1905.0 Developmental Services Nursing Assessment and Documentation

1905.1 Policy Approval Clearance Record

☐ Rural Services Policy ☐ Mental Health Policy ☒ Developmental Services Policy	This policy supersedes:	Number of pages in Policy:
Review by Representative from the Office of the Attorney General: N/A	Date: N/A	Date Policy Effective: 09/14/11
Rural Services Director Approval Signature: *Barbara Legier*	Date: 11/24/11	Policy Lead: Tammy Ponder, Sally Mitchell

1905.2 Statement of Purpose

1905.2.1 **Policy Statement:** Rural Services Developmental Services will identify basic health care assessment standards for individuals receiving services and provide nursing oversight to facilitate access by individuals served.

1905.2.2 **Purpose:** To provide the Developmental Services nurse with a standardized format and with procedures to complete nursing assessments so that individuals served by the agency are assessed and basic health care needs identified.

1905.3 Authority

Medicaid chapter 2100, Home and Community Based Waiver to People with Mental Retardation and Related Conditions

1905.4 Unique Definitions and Acronyms

1905.4.1 **Nursing Health Assessment (nursing assessment):** is part of the nursing process, which includes establishment of a nursing diagnosis, treatment planning, implementation, and evaluation of the effectiveness of the plan. The assessment requires collecting, validating, and trending data. It is the first and most important step in the nursing process and establishes the parameters for the ongoing nursing process.

1905.5 Procedures

1905.5.1 **Nursing Assessment Parameters** – nursing assessment parameters are noted below based on the type of program or service received.

A. For an individual receiving services under the Home and Community Based Waiver for People with Mental Retardation and Related Conditions (waiver), a nursing assessment will be completed no less than every other year with the individual having a comprehensive physical exam by his or her physician in the alternating years.

B. For an individual **not** on the waiver but considered medically fragile, nursing assessments will be conducted as determined by the individual support team if the individual is receiving waiver services and as medically necessary, but not less than every 2 years.

C. For an individual **not** on the waiver and **not** considered medically fragile, nursing assessments will be conducted when determined medically necessary by the support team but no less than every 3 years.

D. For an individual **not** on the waiver, **not** medically fragile, and living the family home and the family maintains the medical health of the individual, a physical exam is necessary every other year. No nursing assessments are necessary unless

requested by Developmental Specialist (DS) III or support team due to a change in medical status.

E. The purpose of the assessment is to collect data on the individual's health status; identify deviations from his/her medical baseline; discover the individual's strengths and coping resources; and identify actual, medical, behavioral issues and factors that place the individual at risk for health problems.

F. It is the responsibility of the DS nurse to maintain appropriate tickler systems in order to track and comply with these requirements.

1905.5.2 Preparing for the First Meeting with an Individual

Ensuring that the nurse is prepared to interact with the individual is critical to successful completion of the nursing assessments. An individual may have a behavioral plan or staff may have information about how to best communicate with the individual. It is important to prepare in advance and access all resources available prior to meeting with the individual. The goal is to better understand communication or behavioral issues so as to know the best approach to take with each individual. Review of the current nursing assessment, social assessment, and individual service plan (ISP) is required prior to conducting the first meeting. Talk with the individual's DS III prior to conducting the assessment to identify any special considerations that may contribute to a successful completion of the assessment. Speak with provider, as appropriate, to gather pertinent information or to gain clarity.

1905.5.3 Nursing Goals and Recommendations

Every area assessed during the nursing assessment will identify nursing goals or nursing recommendations, as appropriate.

A nursing goal is a specific area of change that the nurse and individual have identified as something the individual will address for the betterment of his or her health or welfare.

A nursing recommendation is a possible way to enable a change without great disruption in the individual's daily life. The recommendations must be attainable goals for the individual, measurable, and implementable by the individual or staff with an attached timeline.

