TRINITY CARE XYZ

PCS: CASE MONITORING FORM

DATE OF MONITORING: _____/_____/_____ TIME: _____AM/PM

NAME OF LPN INN HOME AT TIME OF VISIT :

CLIENT: MARTE RUBEN

DOB:

PRIMARY MEDICAL DIAGNOSIS: DX: Cerebral Palsy
Skilled Needs: Gtube feedings, assists with ADLS

NEW OR CHANGE IN MEDICAL CONDITION: *(Please circle all that apply)* **NO CHANGE☐**

☐CARDIAC ☐PULMONARY ☐ENDOCRINE NEUROVASCULAR☐

DEMENTIA/ALZHEIMERS MUSCULAR/SKELETAL GASTRO/INTESTINAL

INTEGUMENTARY /SKIN REPRODUCTIVE PSYCH/SOCIAL OTHER

PLEASE DESCRIBE ALL NEW CHANGES IN MEDICAL STATUS CIRCLED ABOVE:

_____
_____
_____
_____

IS CASE MONITORING VISIT WITHIN 60 DAYS OF LAST VISIT? ☐ **YES** ☐ **NO**

IS THIS VISIT DUE TO A RECENT HOSPITALIZATION DISCHARGE OR INTERRUPTION OF SERVICE?
☐YES NO☐

IF YES, EXPLAIN: _____

EMERGENCY PRIORITY CODE/EMERGENCY PLAN REVIEWED? **YES** **NO**

IS THERE A CHANGE IN PRIORITY CODE/EMERGENCY PLAN? **YES** **NO**

IF YES, WHAT IS THAT CHANGE? _____

IS THERE A CHANGE IN THE EMERGENCY CONTACT: YES NO IF YES, WHO IS THE NEW EMERGENCY CONTACT? Adriana Marte
RELATIONSHIP: MOTHER PHONE #: _201-466-8797

IS THERE A CHANGE IN THE ADVANCED DIRECTIVE? YES NO IN LOCATION? YES NO

IF YES, WHAT ARE THOSE CHANGES? _____

ARE THERE ANY NEW PROBLEMS/CONDITIONS TO THE PATIENT SINCE LAST VISIT? YES NO

IF YES, WHAT ARE THEY? _____

_____

ALLERGIES: NKA YES NO **ALLERGIES**: _____

FUNCTIONAL STATUS: **IS THERE A CHANGE** IN FUNCTIONAL STATUS FROM THE PREVIOUS ASSESSMENT OF THIS CLIENT? YES NO

IF YES, EXPLAIN: _____

MOBILITY: _____ AMBULATES INDEPENDENTLY _____ WALKS WITH CANE/WALKER

_____ NEEDS W/CHAIR _____ BEDREST WITH BRP _____ BED REST ONLY

AUDITORY: ____ NO PROBLEMS _____HOH WEARS HEARING AIDS: _____RT _____LEFT

VISION: _____ WEARS GLASSES _____ LEGALLY BLIND _____ NO VISION

SPEECH: _____ NO DEFICITS _____ DIFFICULTY SPEAKING _____ DOES NOT SPEAK

NEEDS ASSISTANCE WITH: DRESSING BATHING/SHAMPOO ORAL CARE GROOMING

FEEDING BOWEL/BLADDER MEDICATION TRANSFERRING FROM BED TO CHAIR

DOES THE RN ASSESSMENT DETERMINE THE NEED FOR VITAL SIGNS? YES NO

VITAL SIGNS:

TEMP: _____ PULSE: _____ RESPIR: _____ B/P _____/_____

PAIN: YES DENIES **PAIN SCALE USED**: NUMERIC _____ FLACC_____ FACES (PEDS) _____

DESCRIPTION/LOCATION OF PAIN: _____DURATION _____

PSYCH/SOCIAL: □ NO PROBLEMS □ NO CHANGE □ COOPERATIVE □ ANXIOUS
□ DEPRESSED □ AGGRESSIVE □ MEMORY DEFECT □ IMPAIRED DECISION MAKING □ HOSTILE
□ HISTORY OF ALCOHOL ABUSE □ HISTORY OF DRUG ABUSE □ UNCOOPERATIVE

SLEEP PATTERNS: □ NO PROBLEMS □ NO CHANGE □ INSOMNIA □ DISRUPTED SLEEP

NUTRITION: □ NO CHANGE □ REGULAR DIET □ SOFT FOODS □ LOW SODIUM
□ DIEBETIC DIET □ POOR APPETITE □ GOOD APPETITE □ G-TUBE:

FORMULA: _____ RATE: _____ VOl: _____ FREQ: _____

INTERMITTANT FEEDINGS CONTNUOUS FEEDINGS PUMP USED: _____

IS THIS A CHANGE FROM THE PREVIOUS ASSESSMENT? YES NO

New Support Services in place: *No* *Yes* *If yes, what are they?*

_____

CLIENT LIVES: ALONE WITH SPOUSE WITH FAMILY

OTHER: _____

PLAN OF CARE REVIEW:

Does the Plan of Care continue to meet the client's needs? **Yes** **No**

Does the Plan of Care need revision? **Yes** **No** **if yes, what are those revisions?**

_____

_____

The Plan of Care has been reviewed with the client/family member. *Yes* *No*

The Plan of Care has been reviewed with the LPN. Yes No

CLIENT/FAMILY MEMBER UNDERSTANDS THE PLAN OF CARE ☐ YES ☐ NO COMMENTS:
_____

****HOME SAFETY REVIEW/FALL ASSESSMENT****

Is smoking allowed in the home? Yes No
Are there working smoke detectors/alarms in the home? Yes No
Is there an accessible escape in case of fire? Yes No
Are there overcrowded electrical outlets? Yes No
Is a portable heater used in the home? Yes No
Is the stove/oven Electric Gas
Are there any flammable items near the range top? Yes No

Are there any loose rugs, linoleum tiles or mats that could cause tripping? Yes No
Are there loose wires/cords/materials around living areas that could cause trips? Yes No
Are living areas free of clutter? Yes No
Is furniture steady and secured? Yes No
Is the walker/cane/assistive device within arms-reach of client? Yes No
Does the client experience episodes of dizziness/vertigo or unsteadiness? Yes No
Are there proper assistive devices for the client that would help prevent a fall? Yes No
Are there animals in the home? Yes No
If so, are they adequately cared for? Yes No By whom? _____
Are the animals well behaved and non-threatening? Yes No

Is the client taking anti-hypertensive medication? Yes No
Is the client taking antipsychotic medication? Yes No
Does the client take a sleep aid at night? Yes No

IS THIS CLIENT AT RISK OF FALLING BASED ON THE ABOVE ASSESSMENT? Yes No
IS FAMILY AWARE OF CLIENT'S FALL RISK? Yes No
WHAT WILL BE DONE TO PREVENT A FALL FOR THIS CLIENT?

_____

_____

New Nursing Diagnosis, if applicable:

1) _____ *related to* _____.
2) _____ *related to* _____.
3) _____ *related to* _____.

The Primary Care Physician has provided a Certificate of Need for PCS Services. *Yes* *No*

Original Signature of Physician obtained if needed? *Yes* *No*

Nursing Supervisor Name (Print): _____

Nursing Supervisor Signature/Title: _____ Date: ____/_____/___

LPN Name: _____

LPN Signature/title: _____ Date: ____/____/_____