance Needed for Dining/Eating

Eating Assistance

Indicate resident's current ability to eat meals

- ○ Independent
- ○ Set up help only
- ○ Needs frequent cueing with meal
- ○ Dependent for eating
- ○ Resident receives nutrition by another alternative route

Current fluid consistency

- ○ Thin
- ○ Honey
- ○ Nectar
- ○ Pudding

If resident needs frequent cueing with meal, dependent for eating, has had recent episode of coughing or choking while eating, or has history of dysphagia (other swallowing issues) -Recommend restorative dining room, refer to SOP for Communal Dining

Recommendation

Indicate if Restorative Dining Room Recommended

- ○ No
- ○ Yes

Comments

Lift observation Needed

Does resident require a lift transfer

- ○ No
- ○ Yes, complete Lift Observation

Antipsychotic Medication

Antipsychotic Medication

Does resident have a current order for a antipsychotic medication, example- Reglan, Compazine, Haldol, Abilify, Zyprexa, Seroquel, Risperdal, Geodon, Clozaril (not an inclusive list)

- ○ No
- ○ Yes, complete AIMS observation

ADDITIONAL OBSERVATION INFO

Completed By: _____ **Date:**_____