1905.5.4 Completion of the DS Nursing Comprehensive Assessment

The nurse will complete the Developmental Services Nursing Comprehensive Assessment (Attachment A) as follows:

A. Demographics

1. Name of Person Served: the name of the person receiving services.
2. Date Completed: the date the nurse meets with the individual to complete the assessment.
3. Age: Age of individual served in years and months, such as 56 years and 2 months.
4. DOB: Date of birth: entered as MM/DD/YYYY.
5. Living Arrangement: Identify whether the individual lives parents/family, alone, or with roommates. Also identify if the individual receives supported living arrangement (SLA) or 24-hour intensive supported living arrangement (ISLA) services.
6. Height: Indicate number of feet and inches.
7. Weight: Indicate number of pound with individual fully clothed and wearing shoes.

8. Diagnosis: Include all diagnoses, including ate of diagnosis, as well as full scale IQ (FSIQ) and date of IQ test. Also include diagnoses and findings of physician consults, such as elevated cholesterols/lipids. Diagnoses can be viewed in ElCid and the ISP. ISPs can be electronically submitted to the nurse by the DS III.

9. Medications: List all prescribed, over-the-counter medications, and name of prescribing physician. Include medication, name, dose, route, and frequency.

   The use of hyperlinks to provide definitions, side effects, drug interactions, and nursing indications is important so that providers and DS IIIs have easy access to additional information. Example:

   - Lovastatin
     - Side Effects
     - Interactions
     - Nursing Indications

10. Allergies: These include documented allergic reactions to medications. The allergic reaction to the medication must be noted also; i.e., drop in blood pressure and increased heart rate or red face and neck. Due to cognitive or emotional issues, often self-reported food allergies are actually food dislikes. If a food allergy is reported, clarify the reaction and where it occurred so that medical documentation can be requested. If food intolerance is noted, such as dairy products, clarify how this deficiency is addressed or supplemented. Identify whether or not an individual has an Epi-Pen in his/her possession and knows how to use it or if the provider has received training and can assist the individual. Note the expiration date of the Epi-Pen. Examples:

    - Penicillin – causes full body rash and swelling of throat.
    - Tomatoes – causes severe swelling of throat area.

11. Date of Last Nursing Assessment: MM/DD/YYYY

12. Date of Last Physical: MM/DD/YYYY

13. Date of Last Dental Exam: MM/DD/YYYY

14. Date of Last Vision Exam: MM/DD/YYYY

15. Recent medical issues: Note any recent medical issues, such as trips to the emergency room (ER) or consults with specialists (i.e., neurology, OB/GYN, speech therapist, orthopedic, etc.).

    Sample note: Individual had a trip to the ER on 07/07/1977 complaining of pain in the ear. The diagnosis was otitis media (inner ear infection) and was treated with an antibiotic injection of _____ and was prescribed Tylenol for pain, along with _____ (antibiotic) _____ mg to be taken 3 times per day for 10 days. Continue to monitor and follow up in _____ days.

B. Physical Review

1. Vision: Note the date of the last provider examination and findings of the exam.

2. Hearing: Note the date of the last provider examination and findings of the exam. If a hearing aid is used, note when it was last fitted, its condition, and if the person can demonstrate battery replacement.

3. Dental: Note the date of the last provider examination and findings of the exam.

4. Musculoskeletal: Assess gait, posture, muscular palpation, joint palpation, range of motion, deformities, and muscle strength. Sample note:

    - Muscular development and skeletal structure bilaterally equal. No joint deformities, swelling, color change, or tenderness. Full range of motion either active or passive without pain. Normal spinal curve without deformity. Adequate muscle tone and strength bilaterally.

5. Neurological: Evaluate level of consciousness (LOC). A change in LOC can be indicative of a deteriorating condition and whether the individual is in need of further medical assessment and intervention. The following are tools that can be used to assess LOC:

    For stoke patients, use the National Institutes of Health (NIH) Stroke Scale: www.ninds.nih.gov/doctors/NIH_Stroke_Scale.pdf.

    For all other patients, use the Glasgow Coma Scale (GCS) at: www.cdc.gov/masstrauma/resources/gcs.pdf.

