PREPARATION ACTIVITIES
APPENDIX D

HOME CARE PROGRAM CARE PLAN

Client Name:
Band/Settlement:
Date of Birth:
Sex:
Band/Inuit I.D.#:
Address:
Doctor:
Provincial/Territorial Health #:

Allergies: ___________________________
Diagnosis: Code 1 Code 2
Review Date: ________________________
Level of Care: 1 2 3 4 5
Independence: _______________________
Support: ____________________________
Type of Care: _______________________

Home Care Services

Type of Service	Frequency	Type of Service	Frequency
Nursing		Meal Preparation	
Personal Care		Respite Care	
Home Management			

Presenting Problems	Goal Desired Outcomes	Target Date	Met/Unmet	Client/Family/ Other Responsibilities	Home Care Responsibilities

HOME CARE CONTRACT

Client's Name: ______________________________

Primary (or informal) Care giver: ________________

Phone: ____________________________________

Presenting Problem	Tasks Required	By Whom	When

Signature of client and/or Primary (Informal) Care giver involved ________________

Home Care Services are provided to assist clients and family to remain living independently as long as possible.

If you wish any changes to this contract for services please call the Home Care Coordinator.

Date of Reassessment: ____

Signature of Home Care Coordinator: ______________________ **Date:** _________

HOME CARE PROGRAM CLIENT PROFILE

Print Date: ______________________________ Band/Inuit I.D. #: ____________

Client Name: ____________________________

Client Strengths	Client Activities	Referrals	Approach

Approved by: (Signature and Date)

1. ____

2. ____

3. ____

4. ____

HOME CARE PROGRAM CARE PLAN TASK LIST

Name: ______________________________________

Band/Settlement: ___________________________

We have agreed that the Care Plan will include help with the following tasks :

Personal Care	Homemaking Tasks	Time Frame	Client/Family Responsibilities
Bath	Bedroom Cleaned		
Oral Care	Bed Changed		
Shampoo	Sweep/Wash Floors		
Shave	Vacuum/Dust		
Skin Care	Bathroom Cleaned		
Foot/Nail Care	Kitchen Cleaned		
Dress	Fridge Cleaned and/or Defrost		
Comb/Brush/Braid Hair	Stove Top Clean		
	Oven Clean		
	Laundry		
	Other		
	Seasonal Cleaning		
	Dishes		
	Meal Preparation		
	Cook Bannock		
	Respite/Reassurance Visit		
Home Care Nursing Referrals to: (specify) Other Services (specify)			

Date: ____ Time: _________________

Comments: ____

____

Please notify the home health aide if you will not be home for service.

Please note that clients must supply all cleaning and cooking supplies.

Home Care Assessor: ______________________________________ Date: _________________

Client: ____ Date: _________________

HOME HEALTH AIDE MONTHLY RECORD

Please fill in Calendar Dates, Times Spent in the Home (“**H**” for **Home Management** - “**P**” for **Personal Care** - “**O**” for **Other**). **And Have Clients Initial**. Use RED Pen if doing Respite.

Name: ____ **Band/Inuit I.D. #:** __________

Band/Settlement: _____________________________________ _________________________

Client Identification #: **Date:**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
am						
pm						
am						
pm						
am						
pm						
am						
pm						
am						
pm						

Please Circle Tasks Provided and Indicate How Often Done

A. PERSONAL CARE

1. Bathing, shampooing ____ times/wk.
2. Grooming, dressing ____ times/day/wk.
3. Feeding ____ times/day/wk.
4. Toileting ____ times/day/wk.
5. Transferring ______ times/day/wk.
6. Routine skin care ______ times/day/wk.
7. Turning ______ times/day/wk.
8. Backrubs ______ times/day/wk.
9. Activation ____ times/day/wk.
10. Routine foot and nail care Q __ wks.
11. Supervision (Respite) Total Hours This Month____
12. Reassurance visits _____ times/day/wk.

