RESIDENT ASSESSMENT TOOL / NEEDS DETERMINATION

Resident name: _____ Date of Admission _____
PLEASE PRINT MONTH DAY YEAR

Instructions:

- Any person who has been trained to complete this assessment may complete **all sections** of this assessment. However, the person completing the assessment (the assessor) should, when applicable, rely on health care professionals or their examinations to ensure the assessment is completed accurately.
- Complete each question with a Yes, No, or N/A (Not applicable) by placing a check mark in the applicable box. If the answer could be Yes and No or not applicable, use the **COMMENTS FOR ASSESSMENT** section on page 5 and 6 of this assessment. All comments must be written in the comment section at the end of this assessment. See sample assessment.
- For each check mark in a box that is shaded, the facility must consider this need in a care plan and identify the reason, A, B, C, or D, why the need does not require a care plan, if applicable. See acceptable reasons for not care planning on page 5. If the reason for not care planning is a D (other), provide a brief explanation in the **COMMENTS FOR ASSESSMENT** section on page 5 and 6 of this assessment. You may make comments if choosing to care plan but it **is not mandatory**. See sample assessment.
- Any shaded area after a question must be answered if prompted.
- Any RAT trained person may complete the NURSING section on page(s) 4 and 5 provided the trained person relies on the written examinations of health care professionals to ensure this section is completed accurately. If any shaded box in the nursing section is checked, a nurse shall determine if it is necessary to complete a nursing assessment. A nurse shall determine if a care plan is necessary for any shaded box in the nursing section.
- One care plan may contain numerous needs that have a check mark in a shaded area. (Sometimes referred to as clumping).

	Y	N	N/A		**Will You Care Plan** Yes	No	(If no, state reason A, B, C, or D) or (use to reference a comment)
WALKING/AMBULATION							
1. Can the resident walk or propel 50 feet within a minute? If no, how long would it take? _____							
2. Is unsteady when walking.							
3. Walks without any assistive equipment.							
4. Walks with cane.							
5. Walks with walker.							
6. Needs wheelchair and able to move without assistance.							
7. Needs wheelchair but needs assistance to move.							

	Y	N	N/A		Will You Care Plan Yes	No	(If no, state reason A, B, C, or D) or (use to reference a comment)
8. Can walk stairs with or without assistive device.							
9. Unable to walk stairs with or without assistive device							
10. Resident will be on first floor regardless of ability to walk stairs.							
11. Resident will be on second or third floor.							
TRANSFERS							
1. Can move from bed to chair or from chair to standing position or any transferring without assistance.							
2. Needs assist of one to move from bed to chair or from chair to standing position or any transferring.							
3. Needs assist of two to move from bed to chair or from chair to standing position or any transferring.							
4. Requires hoyer lift or other lift equipment to transfer.							
EVACUATION							
1. Could evacuate building independently.							
2. Could evacuate building with verbal assistance.							
3. Could evacuate building with the assistance of one person.							
4. Needs assist of two to evacuate the building.							
FALLS							
1. Is there a history of falls in the past year.							
2. No falls in the past 3 months.							
3. Has fallen in the past 3 months. If yes, how many times?							
4. Reason for falls is unknown.							
5. One reason for choosing to live in assisted living is frequency of falls.							
6. Reason for falls is known but falls are unpreventable.							
7. Reason for falls is known / resident refuses to follow all recommendations to prevent falls.							
MOOD AND BEHAVIOR							
1. Takes medication for anxiety.							
2. Takes medication for depression.							
3. Takes medication for hallucinations or delusions.							
4. Has attempted suicide in the past year.							
5. Intentionally stays in room to avoid social interactions.							
6. Has been verbally or physically aggressive in the past 6 months.							
7. Has been behaviorally disruptive in the past 6 months.							
8. Is resistant to maintaining hygiene.							
COMMUNICATION							
1. English is a first language.							
2. Speaks without difficulty.							
3. Writes basic English.							
4. If applicable, effective non-verbal communication.							