    - A GCS score is based on three patient responses: eye opening, motor response, and verbal response. The patient receives a score for the best response in each of these areas, and the three scores are added together. The total score will range from 3 to 15. A score of 8 or lower typically indicates coma. It is important to assess the pupils during the neurological exam as a change in pupil size, shape, or reactivity can indicate increasing intracranial pressure (ICP) from a mass or fluid.
    - LOC: A/O X 3 (alert and orientated to name, time and place).
    - Verbal response
        - Clear
        - Incoherent, rambling, slurred, stuttering
        - Dysphasia, aphasia
    - Motor response (<, = bilaterally, >)
        - Grips (note strength)
        - Obeys commands, localizes pain, withdrawal, flexion, extension, none
    - Assess pupils
        - Note shape
        - Pupils equally round, react to light, and accommodate (PERRLA), which means the ability of the eyes to focus on objects that are close up and faraway

    Sample note: Individual is alert and orientated to name, time, and place. His mental state is clear and he appears coherent. During the interview, there were no signs of rambling, slurred speech, or stuttering. No evidence of dysphasia or aphasia was present at the interview.

6. Respiratory: Note the respiratory functions to include the LOC; skin color (bluish tones or cyanotic color of the lips, nail beds or skin may indicate reduced arterial oxygen); any active cough and whether it sounds productive or dry; labored breathing; shortness of breath; and any breathing sounds heard *without* using a stethoscope; symmetry of chest; and Kyphosis

(curvature at the top of the spine or humpback) as it can constrict lung expansion.

- Respiratory (12 – 20 normal respirations)
- Breathing: Dyspnea – apnea – deep/shallow
- Shortness of breath – with which activities?
- Chest:
  - Excursion symmetrical/asymmetrical;
  - Lung Sounds (audible all lobes/bases)
  - Rales – crackles – rhonchi – wheezes
- Sputum:
  - Clear – thin/thick – tenacious – note color
  - Measure 0^2 Saturation
  - Pulse Oximeter (90% or higher)

Sample note: Chest is symmetrical. There is no cyanosis at rest. Mucous membranes are pink. No evidence of clubbing. Trachea is midline and easily palpable. Respirations are quiet, equal, regular and within normal limits for age. Breath sounds are clear and equal bilaterally both anteriorly and posteriorly.

7. Cardiovascular (normal pulse 60 -100)
Apical, B/P, Radial PP (present <, = bilaterally, >)

- Rate/Rhythm
  - Regular, Irregular, Strong, Rapid, Weak, Absent, Thready
  - Intensity
    - 1,2 (hypo) slow
    - 3,4 (hyper or bounding)
- Skin
  - Pale, flushed, cyanotic, discolored, moist, cold, clammy
- Edema
  - Pitting – nonpitting
  - Capillary refill < 3 seconds
  - Homan's sign +/-

Sample note: Skin is warm and dry with no evidence of unexplainable diaphoresis. Individual has no cyanosis or mottling with CRT < 3 seconds. Neck veins flat at 45 degrees. There is no sacral or periorbital edema. Peripheral pulses strong, equal to apical rate and equal on all 4 extremities. Apical heart rare is regular and within normal limits for age. No murmurs are present. Current vitals are BP _____, P ____, R ____, pulse ox _____.

8. Gastrointestinal

- Abdomen
  - Soft, firm, rigid, tender, sensitive to touch

        - Enlarged, distended, flat, round
    - Bowel sounds (listen to all four quadrants – 2 to 5 minutes)
        - Normal, faint, hypo, absent, hyper
        - Bowel movement size (small, medium, large)
    - Nausea/Vomiting (N/V) – amount/color/frequency
        - Milliliters, small, large, blood tinged, fecal
        - Projectile (spewing – occurs frequently in tuberculosis)
        - Diarrhea (amount/color/frequency)
        - Appetite (tolerance to prescribed diet)
        - Percentage

    Sample note: Abdomen is soft and non-distended. Bowel sounds active (5-34/min). No pain or tenderness in all 4 quadrants with palpation. Individual tolerates prescribed diet without nausea, vomiting or diarrhea. Having BMs within own normal pattern and consistency.

