BASELINE CARE PLAN

INSTRUCTIONS: The Baseline Care Plan must be developed within the first 48 hours of admission to the facility. The Baseline Care Plan must reflect the resident's stated goals and preferences and include interventions that address his/her current needs. Complete all sections. Signatures are required as designated.

Date of Admission:_____ Time of Admission:_____ ❍ AM ❍ PM Baseline Care Plan Implementation Date:_____ Time:_____ ❍ AM ❍ PM **CODE STATUS:**_____

Admitted from:_____ Allergies:_____ Preferred Name:_____

Resident Representative:_____ Phone Number:_____ Hospice/End-of-Life: ❍ No ❍ Yes

RESIDENT'S GOALS ON ADMISSION

RESIDENT'S DAILY ROUTINE/PREFERENCES

Wakes at:_____

Retires at:_____

Activities:_____

Other:_____

RESIDENT'S ETHNIC/CULTURAL PREFERENCES

Primary language:_____

Other language:_____

Needs interpreter: ❍ No ❍ Yes

Specify ethnic/cultural preferences:_____

RESIDENT'S DISCHARGE GOALS

❍ Return to community/home

❍ Remain here/other LTC setting

❍ Other:_____

COGNITIVE STATUS

❑ Alert/oriented

❑ Confused

❑ Comatose

❑ Other:_____

❑ Intervention(s):_____

SAFETY

❑ No safety issues

❑ Elopement risk - Intervention(s):_____

❑ History of falls/At risk - Intervention(s):_____

❑ Bleeding risk - Intervention(s):_____

❑ Choking risk - Intervention(s):_____

❑ Diabetic - Intervention(s):_____

DIETARY ORDERS

❑ Regular ❑ Other:_____

❑ Fluids: ❍ Normal ❍ Thickened ❍ Thin

❑ Mechanically altered:

❍ Pureed ❍ Ground meat ❍ Other:_____

❑ Tube feeding: ❍ NG ❍ PEG ❍ J-Tube

❑ Other:_____

❍ Feeds self ❍ Needs setup ❍ Needs to be fed

❑ Assistance needed:_____

❑ Adaptive devices:_____

THERAPY(IES) ORDERED

❑ No therapy ordered

❑ PT - Frequency:_____

❑ OT - Frequency:_____

❑ ST/SLP - Frequency:_____

❑ Respiratory - Frequency:_____

❑ Nursing Restorative Program(s):

THERAPY/FUNCTIONAL GOALS

❑ Maintain current status

❑ Improve current status to:_____

❑ Decline anticipated due to:_____

❑ Other:_____

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

BASELINE CARE PLAN

MEAL LOCATION PREFERENCE

- ❍ Dining room
- ❍ Own room
- ❍ Other:_____

DENTURES/TEETH

- ❑ Own teeth - no dentures
- ❑ Upper denture/partial
- ❑ Lower denture/partial
- ❑ Edentulous
- ❑ Implant(s):_____
- ❍ Independent with oral care
- ❍ Needs assistance with oral care:_____
- ❍ Staff provides oral care:_____

ACTIVITIES OF DAILY LIVING

Bed Mobility:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____
- ❍ N/A

Transfer:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____
- ❍ Lift:_____
- ❍ N/A

Walking:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____
- ❍ N/A

Toileting:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____
- ❍ N/A

ACTIVITIES OF DAILY LIVING (Cont'd)

Locomotion On/Off Unit:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____
- ❍ N/A

Grooming/ Hygiene:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____

Bathing:
- ❍ Independent
- ❍ Setup
- ❍ Assist of 1:_____
- ❍ Assist of 2:_____
- ❍ Dependent on staff:_____

Prefers: ❑ Tub ❑ Shower ❑ Whirlpool ❑ Bed bath

Bath Days:_____

Shift:_____

Other:_____

SHAVING
- ❍ Independent
- ❍ Staff assist:_____
- ❍ Dependent on staff:_____

HAIR CARE
- ❍ Independent
- ❍ Staff assist:_____
- ❍ Beauty shop/Barber:_____
- ❍ Other:_____

NAIL CARE
- ❍ Independent
- ❍ Staff assist:_____
- ❍ Podiatrist
- ❍ Other:_____

EQUIPMENT
- ❑ Manual wheelchair
- ❑ Cane
- ❑ Motorized wheelchair
- ❑ Scooter
- ❑ Geri-Chair
- ❑ Walker
- ❑ Other:_____

EQUIPMENT (Cont'd)

