Client Name: Chad Quill ☐ **Client May Not Be Left Unattended If Checked** ☐

Address as: Quill ☑ PCA Appropriate ☐ CNA Required

Client's Overall Condition: Chad is in early stages of Alzheimer's but is in reasonably good physical health

Frequency of Services: 8 hours Saturday and Sunday **Duration**: Ongoing

This Plan of Care is for (Time/Location): Client home, day time

	Client Goal	How Caregiver will help the client achieve the goal
1.	Maintain Safety	Caregiver to provide safety supervision
2.	Keep home clean	Caregiver to provide light housekeeping as needed to maintain clean living areas, laundry, linens
3.	Stay engaged socially	Caregiver to provide transportation to activities and social engagements. Caregiver to provide companionship and conversation

Description: Gender Male Weight 150 Client Language: English ☐ Blind ☐ Deaf ☐ Can't Speak

Orientation Status: Fully Oriented **Cognition** ☑ Alzheimer's ☐ Dementia ☐ Combative ☐ Delusional ☐ Wanderer

Health Information: ☐ Blood Thinner ☐ COPD ☐ Chronic Heart Failure ☐ Hypertension ☐ Ischemic Vascular Disease ☐ Pneumonia ☐ Diabetic ☐ TB ☐ Stroke ☐ Amputations ☐ AIDS ☐ ALS ☐ MS ☐ Parkinson's ☐ Depressed ☐ Anxious ☐ Fearful ☐ History of Falls ☐ Wheelchair ☑ Cane ☑ Hearing Aids ☑ Glasses ☐ Contacts ☐ Oxygen ☐ Hospital Bed ☐ Dentures ☐ DNR ☐ Advanced Directives ☐ Hospice ☐ Walker

Allergies: Sulfa, Peanuts

Attitude Toward Care: Positive

HIPAA Authorized: Frank Quill, Samantha Wright

Caregiver Permitted to Nap on Overnight Shift? N/A

☐ Smoking ☑ Cat(s) Garfield ☐ Dog(s) _____

Personal Care

	Task	Frequency	Level of Assistance	Record on Care Log as:
☑	Bath	PRN	Supervise	Bath (S) Supervise Type (SH) Showe
☑	Dressing	daily	Supervise	(S) Self
☐	Oral / Denture Care		NA	NA
☐	Comb/Brush Hair		NA	NA
☐	Shampoo Hair		NA	NA
☐	Skin Care		NA	Y or N
☐	Electric Shave		NA	Y or N
☑	Medication Reminders	daily	NA	(R) Reminders

Toileting

	Task	Frequency	Level of Assistance	Record on Care Log as:
☑	☐ Bedpan ☐ Urinal ☐ Bedside Commode ☑ Toilet (see next line)		Supervise	(T) Toilet
☑	Client Generally Continent		Record if the client was continent or incontinent today: C or I	
☐	Brief and Perineal Care		NA	Y or N
☐	Urinary Cath/Colostomy		NA	NA
☐	Stool: If care allows you to observe stool indicate whether Formed, Hard, Loose, Smear			F or H or L or S

Ambulation/Movement ☐Fall Precautions

	Task	Frequency	Level of Assistance	Record on Care Log as:
☑	Ambulation/Sit/Stand/Trans	Daily	Supervise	(S) Supervise
☑	Active Range of Motion	Daily	NA	A or /
☐	Positioning		NA	NA

Homemaking/Companionship

	Task	Frequency	Level of Assistance	Record on Care Log as:
☑	Meals/Snacks	daily	☑Setup ☐Prepare	(S) Setup
	☑ Breakfast ☑ Lunch ☐ Dinner ☐ Snack Time _____		☑Diet Restrictions	Peanut Allergy
☐	Feeding		NA	NA
☐	Fluids - No Action		NA	NA
☑	Light Housekeeping	PRN	NA	Y or N
☑	Transportation	PRN	NA	(T) Tranportation
☑	Shopping / Errands	PRN	NA	(E or S) Errands/Shopp
☐	Independence Support		NA	Y or N
☑	Orientation Reminders	Daily	NA	Y or N
☑	Safety Supervision	Daily	NA	Y