9. Genitourinary (30 mL/hr normal output)

    - Urination: independent, catheter, incontinent
        - Amount
        - Color – yellow, amber, bloody, brown, dark red
        - Appearance – clean, cloudy, sediment
        - Odor – offensive, foul, musty, aromatic, ammonia like, odorless
        - Intake/Output (I/O) – all fluids should be balanced with output
    - Bladder distention – check, feel, palpate

    Sample note: Individual is able to empty bladder without discomfort. Bladder is not distended after voiding. Urine clear and yellow to amber.

10. Endocrine: Assessing the endocrine system is a problem-focused assessment. A good resource for assessing the endocrine system is: www.rn.com/getpdf.php/585.pdf

    Physical exam techniques used in the focused endocrine assessment are the same as those used in the general exam to include inspection, auscultation, percussion, and palpation. Examples of what to inspect related to endocrine abnormalities are skin color, location of lesions, bruises or rashes, symmetry, size of body parts, and abnormal sounds or odors.

    Sample note: The individual has no excessive sweating or skin changes since last assessment. No reports of intolerance to heat or cold noted. There are no complaints of excessive thirst or urination. The person has had a 20 lb. decrease in weight due to a healthier diet over the last year, according to provider. Menstrual cycle is predictable and individual has seen no major fluctuations over the past year.

11. Dermatology/Skin

    - Inspection and palpation of the skin
        - Color

- Temperature, texture, turgor
- Dryness or moisture
- Scaling
- Pigmentation
- Vascularity (erythema, abnormal veins)
- Bruises, petechiae (a tiny purplish red spot on the skin)
- Edema (dependent, facial)
- Induration (hardening)
- Individual lesions (color, type, texture, general pattern of distribution, character of edge, whether raised or flat)
- Hair (amount, texture, distribution) and scalp (lesions)
- Nails (shape, texture, discoloration, grooving)
- Mucous membranes
- Skin folds
- Joint involvement

- Other aspects
  - Examine lymph nodes
  - Examine area distal to enlarged lymph nodes

Examples for notes:

- Skin: pink, warm, dry, soft, and elastic; no lesions, discolorations, odor or edema; color is uniform; no flaking of the scalp.
- Nails: pink, smooth and hard with no clubbing, thickening or tenderness.
- Body hair: moderate with uniform distribution.
- Mucous membranes: moist and pink without lesions.
- Lymphadenopathy absent
- Temperature: within normal range, T _____ oral.

Sample note: The individual's skin is warm and dry with no lesions, discolorations, odor or edema. The skin color is normal excepting a birthmark over the right knee, which is approximately a ½-inch oval shaped mark. There are no scalp problems and individual keeps hair cut very short. Nails are smooth with minimal thickening and no clubbing or tenderness is noted. Person does not have increased amount of body hair on face, chest, legs, and back. Mucous membranes are pink and moist with no lesions while they lymph system seems intact. Body temperature is "within normal limits" (WNL).

12. Podiatry: When assessing a person's feet, the nurse pays close attention to certain indicators. Some of these indicators will require the person to be referred to a skilled care podiatry nurse or doctor. Other indicators may only need to be addressed by the provider, after the provider reads and understands the nursing goals and recommendations in the comprehensive assessment.

Indications for evaluation by a podiatrist or visiting nurse may include, but are not limited to:

- A history of diabetes
- A history of peripheral vascular disease
- Evidence of diminished circulation (cool skin, diminished or absent pulses)
- Swelling, loss of sensation, or burning sensation in feet
- Areas of impaired skin integrity of the feet/ankles (ulcers, skin cracks, rashes, wounds, corns, blisters, etc.).
- Toenail problems (thickened, long)
- Evidence of toe abnormalities that may impair mobility or cause pressure on other toes.

