

Individual Name: _____ **Room:** _____ **Date:** _____

ACTIVITIES OF DAILY LIVING

Bed Mobility: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Did individual participate in activity? **Yes** **No**

The most assistance provided was: None (Individual independent in performing activity)
 Verbal (Encouragement, Cueing, Standby)
 Non Weight Bearing Physical (Guiding, Maneuvering)
 Weight Bearing (Assistance bearing physical weight)
 Total – Check only if individual non-participatory

Most Amount of Assistance:

None Set up only One person physical assistance Two (+) persons physical assistance

Is the individual bedfast (bed or recliner in room 22 out of 24 hours per day for 4 of the last 7 days)? **Yes** **No**

Describe why individual needs assistance: _____

Does ability to perform activity vary? (Cognitive changes, Fatigue, Acute episode)

Yes **Why:** _____
 No

Transferring: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Exclude transfers for toileting and baths.

Did individual participate in activity? **Yes** **No**

The most assistance provided was: None (Individual independent in performing activity)
 Verbal (Encouragement, Cueing, Standby)
 Non Weight Bearing Physical (Guiding, Maneuvering)
 Weight Bearing (Assistance bearing physical weight)
 Total – Check only if individual non-participatory

Most Amount of Assistance:

None Set up only One person physical assistance Two (+) persons physical assistance

Describe why individual needs assistance: _____

Does ability to perform activity vary? (Cognitive changes, Fatigue, Acute episode)

Yes **Why:** _____
 No

Any **acute episode** affecting transferring? **No** **Yes** **Describe:** _____

Eating: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Check one: Oral Tube fed Both oral and tube feedings

Did individual participate in activity? **Yes** **No**

The most assistance provided was: None (Individual independent in performing activity)
 Verbal (Encouragement, Cueing, Standby)
 Non Weight Bearing Physical (Guiding, Maneuvering)
 Spoon fed part or all of meal/Tube feeding by staff but participated in eating process
 Total – Check only if individual non-participatory

Most Amount of Assistance:

None Set up only One person physical assistance Two (+) persons physical assistance

Describe why individual needs assistance: _____

Does ability to perform activity vary? (Cognitive changes, Fatigue, Acute episode)

Yes **Why:** _____
 No

Any **acute episode**? **No** **Yes** **Describe:** Nausea Emesis: **Amt.** Small Moderate Large
Color: Clear White Yellow Green Blood Brown Coffee Ground Food Guaiac +
 Pain: Sharp Burning Dull/Ache **Location:** Left Upper Right Upper Left Lower Right Lower
 Other: Describe: (Difficulty chewing, swallowing, etc.) _____

Has there been a significant weight loss? (5% in 30 days or 10% in the last 180 days?) **No** **Yes**

Toileting: (Describe for status in the last 7 days. Check for most dependent status occurring 3 or more times.)

Check all that apply: BR BSC BP Urinal Cath/Ostomy Incont. Care: _____ Bladder _____ BM

Did individual participate in activity? Yes No

The most assistance provided was: None (Individual independent in performing activity)
 Verbal (Encouragement, Cueing, Standby)
 Non Weight Bearing Physical (Guiding, Maneuvering)
 Weight Bearing (Assistance bearing physical weight)
 Total – Check only if individual non-participatory

Most Amount of Assistance:

None Set up only One person physical assistance Two (+) persons physical assistance

Frequency of Incontinence: Bladder: None Less than daily Daily, some control Daily, no control
 Bowel: None Less than weekly Weekly, 1 or more Daily

Describe why individual needs assistance: _____

Does need for help vary? (Difference between Bladder/Bowel; Cognitive changes, Fatigue, Acute episode)

No Yes – Why: _____

Is individual on scheduled toileting? No Yes Describe: _____

Is individual on bladder retraining? No Yes Describe: _____

Any acute bowel episodes? No Yes Check all that apply.

(Assess BS, Abd. tone, Pain – nature and location, Color and Consistency of Stool) Constipation Impaction Diarrhea

Describe: _____

Any acute urinary symptoms? No Yes Check all that apply. Urgency Frequency

Urine: Color: _____ Clear Cloudy Bloody Odor: None Foul Strong

Pain: None Burning Sharp Dull/Ache When voiding Where: _____

Other: _____

Skin Assessment:

Color: WNL Pale Flushed Cyanotic Hot Warm Cool Cold Dry Diaphoretic Clammy

Mucous Membranes: Dry Moist

Integrity: Intact Not-Intact (If multiple sites, use additional sheets.)

