CNA CARE PLAN REFERENCE SHEET

INSTRUCTIONS: For each applicable function enter the code that indicates the type of assistance required. Check all applicable small information boxes. (Boxes or blanks not coded, checked or filled in imply the item does not apply to the resident.) For each item coded, record the coordinating program in the Restorative Nursing column to the right of that item.

CODES: **0** = No setup or physical help from staff **1** = Setup help only **2** = One person physical assist **3** = Two+ person physical assist
8 = ADL activity itself did not occur or family and/or non-facility staff provided care

See reverse for more in depth coding explanations especially as it relates to setup help.

PHYSICAL FUNCTIONING / RESTORATIVE NURSING

Bed Mobility ____

Transfer ____

Bed Mobility/Ambulation Transfer Programs

Ambulation ____
- ❑ Walk in room
- ❑ Walk in corridor
- ❑ Locomotion off unit
- ❑ Assistive ambulation devices: ____________________

Brace/Prosthesis ____

Type: ____________________

Grooming/ Personal Hygiene ____

ADL Program

- ❑ Oral hygiene - teeth:
  - ❑ Own ❑ Dentures
  - ❑ Partial ❑ Edentulous
- ❑ AM hygiene
- ❑ PM hygiene
- ❑ Hair care
  - ❑ Beauty shop
- ❑ Foot Care
  - ❑ Podiatrist ❑ Nurse

Dressing ____
- ❑ Locates clothes
- ❑ Selects clothes
- ❑ Obtain clothes
- ❑ Dresses/undresses upper body
- ❑ Dresses/undresses lower body
- ❑ Puts on/removes socks/ stockings
- ❑ Put on/remove shoes
- ❑ Manages buttons, snaps, zippers
- ❑ Put clothes on in correct order

PHYSICAL FUNCTIONING / RESTORATIVE NURSING

Eating ____

Restorative Dining

- ❑ Opens/pours/cuts
- ❑ Grasps utensils/cups
- ❑ Chews/drinks/swallows
- ❑ Able to stay focused at meals: ❍ Yes ❍ No
- ❑ Assistive eating devices ____________________

Dietary ____

Favorite foods/Beverages:

- ❑ Diet ____________________
- ❑ Tube feeding ____________________
- ❑ Choking risk ____________________
- ❑ Fluid requirements/ restrictions ____________________

Toileting ____

Incontinence Management Program

- ❑ Uses commode at bedside
  - ❑ Day ❑ Night
- ❑ Removes/opens clothes
- ❑ Transfers/positions self
- ❑ Uses toilet: ❑ Wipes self
  - ❑ Flushes ❑ Washes hands
- ❑ Able to lower & rise from toilet
- ❑ Continent of bladder
- ❑ Incontinent of bladder
- ❑ Catheter ____________________
- ❑ Continent of bowel
- ❑ Incontinent of bowel
- ❑ Ostomy ____________________

Toileting schedule ____________________

Bladder retraining ____________________

- ❑ Adult briefs
- ❑ Other ____________________

Bowel program:

Bathing
- ❑ Tub ❑ Whirlpool
- ❑ Shower ❑ Bed bath

Functional Limited ROM ____

ROM Programs

Location ____________________

- ❑ Risk for contractures

Communication ____

Communication Programs

Language ____________________

Skin / RESTORATIVE NURSING

Skin ____
- ❑ Intact
- ❑ Risk for breakdown
- ❑ Ulcers ____________________
- ❑ Skin problems - foot ____________________
- ❑ Other ____________________

- ❑ Special equipment ____________________
- ❑ Preventive schedule ____________________
- ❑ Other ____________________

Behavior ____

Behavior Approaches:

Depression ____

Pain ____

Location ____________________

Relief measures ____________________

Strengths: ____________________

- ❑ Task segmentation needed ❑ Supervision needed

RISK FACTORS

- ❑ Skin (see Skin section) ❑ Choking (see Eating section)
- ❑ Dehydration ❑ Abuse ❑ Elopement ❑ Falls ❑ Infection

Hearing	Vision
❑ Adequate ❑ Minimal	❑ Adequate ❑ Minimal
❑ Difficulty ❑ Deaf	❑ Difficulty ❑ Blind
Aids ____________	Aids ____________

COGNITIVE

- ❑ Alert ❑ Able to make decisions ❑ Confused
- ❑ Oriented ❑ Comatose

CUSTOMARY ROUTINE

Routine daily events ____________________

Family/friend visits ____________________

Preferred activities ____________________

DATE OF REVIEW	GENDER ❍ M ❍ F	MARITAL STATUS ❍ S ❍ M ❍ W ❍ D	ALLERGIES	HOW COMMUNICATES	NICKNAME

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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CNA CARE PLAN REFERENCE SHEET

CODING DEFINITIONS*

0. **No setup or physical help from staff**
1. **Setup help only** — The resident is provided with materials or devices necessary to perform the activities of daily living independently.
2. **One person physical assist**
3. **Two+ persons physical assist**
8. **ADL activity itself did not occur** — The activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

EXAMPLES OF SETUP HELP

- **For bed mobility** — handing the resident the bar on a trapeze; staff raises ½ rails for resident but no further assist.
- **For transfer** — giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**

  Walking — handing the resident a walker or cane.

  Wheeling — unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** — retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating** — cutting meat and opening containers at meals; giving one food item at a time.
- **For toilet use** — handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene** — providing a wash basin and grooming articles.
- **For bathing** — placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

*Long-Term Care Facility Resident Assessment Instrument User's Manual, Centers for Medicare and Medicaid Services, October 2019

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