- ❑ Lift:_____
- ❑ Specialty mattress:_____
- ❑ Cushion in chair/wc
- ❑ Prosthesis(es):_____
- ❑ Orthotic device(s):_____
- ❑ Other:_____

BOWEL/BLADDER NEEDS

Continent of bladder: ❍ No ❍ Yes

Toileting schedule:_____

❑ Indwelling catheter: Size:_____

Care:_____

Reason for catheter:_____

❑ Intermittent catheterization:_____

❑ Uses briefs/pads:_____

❑ Peri-care schedule:_____

Continent of bowel: ❍ No ❍ Yes

Toileting schedule:_____

❑ Bowel program:_____

❑ Ostomy:_____

❑ Bed pan used ❑ Urinal used ❑ Commode used

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BASELINE CARE PLAN

SKIN CARE NEEDS

Skin intact: ❍ No, specify below ❍ Yes

Surgical wound: ❍ No ❍ Yes, specify below

Location:_____

Intervention(s):_____

_____

At risk for skin breakdown: ❍ No ❍ Yes

Intervention(s):_____

_____

Pressure injury present: ❍ No ❍ Yes, specify below

Location:_____

Intervention(s):_____

_____

_____

❑ Turn and reposition every _____ hours

❑ Other skin concerns:_____

_____

_____

❑ Skin treatments - see TAR:_____

COMMUNICATION/VISION/HEARING

❍ Verbal ❍ Non-verbal

Intervention(s):_____

_____

_____

❑ Vision adequate ❑ Vision impaired ❑ Wears glasses

❑ Other:_____

Intervention(s):_____

_____

_____

Hearing impaired: ❍ No ❍ Yes, specify below

❑ Doesn't use hearing aid(s)

❑ Hearing aid(s): ❑ Right ❑ Left ❑ Bilateral

Intervention(s):_____

_____

_____

BEHAVIOR CONCERNS

❑ No behavior concerns identified

Behavior(s) present (describe):_____

_____

_____

_____

Intervention(s):_____

_____

_____

_____

PASARR recommendations: ❍ No ❍ Yes, specify

_____

SOCIAL SERVICE NEEDS

❑ No social service needs identified

Mental health concerns: ❍ No ❍ Yes, specify

_____

_____

Depression screening: ❍ No ❍ Yes, specify

_____

Other:_____

_____

Trauma screening: ❍ No ❍ Yes, specify

_____

_____

Intervention(s):_____

_____

_____

SPECIAL TREATMENTS/PROCEDURES

❑ No special treatments/procedures ordered

❑ Oxygen - Route:_____ LPM:_____

Frequency:_____

❑ Suctioning:_____

❑ Isolation for:_____

Type of Isolation:_____

SPECIAL TREATMENTS/PROCEDURES (Cont'd)

❑ Ventilator ❑ Respirator

❑ Tracheostomy - Cannula size:_____

Care:_____

❑ BiPAP LPM:_____ ❑ CPAP LPM:_____

❑ Chemotherapy ❑ Radiation ❑ Transfusion

❑ IV medication(s):_____

❑ IV fluids:_____

❑ Dialysis:_____

❑ Other:_____

❑ Other:_____

RESTRAINTS/ALARMS/SIDE RAILS

❑ No restraints, alarms or side rails needed or used

❑ Restraint(s) used:_____

_____

_____

❑ Alarm(s) used:_____

_____

_____

❑ Side rail(s) used:_____

_____

_____

PAIN

Pain identified at this time ❍ No ❍ Yes, specify below

Location:_____

Characteristics:_____

Intervention(s):_____

_____

_____

_____

MEDICATION/TREATMENT ORDERS

❑ See MAR/TAR:_____

❑ Other:_____

_____

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BASELINE CARE PLAN

ADDITIONAL COMMENTS/CHANGES FOR BASELINE CARE PLAN - DATE AND SIGN ALL NOTES

SIGNATURES OF IDT MEMBERS INVOLVED IN DEVELOPING BASELINE CARE PLAN

SIGNATURE/TITLE	DATE	SIGNATURE/TITLE	DATE	SIGNATURE/TITLE	DATE

Baseline Care Plan Completed by:

Signature/Title _____ Date _____ Time _____ Signature/Title _____ Date _____ Time _____

BASELINE CARE PLAN CHANGES/UPDATES

Date	Signature/Title	Date	Signature/Title	Date	Signature/Title

❑ **Baseline Care Plan Discontinued** Date:_____ Signature/Title:_____

❍ Resident left facility before completion of comprehensive care plan

❍ Resident expired before completion of comprehensive care plan

❍ Comprehensive care plan developed/implemented

❍ Other:_____

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