Notes:

The cat (Garfield) does not require any attention from our staff
Caregiver to wash linens weekly and PRN. Caregiver to take pants and shirts to dry cleaner, DO NOT wash in machine.
Client usually will not answer the door. A key is hidden under the welcome mat.
Orientation Reminders: Help client stay oriented to date. Talk to the client daily about his children and grandchildren (Frank, single) (Samantha and her husband Ted, grandchildren: Nick, and Brittany). Point them out in the photos while you ask him about them.

Scenario for quiz - You go to work with Quill Saturday and Sunday.

Saturday: You do light housekeeping, remind him to take meds, wash laundry, fix breakfast and lunch, take him to the grocery store, talk about his family, and supervise his bath, dressing, and ambulation. Quill flatly refuses to do range of motion exercises.

Saturday: You do light housekeeping, remind him to take meds, fix breakfast and lunch, talk about his family, do Active ROM, and supervise his dressing, and ambulation but he does not bathe.

Review Date			
Signature			

_____ _____ _____
RN Signature Client or Responsible Party Signature Date

Activity / Care Log

Client Name: _____

		Date:																				
		Day	Saturday			Sunday			Monday			Tuesday			Wednesday			Thursday			Friday		
		Shift	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
Personal Care	Bath (**T**otal / **P**artial / **S**upervise)																					
	Type (**Sp**onge / **B**athtub / **Sh**ower)																					
	Dressing (**A**ssist / **S**elf)																					
	Hair (**B**rush / **S**hampoo)																					
	Skin Care (**Y**es / **N**o)																					
	Mouth Care (**R**outine / **D**entures)																					
	Shave (**Y**es / **N**o)																					
Elimination	Assist (**B**edpan / **U**rinal / **BSC** / **T**oilet)																					
	Elimination (**C**ontinent / **I**ncontinent)																					
	Brief & Perineal Care (**Y**es / **N**o)																					
	Assist (**U**rinary Cath / **C**olostomy Bag)																					
	Stool Description (**F**ormed/**H**ard/**L**oose/**S**mear)																					
Ambulation Movement	Ambulation (**S**upervise / **A**ssist / **I**ndependent)																					
	(**WC**Wheel-chair / **W**alker / **C**ane)																					
	Range of Motion Exercises (**A**ctive)																					
	Positoning (**S**elf / **A**ssist)																					
Homemaking & Companionship	Meals/Snacks: **P**repared / **S**etup																					
	Feeding: **S**elf / **P**rompt / **A**ssist / **T**otal feeding																					
	Fluids: **E**ncourage / **R**estrict																					
	Medications: **I**ndependent / **R**eminder / **F**amily																					
	Light Housekeeping: **Y**es / **N**o																					
	Transportation / **E**rrands / **S**hopping																					
	Independence Suport: **Y**es / **N**o																					
	Orientation Reminders: **Y**es / **N**o																					
	Safety Supervision: **Y**es / **N**o																					
Caregiver's Initials																						

Caregiver's Signature ↓	Initials ↓	Caregiver's Signature ↓	Initials ↓

ONLY RECORD THE TASKS YOU COMPLETE!
DO NOT RECORD WHAT THE CLIENT DOES ON THEIR OWN WITHOUT YOUR ASSISTANCE

Client Signature: _____

Activity / Care Log: effective 03/25/2019

Note any changes in client condition below. Include information provided by family or private caregivers. Call office immediately if any significant changes occur.

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Any change in mobility or ROM?							
Nutrition: Eating more or less? Difficulty in swallowing?							
Bowel or bladder elimination problems?							
Falls, injuries, or complaints of pain? *If client falls on your shift call office immediately!							
New skin breakdown? Cuts/Sores/ Ulcers?							
Change in mental Status? New/worsening confusion?							
Other notes:							

Incident Documentation (Description, Date, Time): _____

_____

_____