08/07/02

Instructions

for

Completing

NURSE'S ASSESSMENT VISIT REPORT
M-27r

HUMAN RESOURCES ADMINISTRATION
MEDICAL ASSISTANCE PROGRAM

HOME CARE SERVICES PROGRAM

INSTRUCTIONS FOR COMPLETING THE M-27r
NURSE'S ASSESSMENT VISIT REPORT

SECTION I

A. IDENTIFYING INFORMATION	
Field Office	Indicate the CASA by number. If case is active with PSA, DAS or ACS indicate which office and borough.
Case Manager	Name of case manager if known.
Client's Name	Last name, first name and middle initial, if any.
Date of Birth	Indicate month, day and year.
Mutual Case	If case is mutual, use this space to give the other client's name and social security number.
Address	The client's place of residence. Please be sure to include the apartment number and floor.
Social Security Number	Nine-digit social security number.
Medicaid	Use the CIN.
Medicare	Please check whether the client has Medicare and provide the Medicare number.
Assessment Agency	CHHA should check Home Health Agency; Home Attendant Contract Agency should check Home Attendant.
Billable Hours	If client is currently receiving home attendant service, indicate the billable and authorized hours. If the client is receiving CHHA or private pay services, indicate the number of hours and write whether the service is private pay or CHHA. If CHHA, write name of CHHA below authorized hours.
Recommendation for Authorization of Services (in hours) _____	Your recommendation for services (in hours) should be filled in after you have completed the assessment. If client has unscheduled needs for assistance with ambulating, transferring and/or toileting which are documented in this form, your recommendation for authorization of services (in hours) should include the daily span of time over which

Recommendation for Authorization of Services (in hours) _____ (Continued)	the home attendant's assistance will be required. If the purpose of the visit is an initial assessment for home attendant or housekeeping services, check "start" or "deny." These are the only boxes that should be checked in this part for an initial case. If the assessment indicates the client is appropriate for home attendant or housekeeping services, check "start." If the client is inappropriate, check "deny." If the purpose of the visit is a reassessment or change, check whether the current service plan should be "continued," "discontinued" or whether the client requires an "increase in tasks" or a "decrease in tasks." Check these 4 boxes only for current home attendant or housekeeping cases. If the client requires an increase in task(s) or a decrease in task(s), please be sure to specify which task(s) are now needed or are no longer needed and the reason(s) for the change. This information should be written on Page 4 or Page 7, in Section VIII. *D. Comments, Special Instructions, Plans or Goals for Continued Service.*
Present at Interview	It is important to indicate who was present during the interview and who was the source of your information. For example, if the sister of the client was present and provided information about the client, check "relative/friend" and indicate sister and provide the name, address and telephone number of the sister. If an interpreter was used, indicate the relationship of the interpreter to the client, e.g., neighbor.
Recommended Level of Care	Complete this section for all clients. Indicate the appropriate level of care.

Contact Person	Provide the name and telephone number of a relative or friend who can be contacted in an emergency or can provide additional information.
Purpose of Visit	Indicate whether this is an initial assessment, a reassessment of current services, or a request for a change in service.
B. MEDICAL INFORMATION	
Diagnosis	In most instances the diagnoses will be those listed on the M-11q, *Medical Request for Home Care Services.* If date of onset is not on the M-11q, indicate the date(s) of onset on the M-27r, *Nursing Assessment Visit Report.*
Significant Symptoms	Please be sure to indicate those symptoms leading to task needs.
Vital Signs	Pulse, temperature, respiration, blood pressure.
Client's Primary Medical Provider	This person may be different than the name of the physician on the M-11q. If so, please provide complete information including the name, address, telephone number and specialty.
Regularly Scheduled Appointments	This section is extremely important in planning the schedule of services for the client. If client has no regularly scheduled appointments, indicate "none." Please note that this includes non-medical as well as medical appointments.

SECTION II

A. IMPAIRMENTS	If you checked "yes," please describe the impairment. If you checked "yes" for dominant hand/arm, examples of comments may be "client has tremors," or "cannot lift arm above waist," "hand is severely deformed due to arthritis and cannot grasp an object." Write "R" or "L" to indicate dominant hand/arm.
ADDITIONAL FUNCTIONAL IMPAIRMENT SECTION	
B. Bladder Control	If you indicate sometimes incontinent, please indicate the frequency and reason.