Sample note: Individual has a history of diabetes and peripheral vascular disease. There is evidence of decreased pedal pulses in both feet, with a loss of sensation along with non-healing skin ulcers. Person's toenails are thick, crusty, and show a yellow color. This is possibly due to a fungal infection under the nails. There are no abnormalities in the structure of the toes themselves.

C. Health History

1. Family Medical History: Note the medical history of the individual's parents, siblings, and other immediate family members in order to identify possible risk factors of disease for the individual. This knowledge can alert the individual and his/her team of risk factors that should be avoided, if possible. The knowledge can also be utilized as an educational opportunity for individualized teaching or developing supports. Family medical history is to updated by contacting family members of the individual, with written permission, as necessary.

Sample note: Mother is 65 years old and other than hypothyroidism is healthy. Father is 66 years old and health. _____ has two brothers who are healthy, and one sister who has Down's syndrome.

2. Neonatal and birth history: The neonatal assessment is necessary on an initial comprehensive nursing assessment for the application for Community Based Waiver. It frequently can be located on other professional records assessments and the agency application form.

Neonatal history and birth history are used by the DS nurse to help establish baselines on the nursing assessment.

Sample note: The pregnancy was normal, but delivery at Renown was two weeks past due. _____ was delivered with signs of meconium in his trachea. He was not breathing and suffered oxygen deprivation.

3. Past Medical History, Childhood Diseases, Hospitalizations, and Surgeries: Describe past medical history, childhood diseases, hospitalizations, and surgeries.

Sample note: Individual had a history of ear infections, pneumonia at an early age <6. At age 7 individual had mumps and measles with chicken pox the following year. At the age 8, he choked on a piece of food and was unconscious for 3 – 5 minutes while workers resuscitated him. In 2001, he was admitted to Mercy General for acute appendicitis and had surgery to

remove his appendix. At the age of 16, he was bitten by a copperhead snake and was in and out of Advent Hospital for a month due to an allergic reaction to anti-venom.

4. Developmental History: Note the age that developmental markers occurred, and if the individual followed normal developmental progression. If normal developmental progression did not occur, note the age any deficits were noted. Note if and when the developmental deficits were diagnosed.

Sample note: At two years _____ began having seizures. At the age of 2½ years, he was diagnosed with Sturge-Weber. He had a stroke at 36 months of age. _____'s development was normal until he suffered the stroke and had to relearn how to walk, crawl, and talk. He also went from left to right hand dominance.

5. Medications, Immunizations and Vaccinations: Supports needed for administration and side effects:

- Medications – Sample Table:

Zanaflex 2 mg 1 tab PO TID	Name of Prescribing Physician
Synthroid 125 mcgm 1 tab PO Daily	Name of Prescribing Physician
Vit D3 1 tab Daily	Name of Prescribing Physician

- Immunizations/Vaccinations – Individual has received all required immunizations/vaccinations, and shot record is up to date.
  - Name of immunization, date received; booster due date

  Sample note: It is recommended that individual be evaluated by his primary physician for recent scratch from rusty metal to determine if he is a candidate for a Tetanus booster.

- Supports needed for medication administration:

  Sample note: Individual has assistance to help him fill his pill planner and take meds on time.

- Side effects – A side effect link can be hyperlinked to each and every medication the individual is taking right on the nursing assessment. It can also be printed out to keep with the medication wherever the medication is administered.

  Sample hyperlink: Doxycycline 200 mg PO BID two times a day at 6 a.m. and 6 p.m.

6. Nutrition: Weight Gain or Loss Over the Last 12 Months: Determine if the individual has experienced any significant weight gain or loss since the last assessment. If so, note the amount of weight gain or loss and possible reasons for the change in weight.

Sample note: Individual has lost 30 pounds since last year's nursing assessment. This is attributed to the complete overhaul of the diet in the house. The diet consisted of eliminating caffeine, sugar and soft drinks. The results are: consistently lower blood sugars, better attention span, and less fatigue. Person follows direction betters, and is much happier with new body image.