B. HOME MANAGEMENT

1. General household cleaning Q ____ wks.
2. Menu planning Q __ wks.
3. Meal preparation __ times/day/wk.
4. Laundry Q __ wks.
5. Changing linen Q __ wks.
6. Seasonal cleaning Q ____ wks.
7. Other (specify)

____

____

Home Management ____ Hours Personal Care ____ Hours Other (see H.H.A. notes) ____ Hours Total Hours ___

Visits: ____ **Total Hours:** ______________

Attempted Visits: ____________________________________

H.H.A. Signature: ____________________________________ **Date:** ____________________

Supervisor's Signature: ________________________________ **Date:** ____________________

Name: ____ Client I.D. #: ______________________

A. PHYSICAL HEALTH

1. Does your client appear
   AS USUAL ❑ ***WEAKER*** ❑ ***IMPROVING*** ❑
2. Has your client had any new
   health complaints? .... YES ❑ NO ❑
3. Have you observed any:
   new health problems .... YES ❑ NO ❑
   skin abrasions/rashes .... YES ❑ NO ❑
   changes in mobility .... YES ❑ NO ❑

B. MENTAL HEALTH

1. Have you observed any changes in:
   behaviour .... YES ❑ NO ❑
   memory .... YES ❑ NO ❑
   alertness .... YES ❑ NO ❑

C. PERSONAL CARE

1. If you are assisting with personal care
   are you managing safely? .... YES ❑ NO ❑
2. Do you feel your client neglects
   personal care? _____________ YES ❑ NO ❑
3. Do you recognize a need for:
   additional personal care .... YES ❑ NO ❑
   additional independence
   equipment .... YES ❑ NO ❑

D. NUTRITION

1. Have you observed any
   nutritional problems? .... YES ❑ NO ❑
2. Does your client receive Meals
   on Wheels? .... YES ❑ NO ❑
3. Do you do meal preparation? .... YES ❑
   .... NO ❑

E. HOUSEHOLD TASKS

1. Has the client requested tasks
   other than on the care plan? ..... YES ❑ NO ❑
2. Are you doing tasks:
   other than on the care plan? ...... YES ❑ NO ❑
   that you feel the client should be
   able to do on his/her own? .... YES ❑ NO ❑

F. COMMUNICATION

1. Have you observed any changes
   in ability to communicate? .... YES ❑ NO ❑

G. SUPPORT SYSTEM

1. Are you aware of any changes
   in the support system? .... YES ❑ NO ❑

H.H.A. Notes (please comment on changes and/or explain OTHER visits)

____

____

____

____

Home Health Aide Signature ____

Additional Comments Supervisory Staff (please date and sign)

____

____

____

____

ASSESSMENT & CARE COORDINATION RECORD

Name: ____ **Band/Inuit I.D. #:** ___________________

Band/Settlement: __________________________________ __________________________________

Client Identification #: _______________________________ **Date:** ____________________________

Please fill in calendar dates, primary, secondary and recording times. Identify "**A**" for **Assessment** and "**C**" for **Care Coordination**.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
am						
pm						
am						
pm						
am						
pm						
am						
pm						
am						
pm						

	Hours - Primary	**Hours - Secondary**	**Hours - Recording**	**TOTAL HOURS**
Assessment				
Care Cooridination				

Assessments Completed

Initial	**One Month Review**	**Annual**	**Reassessment**	**Other**

Total Assessment Visits ________ **Total Care Coordination Visits** __________ **Total Visits** _________