Bowel Control	Same as above.
C. Sight	If you indicate total or legally blind, please indicate the date of onset and the reason if not clear from diagnosis. Indicate potential for training and utilization of equipment.
Hearing	If client has a hearing aid, does client utilize it?
PAGE 2 OF M-27r **SECTION III**	
A. Mobility	See definition on Page 11 of instructions.
Can Independently	This means client walks, wheels, and gets up and transfers without the use of mechanical aids and without the aid of a person. Client may hold on to furniture or touch the walls.
Can w/mech-aid	This means client walks, wheels, gets up and transfers with the use of mechanical aids and without the aid of a person.
Can w/person	This means that the client requires a person to assist whether the client uses mechanical aids or not. An example would be a person in a wheelchair who needs someone to push the wheelchair outside. If the client needs mechanical aid and a person, you must specify the reason.
B. Client Endurance	Explained on form.
Telephone Usage	If a client cannot use the telephone, it is essential to specify the reason(s). Some examples are aphasia, Alzheimer's, or in some instances, client cannot dial phone or grasp receiver. Consider whether telephone can be changed to accommodate client's incapacity.
Personal Emergency Response System (PERS)	Please indicate whether client has a PERS.
C. Client Preferences	While we cannot always accommodate client preferences regarding the time of service, it is important that we are aware of these preferences and that these preferences be accommodated where possible.
D. Client Status Variations	There may be periods during the day when the client experiences periods of weakness or pain, or conversely may be more able to accomplish ADLS. Client may be going for chemotherapy or dialysis, and more assistance may be required prior to or after

D. Client Status Variations (Continued)	the treatments. If so, please specify.

SECTION IV

A. Mental Status	If the client is impaired in any of these areas, you are required to specify in the Comments Section.
Oriented to Time, Person, Place	If no, please indicate whether all three, or if one or two. Also, if one or two, specify the areas of disorientation.
Alert	Responsive and aware of surroundings.
Able to Learn	Can client understand and retain information relating to new information or instructions? For example, will client be able to understand and follow through on instructions relating to special equipment?
Able to Direct	Self-directing means that the client is capable of making choices about activities of daily living, understanding the impact of the choice and assuming responsibility for the results of the choice. If client is unable to direct, please indicate who will direct.
Impaired Recent Memory	Is client able to remember recent events, e.g., information you provide during the interview?
Agitated	Client may be restless, exhibit increased activity intermingled with anxiety, fear or tension.
Wanders	This activity refers to physically wandering. Please indicate whether the client wanders around the apartment building or leaves the building. If there is a history of wandering, be very specific as to time of day, conditions, last known incident, etc.
Depressed	If yes, indicate if depression is appropriate. For example, client may have recently learned of serious diagnosis, may have had a relative or friend die, etc.
Anxious	Client is apprehensive, uncertain or fearful without a specific cause. There may be physiological symptoms such as tachycardia or sweating.
B. Judgement	Please ask the client the questions in Section IV, B. and check whether the

B. Judgement (Continued)	answers are appropriate, fair or inappropriate. If "fair" or "inappropriate," please indicate client's answer.
Abusive/Assaultive/Etc.	If you check any of these, please explain. If you are reporting a specific incident, indicate the date. Also, who is your source of information?
PAGE 3 OF M-27r **SECTION V**	
Functional Aids	It is essential that a complete assessment be done on what functional aids the client has, and the client's ability to use the aids correctly. If the client is not using the aids correctly, or needs additional or different aids, the client's doctor should be contacted to order the aids, or arrange for assessment/training of client in functional aids/devices.
SECTION VI	
A. Skilled Needs	Review skilled needs listed. If provider is a CHHA, indicate which CHHA. If the provider is a relative/friend, give the name, telephone, and relationship. If client does self-care, write "self."
B. Additional Service/Referral	If referral is needed, please be specific as to reason. If the client is receiving service, specify the name and telephone number of the service provider.
C. Current Medications	Self-administration means that the client directly swallows, applies, inhales, inserts, or injects a medication into his/her body. Assisting with the self-administration of medication includes reminding the client when to take medications, reading the label for the client, opening the container, positioning the client for medication administration, providing appropriate liquids for swallowing medication, storing, cleaning and disposal of used supplies and equipment and storing medication properly. Please list all medications. If client requires administration, be very specific as to the reason. For example, client's hand shakes and she would be unable to place a