D. Goals and Recommendations

1. Nutrition Goals:

- To determine the status of the nutritional processes of ingestion, digestion, absorption, transport, and metabolism.

- To identify signs of altered nutrition.

Sample note: Individual is underweight and has evidence of muscle wasting. Diet choices are not sufficient to maintain health, such as decreased immune system, poor healing, and increased risk of disease. BMI INDEX: BMI Calculator

Example of a goal: Increase lead muscle mass by changes in diet.\

Example of a plan: Discuss diet with individual; find out if he/she understands the choices he/she is making and if he/she would like to make a change to his/her food lifestyle.

Example of an intervention: Choose nutrient dense foods that the individual agrees to consume and make a meal planner to assist the person stay with those choices. The choices should be written and in plain sight to reduce the process of having to think about every meal when it is time to eat. A snack list for between meals should also be posted.

There are many ways to accomplish this goal, such as pocket planners or planners on the kitchen bulletin board or refrigerator.

2. Mobility and Activities of Daily Living: Document an individual's specific and routine activities, such as climbing stairs to an apartment, bicycle riding, or walking home and/or to the store, Identify the frequency of specific sports, such as softball, basketball, or Special Olympics. Educate the person about local activities in which the individual may want to participate, as increasing activity is a natural and efficient method to combat many medical and psychological issues.

3. Communication: Assess the level of communication of the individual.

- Verbal
- Verbal – needs communication assistance
- Non-Verbal – needs communication assistance
- Use of adaptive communication device.

If the individual uses sign language, indicate his/her proficiency.

- Low = uses a few signs, may be unique to the individual
- Medium = uses standard signs, can make basic needs known
- High = uses standard signs, can communicate well

Sample note: This individual is able to speak in 3-4 word sentences and can be understood if time is taken to listen. Most people who are socially connected to individual learn to understand him just fine.

4. Psychiatric and Behavioral Issues, Social Adjustment, Psychological Issues:

- Psychosocial Assessment: Parents/caretakers show evidence of coping with their own or their child's treatment program by:
  - Establishing eye contact.
  - Asking appropriate questions based on reason for treatment.
  - Verbalizing any concerns or requests.
  - Comforting/supporting the individual prior to, during, and after stressful procedures.

Sample note: Individual enjoys participating with Movers and Doers activities and going to the library with her friends. When at home, she spends time on the computer playing card games and Facebook with her friends. She works with power lifting two days per week, softball one day per week during the season, and track one day per week. She also spends time with a friend's family during the week.

5. Sexual Health and Training Needs: Assess the level of interest and knowledge.

Sample note: Individual is not currently sexually active, but he understands the levels of relationships. He is very knowledgeable about the need to have safe sex and protection.

6. Disaster Preparedness: There are different types of disasters that are prevalent to Nevada, such as earthquakes, wildfires, avalanches, and high winds. It is important to ensure individuals know what to do in case of a disaster; what resources are available; emergency plans are developed; and emergency packs prepared.

Sample note: John understands what disasters and emergencies are and he has the ability to exit a building without assistance. John knows how to call emergency 911 for help. In the hallway closet, there is a 72-hour emergency evacuation kit that should be replaced yearly on the date _____. There is also at least a 5-day supply of food and water in the home at all times. This supply should be continually rotated throughout the year. There is a minimum of a 5-day supply of medications available at all times. John participates in monthly evacuation drills.

7. Animal Ownership: Note any animals or pets in the home or outside the home. Review pet vaccination records and the name and phone number of the vet.

Sample note: there are 2 dogs that have required vaccinations that stay in the house with Jack, and there are 3 outside cats, which are not vaccinated. Jack does not play with the cats, but he loves his dogs. They are his constant companions.

E. Resources Accessed for Completion of the Nursing Assessment

1. The individual, guardian, DS III, hard copy and electronic files, JDT personnel, last nursing assessment and physical, ELCID and DSNOW notes must all be accessed as necessary to conduct a thorough nursing assessment.