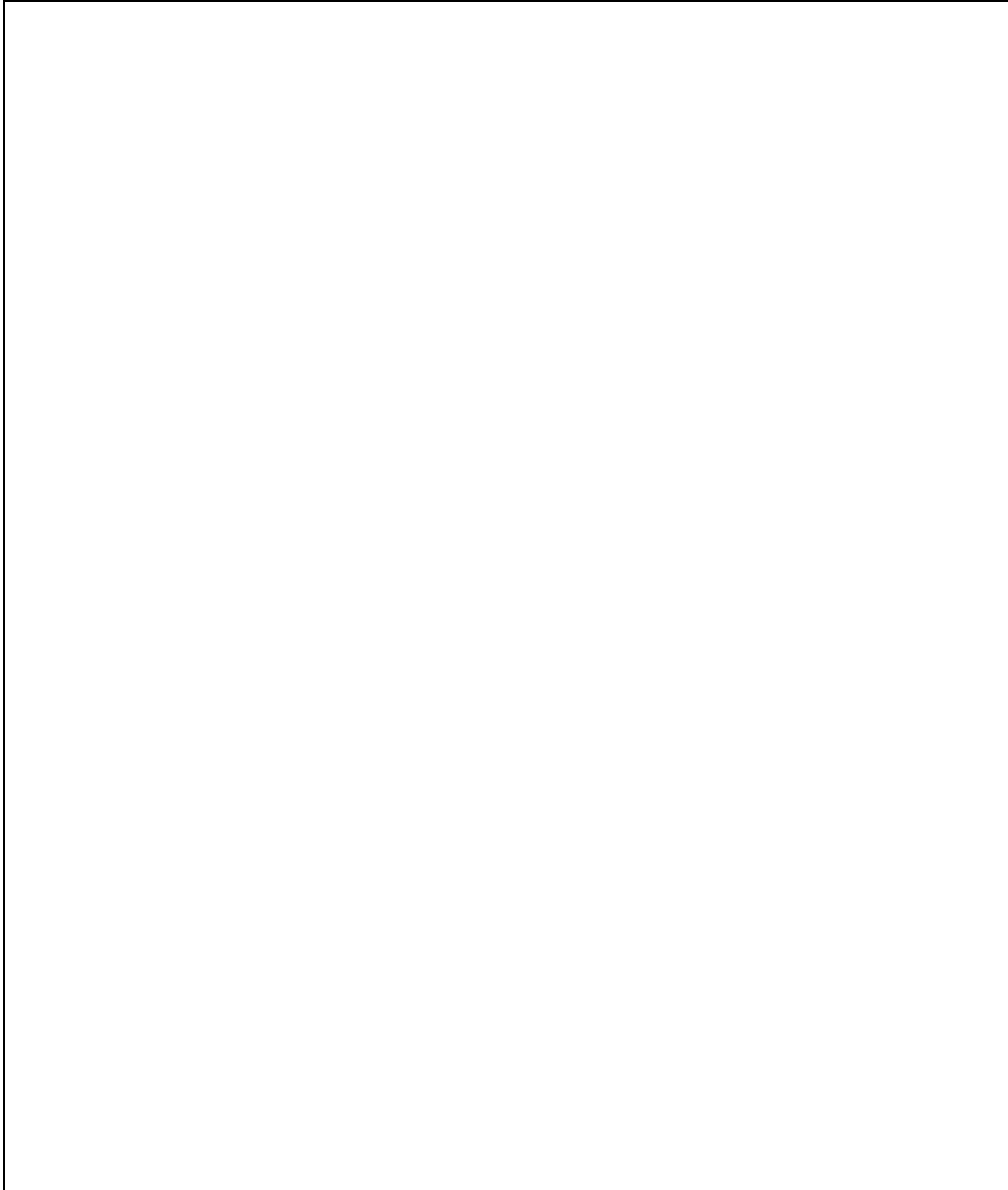
Signature: ____ **Date:** _________________________

Supervisor Signature: __________________________________

Name: ___________________________________ Band/Inuit I.D. #: ________________________

Date	Summary of Assessment and Care Coordination Duties (Please Sign all Entries)

Nursing Charts



HOME CARE PAIN FLOW SHEET

Date: ___________ **Band/Settlement:** ______________ **Client I.D. #:** ______________

Non-Pharmacological Treatment		Sedation Level	
HA – Heat Application	**RP** – Repositioning	**1.** Awake/Alert	**4.** Sleeping
CA – Cold Application	**RT** – Relaxation Therapy	**2.** Awaken with Stimulus	**5.** Unarousable
MT – Music Therapy	**CS** – Cutaneous Stimulation	**3.** Disoriented	

Date:					
Time:					
Initials:					
Pain	10				
Intensity	9				
Rating	8				
	7				
0=No Pain	6				
10=Worst Pain	5				
	4				
	3				
	2				
	1				
	0				
Analgestic					
Non-Pharma. Tx.					
Sed. Level					
Rep. Rate					
Pulse Rate					
Blood Pressure					
Quality					
Location					

INITIAL PAIN ASSESSMENT TOOL

Patient's Name: ______________________________ **Date:** ____________________

Diagnosis: ______________________________ **Age:** _______ **Room:** __________

Nurse: ______________________________ **Physician:** ____________________

1. Location: Patient or nurse mark drawing.

2. Intensity: Patient rates the pain. Scale used ....

Present: ....