Bruise Rash Skin Tear Burn: Degree _____

Laceration Surgical Wound Other Wound

Ulcer (If more than one ulcer, use additional pages to describe.)

Size: _____ Stage: _____ Color: _____ Necrosis Eschar

Drainage: None Yes – Amount: Small Moderate Large

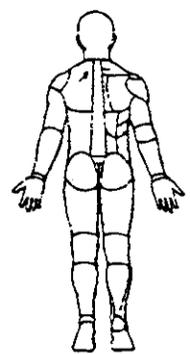
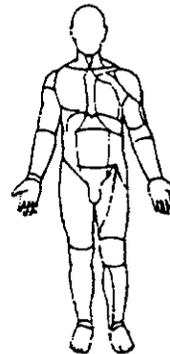
Color: Clear White Yellow Green Bloody

Odor: None Yes: Describe: _____

Tunneling: No Yes

Turgor: Describe: _____

Edema: Where: _____ Amt.: _____ +



Vital Signs: Temp: _____ B/P: _____ Pulse: _____ Resp: _____

SOB: No Yes (*assess breath sounds): At rest Lying down With exertion All the time

Chest Pain: No Yes (*assess breath sounds): Describe: _____

Cough: No Yes (*assess breath sounds): Dry Wet Loose Tight Rattling

*Breath sounds: Describe: _____

Secretions: No Yes – Cough Suction Amt.: Small Moderate Large Consistency: Thin Thick

Color: Clear White Yellow Green Bloody Brown Other: _____

Psycho-Social: Memory: Short Term Intact Impaired Oriented to: _____

Decision making: Appropriate Cueing/Supervision needed None

Mood State Indicators: Verbal expressions of distress (Negative statements, Repetitive questions/statements, Anger with self or others, Self-deprecation, Expresses unrealistic fears, Repetitive statements something terrible is about to happen. Repetitive health or other complaints)

No Yes – Describe: _____

Physical Manifestations of Distress: (Unpleasant mood in morning, Insomnia, Change in sleep pattern, Sad/Pained affect, Crying/tearfulness, Repetitive movements, Withdrawal activities on interest, Reduced social interaction)

No Yes – Describe: _____

Are there changes in cognition or mood since last assessment? No Yes – Changes last 7 days? No Yes

RN Signature: _____

Date: _____

CBA Semiannual Nursing Assessment (cont.)

Behavior Patterns

Code for Status Last 7 Days

0 – None 1– Behavior Occurred Less Than Daily 2 – Behavior Occurred Daily

_____ Verbal Aggression _____ Physical Aggression _____ Other Socially Inappropriate _____ Resists Care

Diagnosis

List any NEW DIAGNOSES in the last 3 months which are still affecting care needs.

1. _____
2. _____
3. _____
4. _____

Health Conditions

Check any conditions occurring in the last 7 days.

- | | |
|---|--|
| <input type="checkbox"/> Inability to lie flat due to shortness of breath | <input type="checkbox"/> Dehydrated |
| <input type="checkbox"/> Delusions | <input type="checkbox"/> Dizziness / Vertigo |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Syncope |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Unsteady gait |
- Pain – If checked, was pain: Less than daily Daily Multiple times a day Highest Severity was: Mild Moderate Severe
- Fall in last 30 days
- Fall in last 180 days
- Hip fracture in last 180 days
- Other fracture in last 180 days

Dietary

Diet: _____ Is Mechanical Alteration Used? No Yes _____

Has there been a change in the last 90 days? No Yes _____

Treatments and Health Interventions

_____ Number of medications last 7 days New medications last 3 months? No Yes

Check for any used in last 2 weeks:

- | | | | | | |
|---------------------------------------|-------------------------------------|--------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Radiation | <input type="checkbox"/> Dialysis | <input type="checkbox"/> IV Fluids | <input type="checkbox"/> IV Medications | <input type="checkbox"/> Transfusions |
| <input type="checkbox"/> Oxygen | <input type="checkbox"/> Suctioning | <input type="checkbox"/> Trach. Care | <input type="checkbox"/> Ventilator/Respirator | | |

Restraints: (Code whether device is used for positioning or restraint) 0 – Not Used 1– Used Less Than Daily 2 – Used Daily

_____ Bed rails _____ Trunk restraint _____ Limb restraint _____ Chair prevents rising

Code Number of Times Client was:

_____ Hospitalized for an overnight stay or longer in the last 3 months.

_____ Seen in **emergency room** in the last 3 months.

_____ Seen by physician (excluding hospital stays) in the last 14 days.

Have there been abnormal lab values/test results in the last 3 months? No Yes – What: _____