Sample note: I met with Jack at his parent's home for his annual nursing assessment. Both parents were available and helped with some of the information requested. The Developmental Specialist briefed me before I went to the home. The provider staff person was present. Data accessed – ELCID, the last physical, last nursing assessment, and DSNOW notes. The last nursing assessment was distributed to the DON, DS III, and DS IV. The electronic version of the nursing assessment is saved to the H drive and the Z drive, in the Nursing Assessments folder, by individual's first and last initials, ID number, date of assessment, and title of document. Example:

A.B. 23456 9-9-11 Nursing Assessment

2. Progress notes are completed by the DS nurse in the DSNOW electronic record for every client contact within 2 working days of the date of contact. A summary progress note will be written by the nurse, at a minimum, quarterly. A progress note must also be written every time as assessment is

completed. The progress note will include significant events or changes in the life of the individual, in DAP format. The end of the progress note must contain the name of the nurse and the nurse's credentials (e.g., RN).

- Yearly: Note that the nursing assessment has been completed.
- Quarterly: To maintain communication with individual and assess his/her medical needs.
- As needed: Progress notes contain information on any unusual events, significant observations, or interactions with the individual.

Example of DAP:

- D = Describe – individual's right arm is sore from a fall.
- A = Assess – no obvious broken bones, fingers are warm to the touch and capillary refill is within 3 seconds. Person has some grimacing or pain when moving arm.
- P = Plan – use ice pack on arm this evening and re-assess in morning. If there is no relief by morning, contact PCP. John Boy, Jr., RN 8/2/2011.

Example of assessments:

- Yearly: the individual was met at his home. The comprehensive nursing assessment has been completed. There are no follow-up issues. He will be seen again in 2 years to update the assessment.
- Quarterly: Individual contacted by phone at home. He reports his health and safety is reported as stable at this time. Will follow-up again next quarter.
- As needed: Individual had a fall on left arm this morning and was taken to ER. X-rays were performed, which were negative for fractures. Individual was given a prescription – Ibuprofen 800mg, by mouth, three times a day until gone – and sent home with ice packs for injured area.

3. The nurse must follow-up with each DS III regarding recommendations made on the Nursing Assessment. Recommendations requiring immediate action by the DS III must be followed up by the nurse within 2 working days. Recommendations not requiring immediate action by the DS III must be followed up by the nurse within 7 working days and monthly at the DS Leadership meeting until completed or determined unnecessary. This follow up will be documented in a case note. Lack of action by the DS III will be referred to the DS IV.

The DS nurse will communicate with staff via email and copy the DS IV regarding any immediate actions needed.

The nurse will use the email system to track follow up of nursing recommendations. The DS nurse will keep an Excel spreadsheet to track nursing recommendations and progress with due dates, along with a tickler file on the Outlook calendar.

4. The nurse must track completion of nursing assessments in ELCID and establish a system to track the need for reassessments. If the nursing assessment is waived, a physical must be completed that year, which is the responsibility of the DS III to monitor.

5. Providers are a wealth of information. To set up appointments for home visits, environmental checks, and medication management assessment, good rapport with the provider is necessary. Coordinating home visits and jobs/day training site visits with the provider involved is critical. Unannounced visits can create obstacles that can interfere with the completion of a nursing assessment or follow-up visit. The DS III is a good resource for any provider questions.

1905.5.5 Timelines

Table 1905.5.5 Timelines for Developmental Services Nursing Assessment and Documentation

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
Nursing Comprehensive	No more than 365 days from previous Nursing Comprehensive or Annual Physical.	Previous Nursing Comprehensive or Annual Physical	DS III will schedule DS Nurse or Contracted Nurse to complete Nursing Comprehensive	DS III will make a referral for a Nursing Comprehensive to be completed.
Nursing Case Notes	Within 2 working days of interaction with individual	Date of interaction/assessment of individual	DS Nurse	DS Nurse will document in DAP format in DSNOW Case notes all communication with individual.
Quarterly Summary	Once every 4 months	Date of interaction	DS Nurse	DS Nurse will document in DAP format in DSNOW Case notes all communication with individual.