Worst pain gets: ....

Best pain gets: ....

Acceptable level of pain: ....

3. Quality: (use patient's own words, e.g. prick, ache, burn, throb, pull, sharp)

....

4. Onset, Duration, Variations, Rhythms: ....

....

5. Manner of Expressing Pain: ....

....

6. What Relieves the Pain? ....

....

7. What Causes or Increases the Pain? ....

....

8. Effects of Pain: (Note decreased function, decreased quality of life.)

Accompanying symptoms (e.g. nausea) ....

Sleep ....

Appetite ....

Physical Activity ....

Relationship with others (e.g. irritability) ....

Emotions (e.g. anger, suicidal, crying) ....

Concentration ....

Other ....

9. Other Comments: ....

……

10. Plan: ………

……

Name: ______________________________ **Phone:** _______________ **Age:** __________

Diagnosis: ____

Doctor: ____________________________ **Phone:** _________________________________

Services being given:

____

____

____

____

Frequency of visit (e.g. once a week): _______________________________________

Description of Special Procedures (e.g., dressing changes):

____

____

____

____

____

____

____

Comments:

____

____

____

____

____

____

____

____

NURSING DATA BASE

Client: ____

Surname Given names

Band/Settlement: ______________________________________

Address: ____

Reasons for referral (medical if available)

____

____

____

Previous illnesses and hospitalizations (include dates if known)

____

____

____

Diet and dietary habits

____

____

Allergies and type of reaction

____

____

Physical data

Weight ____________________

Temperature ____________________ Pulse ____________________

Rate Rhythm Quality

Blood presssure ______________ Pulse ____________________

Rate Rhythm Quality

1. Over-all appearance ________________________________

____

2. Skin ____

____

3. Eyes and vision ____________________________________

____

4. Ears and hearing ___________________________________

____

5. Nose and throat ____________________________________

6. Breasts ____

____

7. Chest, lungs and cardiovascular ____

____

8. Extremities ____

____

9. Gastrointestinal ____

____

10. Nose and throat ____

____

Activities of daily living

1. Rest and sleep pattern ____

____

2. Ambulation ____

____

3. Level of activity ____

____

Behavioural data

Knowledge of condition and treatment

____

____

Percpetion of and adjustment to illness

____

____

Mental status and/or recent past or apparent psychiatric disorders

____

____

Additional comments

____

____

Date of initial assessment ____ / ____ / _____ Nurse’s signature ____________________

SKIN ILLUSTRATION

Client: ____

Surname Given names

Band/Settlement: ____

Address: ____

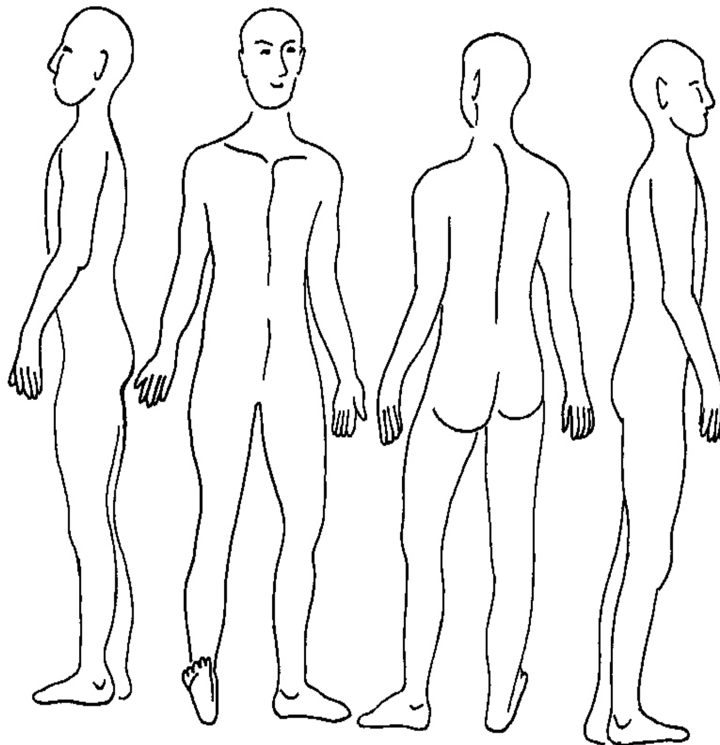
Diagramming code (see Narrative Progress for Description)

