CNA CARE PLAN REFERENCE SHEET

Directions: Check (✓) the box only if that item applies to the resident. When the item is checked, complete any additional items that apply and/or write in a response when indicated on the lines provided.

Physical Functioning/ADLs

Ambulation/Joints

Bed mobility ❑ Turns side to side
❑ Moves to and from lying position
❑ Positions in bed ❑ Transfer
❑ Independent ROM ❑ Needs assist
❑ Arm ❑ Lt ❑ Rt ❑ Leg ❑ Lt ❑ Rt
❑ Other ____________
❑ At risk for contractures
❑ Splint/Brace Location____________
Walk ❑ In room ❑ In hall ❑ All areas
❑ Walking assistive devices ❑ Cane
❑ Quad cane ❑ Walker ❑ Behind WC
❑ Crutches ❑ Other____________
❑ Amputation/Prosthesis
Location____________

Oral Care/Grooming/Dressing

❑ Oral care ❑ Brushes teeth
❑ Dentures ❑ Upper ❑ Lower ❑ Partial
Hygiene: ❑ AM ❑ PM ❑ Hair care
❑ Beautician ❑ Nail care
❑ Foot care ❑ Podiatry appointments
Clothes: ❑ Locates ❑ Selects ❑ Obtains
❑ Needs assist ❑ Staff performs
Dresses: ❑ Upper body ❑ Lower body
❑ Needs assist ❑ Staff performs
Undresses: ❑ Upper body ❑ Lower body
❑ Needs assist ❑ Staff performs
Socks: ❑ Puts on ❑ Removes
❑ Needs assist ❑ Staff performs
TED hose: ❑ Puts on ❑ Removes
❑ Needs assist ❑ Staff performs
Shoes: ❑ Puts on ❑ Removes
❑ Needs assist ❑ Staff performs
Manages: ❑ Buttons ❑ Snaps ❑ Zippers
❑ Needs assist ❑ Staff performs

❑ **NEEDS TASK SEGMENTATION**

Restorative Programs

❑ Bed mobility
❑ Transfer
❑ ROM
❑ Passive ❑ Active
❑ Splint/Brace assistance
❑ Resident education
❑ Staff performs
❑ Walking program
❑ Walk to dine
❑ Amputation/Prosthesis care
❑ Resident education
❑ Staff performs

❑ Grooming
❑ Dressing
❑ Personal hygiene
❑ Eating ❑ Swallowing
❑ Restorative dining
❑ Dressing
❑ Toileting
❑ Prompted voiding
❑ Habit/Scheduled voiding
❑ Bladder retraining
❑ Bowel program

Communication

Language____________
____
❑ Needs interpreter
❑ Other____________
____

Other Cares

❑ Uses oxygen
❑ Isolation precautions
❑ Other____________
____

Dietary

Favorite foods ____________
____
❑ Regular diet ❑ Special diet Type____________
Fluid requirements/limitations ____________
At risk for ❑ Dehydration ❑ Weight loss ❑ Weight gain
❑ Choking
❑ Tube feeding ❑ Other nourishment method____________
❑ At risk for weight loss Approaches: ❑ Supplement
❑ Other____________
❑ Assistance needed to cut food ❑ Staff feeds
❑ Open packaged items ❑ Butter food
❑ Transport to/from meals
❑ Remind of each mealtime ❑ Prompt to eat
❑ Assistive devices for eating ____________
❑ Other assistance____________
____

Skin

❑ Intact ❑ Pressure ulcers and/or other open areas including feet Location ____________
❑ At risk for skin breakdown Special equipment____________
____
❑ Turning/Positioning schedule Frequency____________
❑ Wheelchair weight shifts Frequency____________
❑ Restraint release Frequency____________

Bladder & Bowel

❑ Uses commode ❑ Day ❑ Night
❑ Opens and removes clothes
❑ Toilet transfer ❑ On ❑ Off ❑ Wipes self
❑ Washes hands ❑ Other____________
❑ Indwelling catheter Catheter size____________
❑ Intermittent catherization____________ ❑ Suprapubic
❑ Nephrostomy tube ❑ Other____________
❑ Other urine collection devices____________
❑ Check and change ❑ Absorbent products ❑ Pads
❑ Adults briefs ❑ Other____________
❑ Ostomy

Hearing/Vision/Cognition

Hearing ❑ Adequate ❑ Difficult
❑ Minimal ❑ Deaf
❑ Hearing aid ❑ Lt ❑ Rt
❑ Other ____________

Vision ❑ Adequate ❑ Difficult
❑ Minimal ❑ Blind ❑ Glasses
❑ Other ____________
____

Cognition ❑ Alert ❑ Oriented
❑ Confused
❑ Able to make decisions
❑ Decisions poor
❑ Supervision/cueing required
❑ Severely impaired
❑ Unable to make decisions
❑ Comatose

❑ Behavior Plan ____________
____
❑ Increased Falls Plan____________
____
❑ Wandering/Elopement Plan
____
____
❑ Depression Plan ____________
____
❑ Pain Location ____________
____
Plan____________
____
❑ Alarms in use____________

Customary routine/Preferences
____
____
____
Strengths____________

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

SAMPLE © www.BriggsHealthcare.com (800) 247-2343