C. Current Medications (Continued)	pill in her mouth.
PAGE 4 OF M-27r **SECTION VII**	
RECOMMENDED PLAN OF CARE	Please note that the assessor nurse is required to identify the personal care tasks with which the client needs assistance and calculate the weekly time required by the home attendant. *Note: If your determination is that the client has need for assistance over a 24-hour period, which is documented in this form, you should identify each personal care and chore service task with which the client needs assistance and whether the assistance is some or total, but you do not have to calculate the weekly time required by the home attendant to complete each task.* Some tasks are calculated on a daily basis, e.g., bathing; while other tasks are calculated on a weekly basis, e.g., housekeeping activities. Some tasks may be performed on a monthly basis, e.g., escort to the physician, and others are calculated on a per event basis, e.g., feeding. The specific amount of time required for a task is printed on the form. If this standard time will not meet the client's needs, adjust the task time by crossing out the standard time and writing in the appropriate adjusted task time immediately above the crossed-out time. Indicate the reason for the adjustment in the comment sections on Pages 4 and 7. E.g., client is recuperating from a CVA, has R/S weakness and requires additional assistance with bathing, dressing and grooming to encourage client to perform these tasks. Calculate the total weekly time by multiplying the specific time and the

RECOMMENDED PLAN OF CARE (Continued)	weekly frequency. For example, a client requires total assistance with bathing, the standard time meets the client's needs and the client is bathed 5 days a week: the task time is 20 mqd x 5 which equals 100 minutes. Therefore, the number 5 is written under the frequency column and 100 under the total weekly time column. Tasks that may be needed by the client but that will be performed by anyone other than the home attendant are not to be indicated in the frequency column nor in the total weekly time column. <u>The frequency column and the total weekly time column are only to be used to calculate the home attendant weekly time</u>. Compute the subtotal time in minutes on Pages 4, 5 and 6 and enter the total weekly time on Page 6, converting the total minutes into total weekly hours. Please be sure that your calculations are correct. If the client has no unscheduled ambulating, transferring and/or toileting needs, enter the total weekly task time on Page 1 under "recommendation for authorization of services (in hours) _____." If unscheduled ambulating, transferring and/or toileting needs are documented on this form, see instructions re: "Span of time" under "toileting," "transferring," and "mobility." The "recommendation for authorization of services (in hours) _____" must include the span of time.
Personal Care Activities	It is essential that you be very specific in this section. Please use the following definitions:
Not Needed	Client does not require this task. For example, the client does not need lotion on his/her skin.
Independent	The client is able to perform the task independently without the assistance of a person with or without the use of

Independent (Continued)	mechanical devices or aids.
Some (Partial)	New York State Regulations defines "some" as meaning that a specific function or task is performed and completed by the patient with help from another individual. An example of some assistance with bathing is that the client can bathe herself, but needs assistance getting into and out of the tub. If you indicate "some" for any ADL, you must specify in the Comments Section at the bottom of the Page, the type of assistance required and the reason. For example, client is unable to climb in and out of tub and wash self as a result of (L/S) paresis.
Total	This means that the task is performed for the client, e.g., the client is bathed by someone else.
PERSONAL CARE ACTIVITIES	
1. Bathing	Includes bed, sponge and tub bathing, as well as getting into and out of tub or shower. Please consider whether a shower chair, safety bars, or any other equipment could be utilized to permit the client to bathe independently.
2. Dressing	Putting on and taking off clothing. This may be with difficulty or it may take time, but consider whether client can do this task independently. If client requires assistance, please specify reason.
3. Grooming	See listed tasks.
4. Toileting	This includes hygiene, adjusting clothing and assisting with the use of bedpan, urinal, commode or toilet. Consider whether raised seat or grab bars would help. Client may use the toilet during the day, but may be able to use bedpan, urinal or commode at night.