C – Contusion E – Erythema P – Petichia S – Scar

D – Decubitus L – Laceration

R– Rash

B – Burn



Measurement of Area: ____

____

____

____

Date of Initial Diagram: ______________________________

Nurse's Signature: ________________________________

MEDICATION RECORD

Client: ____

Surname Given names

Band/Settlement: ____

Address: ____

Drug allergies and type of reaction: ____

List of all medications, prescription and non-prescription, being taken by client:

Date started	Medication	Dosage and frequency	Ordered by	Date Discontinued	Comments

Datestarted	Medication	Dosageand frequency	Ordered by	Date Discon-tinued	Comments

DOCTOR'S ORDERS

Client: ____

Surname Given names

Band/Settlement: ______________________________________

Address: ____

continued on reverse side

NARRATIVE PROGRESS NOTES

Client: ____

Surname Given names

Band/Settlement: ______________________________________

Address: ____

Date	Problem number	SOAP Narrative Notes S-Subjective O-Objective A-Assessment P-Plans

Continued on reverse side

Date	Problem number	SOAP Narrative Notes S-Subjective O-Objective A-Assessment P-Plans

FOOT CARE ASSESSMENT FORM

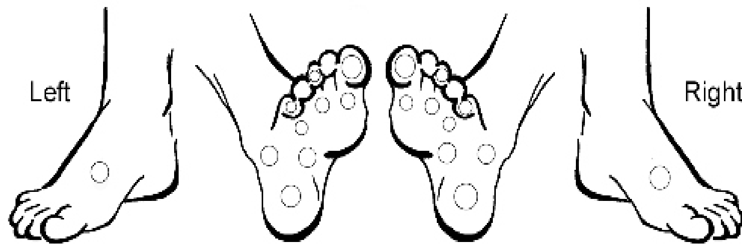
Name:____________________ **D.O.B.:**_______________ **Band/Inuit I.D. #:**____________

Label: Sensory level with a "+" in the circled area of the foot if the client can feel the 10 gram nylon filament and "-" if client cannot feel the 10 gram filament.

Draw in: Callus Pre-Ulcer ☒ Ulcer ◙ (Note width/depth in CM)

Label: Skin condition with

R – Redness **W** – Warmth **M** – Maceration **S -** Swelling **D** – Dryness



Risk Category:

____ **0** No loss of protective sensation

____ **1** Loss of protective sensation (no weakness, deformity, callus, pre-ulcer, or hx. or ulceration

____ **2** Loss of protective sensation with weakness, deformity, pre-ulcer or callus but not hx. ulceration

____ **3** History of plantar ulceration

Initial and Date Changes:

Sensation	R	L	Structural Deformities	R	L
Pain in feet or legs			Hallux Valgus		
			Overlap Digits		
Insensitivity					
Paraesthesia					
	R	L	Nails ———————————————————		
Hammer Toes			Onychauxis (Thickened) ——————————		
Other			Onychogryphosis (Ram's Horn) ————————		
Involuted			Onychomicosis (Fungal) ——————————		
Overgrown			Onychocryptosis (Ingrown) —————————		
Discoloured					
Other			Comments: ————————————————		

Date of initial assessment: ————————————————

Signature: ————————————————————

Date							
Color	P/F						
Temperature	P/F						
Discoloration	P/F						
Ingrown Toenails	P/F						
Crack	P/F						
Edema	P/F						
Skin Rash/Ichiness	P/F						
Ulcerations	P/F						
Various Veins	P/F						
Infection	P/F						
Signature							