	Y	N	N/A		Will You Care Plan Yes	No	(If no, state reason A, B, C, or D) or (use to reference a comment)
5. Requires large print.							
6. Has a diagnosis of glaucoma, macular degeneration, or retinal disease.							
7. Can complete ADLs with limited assistance despite a yes answer for # 6 above.							
8. Wears corrective lenses.							
9. Refuses to wear corrective lenses or have follow-up visual care.							
10. Has trouble hearing conversations of 2 or more people.							
11. Must have increased volume on TV.							
12. Has trouble hearing over phone.							
13. Has had professional ear cleaning in last 90 days.							
14. Has hearing aides.							
15. Refuses to wear hearing aides.							
16. Refuses to have hearing test.							
ORAL/NUTRITION							
1. Has dentures (full) (partial)(bridge).							
2. Has broken, decaying, loose teeth							
3. Requires assistance (total) (partial) with dental care							
4. Has a documented chewing/swallowing issue							
5. Has a special diet need due to health issues or religious preference. If yes, specify.							
6. Requires food to be cut							
7. Requires or benefits from meal supplements							
8. Requires adaptive eating utensils							
9. Has had a weight change of 5% in the past 30 days.							
DEMENTIA							
1. Has early stage of dementia.							
2. Has mid stage dementia.							
3. May attempt to exit home or building.							
MEDICATIONS / TREATMENTS							
1. Takes all medication without any assistance.							
2. Requires someone to observe the taking of all medications.							
3. Requires a nurse or other licensed staff to give all medications.							
4. Has had 3 or more new or changed medications (excluding OTC meds) in the past 90 days.							
5. Requires someone to order and re-order all medications.							
6. Requires supervision of nebulizer treatments.							
7. Needs oxygen occasionally.							
8. Needs oxygen continually.							

	Y	N	N/A		Will You Care Plan Yes	No	(If no, state reason A, B, C, or D) or (use to reference a comment)
HYGIENE / ADL ASSISTANCE							
1. Is incontinent of bladder.							
2. Is incontinent of bowel.							
3. Is independent with bathing.							
4. Capable of bathing independently but reluctant to bath.							
5. Needs assistance to bath. If yes, how much assistance?							
6. Needs assistance with dressing. If yes, how much assistance?							
7. Capable of grooming independently but reluctant to groom.							
8. Needs assistance with toileting. If yes, verbal or physical assist?							
9. Capable of changing adult incontinent products independently but reluctant to change.							
10. Needs assistance changing adult incontinent products. If yes, verbal or physical assist?							
11. Capable of brushing teeth independently but reluctant to brush.							
12. Needs assistance to brush teeth. If yes, verbal or physical assist?							
13. Has frequent urinary tract infections.							
14. Has chronic constipation.							
SAFETY DEVICES							
1. Requires safety belt on chair to prevent falls.							
2. Requires a helmet to prevent injury to head.							
3. Requires mittens to prevent injurious scratching.							
4. Requires a wander guard bracelet.							
5. Requires bed or chair alarm to prevent falls.							
HEALTH MAINTENANCE							
1. Is receiving hospice care.							
2. Is receiving dialysis.							
3. Is receiving radiation treatment.							
4. Is receiving chemo-therapy treatment.							
5. Receives nutrition through parenteral IV or feeding tube.							
6. Is receiving OTC or prescription medication for pain.							
7. Uses other therapies to relieve pain such as hydro therapy etc. If yes, please specify below.							
8. Has indwelling catheter.							

NURSING	Y	N	N/A	Will You Care Plan: Yes	Will You Care Plan: No	(If no, state reason A, B, C, or D) or (use to reference a comment)
1. Currently has a pressure ulcer or has had a pressure ulcer in the past 3 months.						
2. Requires ostomy care.						
3. Requires monitoring of new/changed/or deteriorating medical condition. If yes, specify.						
4. Requires tracheostomy care.						
5. Has late stage Alzheimer's or late stage dementia.						
6. Bedfast most of the time						
7. Unable to give insulin injection.						
8. Requires wound care after surgery or significant injury.						

COMPLETED BY: _____ , on _____
Signature Month Day Year

ACCEPTABLE REASONS FOR NOT CARE PLANNING FOR A NEED IN A BOX THAT IS SHADED.

Reason A = This need is met for all residents as part of the basic services and all staff provide this need per their job description, responsibilities and / or facility policy.

Reason B = This need is met by other health care professionals not employed by the facility but with oversight provided by facility staff.

Reason C = The facility, and others, have exhausted all reasonable attempts to meet this need. The resident, legal agent, and family are aware and agree this need will not have a care plan.

Reason D = Other. Provide explanation below.

COMMENTS FOR ASSESSMENT

_____
_____
_____
_____
_____

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