4. Toileting (Continued)	If you indicate "some" or "total," you must be very specific in your comments explaining why client needs assistance and relate to diagnosis. If client's needs are unscheduled, indicate span of time over which HA's (home attendant's) assistance will be required in Comments Section on Page 4. For example, client lives alone and requires assistance with getting up from seated position and ambulating to bathroom. Can reliably transfer to commode at night. Requires presence of HA from 9AM to 8PM.
5. Transferring	Includes from bed to chair or wheelchair. If client requires assistance with transferring to toilet, include under "toileting." If a client requires "some" or "total" assistance, please specify in the Comments Section, and relate to diagnosis. If need is unscheduled, indicate span of time over which HA's assistance will be required in the Comments Section on Page 4.
6. Mobility	Mobility includes walking (with cane, walker, etc.) as well as wheeling. A client is independent if he/she can ambulate with or without specialized equipment even with difficulty or very slowly, or even with some pain or shortness of breath. A client may be independent inside but require assistance outside. Some clients need no assistance because they are bed-bound. If a client requires "some" or "total" assistance, explain why in the Comments Section, and relate to a diagnosis. If client would be at serious risk of falling as a result of impaired mobility, note this information in the Comments Section. If need for assistance with mobility is an unscheduled need, indicate span of time over which HA's assistance will be required in the Comments Section on page 4.
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7. Prepare for Bed	Assist client with the tasks needed to prepare for bed.
8. Medical Supplies	Please indicate which supplies and why client requires assistance.
9. Dressing	Please note that this assistance is limited to a stable (closed, not infected) wound. Assistance is limited to removing the old dressing, cleansing around the wound and applying a new dressing.
10. Stable Colostomy Care	Routine cleaning around the area of a stable colostomy and emptying and changing the bag.
11. Foley Catheter Care	Routine care including cleansing area and emptying bag.
12. Texas Catheter Care	Apply condom catheter (Texas, external). Change bag and/or leg bag of external catheter.
13. Bed bound Positioning Turning	Please indicate reason in Comments and relate to diagnosis.
14. Escort	Accompanying/assisting the client to and from appointments.
15. Prepare for Day Care or Special Treatment	Please be sure that the name and address of program, agency (clinic, etc.) is indicated on Page. 1.
16. Other	Indicate the task, the frequency and the weekly time required for the home attendant to perform the task.
NUTRITIONAL ACTIVITIES	
17. Meal Preparation	Preparation of a regular diet.
18. Special Diet	Preparation of a special diet. An example of a special diet that would require extra time to be added to task time is a pureed diet.
19. Feeding	The process of getting food by any means from receptacle into the body. The receptacle may be a plate, glass or tube. If client requires help with actual feeding, please indicate why and relate to diagnosis. Be certain to indicate in the appropriate column on Page 5, the daily frequency with which the client will require the home attendant's assistance and identify feeding as a recurring need in the Comments

19. Feeding (Continued)	Section on Page 7.
PAGE 6 OF M-27r	
20. Medication	If client requires assistance, please specify the reason as well as indicating the type and frequency of assistance required. If home attendant must be present to provide the required assistance, explain why and indicate that this is a daily recurring need in the Comments Section on Page 7.
21. Other	Indicate any other personal care task that may be required.
22. Housekeeping Activities	See listed activities.
PAGE 7 OF M-27r **SECTION VIII**	
A. Environment	Please describe the environment as it impacts on home care. Also, note any problems that may affect task times.
B. Sleep-In Facilities	Please indicate whether there is a separate bed and private space for personal belongings for a home attendant.
C. Other Factors	This section is to be used to advise HCSP of any factors that may impact on HCSP's ability to provide personal care. For example, a client's medical condition must be stable which means that the condition is not expected to exhibit sudden deterioration or improvement. The condition should not require frequent medical or nursing judgement to determine changes in the client's plan of care.
D. Comments	Please use this section for any information relevant to the client's situation that has not been covered or requires amplification. Specify daily recurring needs for assistance with feeding and/or medication. If client has unscheduled needs for assistance with toileting, transferring and/or indoor mobility (ambulating) which are documented in this form, elaborate here. Be specific as to period of time HA's presence will be required to meet unscheduled ambulating, transferring and/or toileting needs. In addition, explain

D. Comments (Continued)	any need for assistance during nighttime hours, even if those services are provided by an informal caregiver.
Name/Agency	Please write your name and signature in the space provided. Write the name of your agency and the telephone number at which you can be reached in the space below your name.