FLOW SHEET

Name:______________________________ Band/Inuit I.D. #:_____________________

# of visit	Date	T.P.R.	B.P.					Signature

LABORATORY REPORTS

Name: ____ **Band/Inuit I.D. #:** _____________

FOOT CARE FLOW SHEET

Date: ______________ **D.O.B.:** _______________ **Band/Inuit I.D. #:** ____________

Date	Nail	Tibial Pulse Y/N	Dorsalis Pedis Pulse Y/N						Comments	Signature

PHYSICIAN'S INSTRUCTIONS

District Information (Please Print)

Name and Location of District:

____

____

____

To be completed by the client's attending physician as required

Type of order: Initial Update

Client Information

____ __________________________

Surname First Initial Telephone Number

____

Address (city, town, village, Box #, if farm state RM) Postal Code Hospital Services #

Diagnosis ____

____

____

____

Physician's Instructions: (treatment, medication, dose, frequency)
Should it appear to the registered nurse, following an injection, that an Anaphylactic Reaction has occurred, I authorize the Registered Nurse to give Adults 0.31 ml of Epinephrine Hydrochloride (adrenalin) 1:1000 by subcutaneous injection. This injection could be repeated in 15 minutes if there is no change in condition. In children the dosage will be 0.1 ml - 0.2 ml up to 12 years. The client would immediately be referred for treatment.

____

____

____

____

____
Physician's Name (Please Print)

_______________________________ _______________________________
Physician's Signature **Date** (Year/Month/Day)

White– HOME CARE Yellow – HOSPITAL Pink – CLIENT Goldenrod -PHYSICIAN'S COPY

HOME CARE ADMISSION

Client's Name: ____
Surname First Initial

Band/Settlement: ______________________ **Band/Inuit I.D. #:** ______________________

Provincial/Territorial Health #: _______________________________________

Sex: **Male** **Female** **D.O.B.:** ______________________
Year Month Day

Type of Admission	Living Arrangements
Regular	Alone
Short Term	With Spouse Only
Hospital Discharge:	With Spouse and Others
Yes	With Other Family Members
Within Past 30 Days	With Others
No	
Type of Residence	Type of Care

House Elders Lodge Home Care Other ______________________________	Palliative Acute Supportive
TYPE AND FREQUENCY OF SERVICE	
Nursing ____________________________ Meals ______________________________ Home Management __________________ ____________________________________ Respite ____________________________	Personal Care ______________________ Nursing Personal Care ________________ Other ______________________________
SUPPORT SYSTEM RATING: (Circle one)	LEVEL OF CARE: (Circle one)
1 2 3	1 2 3

Admission Date :

....

Year Month Day Assessor

Copy to C.H.N.

HOME CARE SERVICES DISCONTINUED

Client's Name: ____
Surname First Initial

Band/Settlement: ________________________ **Band/Inuit I.D. #:** ________________

Provincial/Territorial Health #: _____________ **D.O.B.:** ________________________

Sex: **Male** **Female**

Nursing Service **Home Health Aide Service**

Reason for discharge (select one)	Alternative Arrangements (Leave blank if client deceased or recovered)
Deceased	Acute Care Hospital Stay
Recovered	Special Care Home/Level 4 Hospital Stay
Moved Off First Nation Reserve/Inuit Settlement	Other Care Home
Refused Further Service	Self/Family Care
Care Needs Beyond Capacity of Home Care	Other ______________________________

Functional Improvement Support System Improved Other ____________________________	
Narrative:	
____ ____ ____ ____ ____ ____ ____	

Assessor: ____

Date: .... Copy to C.H.N.

CLIENT REFERRAL FORM

PRIORITY

Urgent **Soon as Possible** **No Reply Necesssary**

From: _________________________ **Date:** ___________________________________

Send To:

Client Name: _________________________________

Band/Settlement:

Address/Residence:

D.O.B.: ________________ **Phone:**

Next of Kin:

Reason for Referral

____

____

____

____

____

____

Is this client aware of this referral? Yes No Who requested service? _________________

Reply

____

____

____

____

____

____

____

Reply date: **Reply from:**

Copy to: ____________________________