1905.5.6 Documentation

A. Case File Documentation (paper):

Table 1905.5.6.A Case File Documentation (paper) for Developmental Services Nursing Assessment and Documentation

File Location	Data Required
Individual's Regional Center File and SLA Provider File	Nursing Comprehensive

B. AVATAR/DSNOW Documentation (electronic):

Table 1905.5.6.A Case File Documentation (electronic) for Developmental Services Nursing Assessment and Documentation

Applicable UNITY Screen	Data Required
ELCID	Completion date for all Nursing Assessments
DSNOW	Documentation of case notes and quarterly reviews.

1905.5.7 Supervisory Responsibilities: Supervisors will provide in-service training to ensure all staff understands the requirements of this policy and its procedures. Supervisors will revisit this policy periodically, but no less than annually to identify recommendations for improvement.

1905.6 Policy Cross Reference

1905.6.1 RS 2904, Health Supports in Residential Settings

1905.7 Attachments

1905.7.1 RS1905A, Developmental Services Nursing Comprehensive Assessment

1905.7.1
ATTACHMENT RS 1905A
DEVELOPMENTAL SERVICES
NURSING COMPREHENSIVE ASSESSMENT

Developmental Services Nursing Comprehensive Assessment

Name of Person Served	Date Completed	Living Arrangement	
Age	**DOB**	**Height**	**Weight**

Diagnosis:
Medications:
Allergies:
Date of Last Nursing Assessment:
Date of Last Dental Exam:
Recent Medical Issues:

Date of Picture:

Date of Last Physical:
Date of Last Vision Exam:

SPECIALTY	NAME	ADDRESS/PHONE
Primary Physician		
Psychiatrist		
Optometrist/Ophth		
Dentist		
Other:		

Physical Review

Note: Add footnotes and hyperlinks where appropriate.

Vision:

Nursing Goals and Recommendations:

Hearing:

Nursing Goals and Recommendations:

Dental:
Nursing Goals and Recommendations:

Musculoskeletal:

Nursing Goals and Recommendations:

Neurological:
Nursing Goals and Recommendations:

Respiratory:

Nursing Goals and Recommendations:

Cardiac:

Nursing Goals and Recommendations:

Genitourinary and Gastrointestinal:

Nursing Goals and Recommendations:

Endocrine:

Nursing Goals and Recommendations:

Dermatology/Podiatry:

Nursing Goals and Recommendations:

Family Medical History:

Nursing Goals and Recommendations:

Neonatal and Birth History:

Nursing Goals and Recommendations:

Past Medical History, Childhood Diseases, Hospitalizations and Surgeries:

Nursing Goals and Recommendations

Developmental History:

Nursing Goals and Recommendations:

Immunizations and Vaccinations:

Nursing Goals and Recommendations:

Medications and Supports Needed for Administration:

Side Effects:
Nursing Goals and Recommendations:

Nutrition:

Any weight gain or loss over the last 12 months: ___ Yes ___ No
If yes, explain:
Nursing Goals and Recommendations:

Developmental Services Nursing Comprehensive Assessment

Mobility and Activities of Daily Living:

Nursing Goals and Recommendations:

Communication:

Nursing Goals and Recommendations:

Psychiatric and Behavioral Issues:

Social Adjustment:

Nursing Goals and Recommendations:

Psychological Issues:

Nursing Goals and Recommendations:

Sexual Health and Training Needs:

Nursing Goals and Recommendations:

Disaster Preparedness:

Nursing Goals and Recommendations:

Animal Ownership:

Nursing Goals and Recommendations:

Resources Accessed For Completion of the Nursing Assessment	
___ Developmental Specialist III	___ Physical Exam Report
___ Record Review	___ Provider Staff
___ Family Member	Other: _____

R.N Signature	Date:

Distribution: Post to Electronic File Z Drive; Email copy to DSIVs, DS IIIs and Director of Nursing.