AANAC
AMERICAN ASSOCIATION OF NURSE ASSESSMENT COORDINATION

American Association of Directors of Nursing Services

Baseline Care Plan

Resident: _____ MR#: _____

Admission Date: _____ Allergies: _____ Code Status: _____

Initial Goals

- ☐ Discharge to community
- ☐ Remain LTC
- ☐ Other: _____

Resident information

Resident preferred name:

_____

Representative name:

_____

Cognition

- ☐ Alert/cognitively intact
- ☐ Confused
- ☐ Elopement risk
- ☐ Intervention: _____

Communication

- ☐ Verbal
- ☐ Non-verbal
- ☐ Preferred language or method of communication:

_____

Vision

- ☐ Vision adequate
- ☐ Vision impaired: _____
- ☐ Appliance: _____

Hearing

- ☐ Hearing adequate
- ☐ Hearing impaired: _____
- ☐ Appliance: _____

Communication, hearing or vision risk

- ☐ Interventions:

_____

Dietary Orders

- ☐ Regular diet
- ☐ Other: _____
- ☐ TPN or tube feeding:

_____

- ☐ IV fluids: _____

Resident's dietary preferences

_____

_____

Dietary risks

- ☐ Risk for weight loss
- ☐ Risk for swallowing problems
- ☐ Risk for chewing problems
- ☐ _____

Resident's dietary goal

- ☐ Maintain current weight
- ☐ Prevent weight loss
- ☐ _____
- ☐ _____

Dietary interventions

- ☐ Eats in dining area
- ☐ Eats in room
- ☐ Dentures or partials
- ☐ Specialty utensils or devices:

_____

- ☐ _____

_____

_____

_____

Therapy Services

- ☐ PT: _____
- ☐ OT: _____
- ☐ SLP: _____

Restorative

- ☐ Program(s):

_____

_____

Resident's functional goals

- ☐ Maintain current functional status
- ☐ Improvement:

_____

- ☐ Decline:

_____

_____

Functional interventions

- ☐ _____
- ☐ _____

Safety

Safety

- ☐ History of falls:

_____

- ☐ History of fall-related injury:

_____

- ☐ _____

_____

_____

Social Services

- ☐ Mental health needs:

_____

_____

- ☐ Behavior concerns:

_____

_____

- ☐ PASARR Level II recommendation:

_____

_____

- ☐ Depression screening:

_____

_____

Able to recognize need for placement in nursing home:

_____

_____

Resident's psychosocial goals

_____

_____

_____

Social services/psychosocial interventions

- ☐ Behavioral interventions:

_____

- ☐ _____

_____

- ☐ _____

_____

- ☐ _____

_____

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ADLs

Bed Mobility	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A	**Locomotion**	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A
Transfer	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A	**Eating**	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A
Walking	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A	**Grooming/ hygiene**	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A
Toileting	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A	**Bathing**	☐ Independent ☐ Setup ☐ Assist of 1 ☐ Assist of 2+ ☐ Total dependence ☐ N/A

Equipment

☐ Wheelchair ☐ Scooter
Type: _____

☐ Cane ☐ Walker
Type: _____
_____

☐ Side rails: _____
Type: _____

☐ Mechanical lift: _____
Type: _____

☐ Other: _____

Additional information:
_____
_____
_____
_____
_____
_____

Special Treatments/Procedures

☐ **Transfusions**
☐ **Radiation**
☐ **Chemotherapy:** _____
☐ **IV Medication:** _____
Type: _____
Location: _____
Dressing change: _____

☐ **Ventilator**
☐ **Tracheostomy:** cannula size _____
☐ **Suction:** _____
☐ **Oxygen:** _____
Liters per minute: _____
☐ **BiPAP:** _____
Liters per minute: _____
☐ **CPAP:** _____
Liters per minute: _____

☐ **Isolation/quarantine for:** _____
Type: _____

Other treatment/procedure:
☐ _____
_____
_____
☐ _____
_____
_____
☐ _____
_____
_____

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Bowel and Bladder

Bowel
- ☐ Continent
- ☐ Incontinent
- ☐ Appliance: _____

Bladder
- ☐ Continent
- ☐ Incontinent
- ☐ Appliance: _____
- ☐ Incontinence briefs or pads
- ☐ Size: _____

Bowel and bladder risk
- ☐ Risk for incontinence
- ☐ _____

Bowel and bladder goal
- ☐ _____

Bowel and bladder interventions
- ☐ Scheduled toileting: _____
- ☐ _____

Alarms and Restraints
- ☐ Alarm: _____
- ☐ Restraint: _____
- ☐ Medical symptom to justify use: _____

Alarms/restraints reduction goals
- ☐ Maintain current alarm/restraint as ordered
- ☐ Reduction plan: _____
- ☐ Resident/representative decline, education provided

Skin Concerns
- ☐ Skin intact
- ☐ Current pressure ulcer: _____
- ☐ Other skin concern or wound: _____
- ☐ Wound vac

Skin break risk
- ☐ _____

Resident's skin integrity goal
- ☐ _____

Skin break interventions
- ☐ Turn and reposition: _____
- ☐ Specialty mattress: _____
- ☐ Cushions or wedges: _____
- ☐ _____
- ☐ Skin and wound treatments
- ☐ _____
- ☐ _____

Other
- ☐ _____
- ☐ _____
- ☐ _____

Other Condition
- ☐ _____
- ☐ Risk: _____
- ☐ Goal: _____
- ☐ Intervention: _____

Other Condition
- ☐ _____
- ☐ Risk: _____
- ☐ Goal: _____
- ☐ Intervention: _____

Other Condition
- ☐ _____
- ☐ Risk: _____
- ☐ Goal: _____
- ☐ Intervention: _____

Other Condition
- ☐ _____
- ☐ Risk: _____
- ☐ Goal: _____
- Intervention: _____

Resident's life history notes prior to residing in nursing home:
_____

Resident's daily routine and preferences:
_____

Resident's cultural and ethnic preferences:
_____

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Physician Orders

- ☐ See current MAR and TAR
- ☐ Current medication list provided to resident/representative
- ☐ Medication list reconciled with resident/representative
- ☐ Self-administer medications

Medications

- ☐ **High-risk/black box medication:** _____
- ☐ **Insulin:** _____
  - ☐ Blood glucose checks: _____
- ☐ **Psychotropic medication:** _____
  - ☐ Adverse effects: _____
- ☐ **Anticoagulant:** _____
  - ☐ Lab monitoring: _____
  - ☐ Monitor for s/s of uncontrolled bleeding: _____
- ☐ **Antibiotic:** _____
  - ☐ Lab monitoring: _____
- ☐ **Pharmacological pain regimen:** _____
  - ☐ Presence of pain: _____
  - ☐ Location of pain: _____
  - ☐ Characteristics of pain: _____

Other Medications/Indication for Use

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Discharge Plans

Location: _____
Caregiver: _____
Equipment needed: _____
Home services: _____

Barriers to Resident's Discharge/Goals

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Resident or Caregiver Education Needs

_____
_____
_____

Hospice Coordination

☐ Provider: _____ Address: _____
Phone: _____ Instructions: _____

Outside Coordination

☐ Hemodialysis
Provider: _____
Phone: _____
Address: _____
_____
Schedule: ☐S ☐M ☐T ☐W ☐Th ☐F ☐S
Primary transport: _____
Alternative transport: _____
Meal prep required: _____
Physician managing: _____

☐ _____
Provider: _____
Phone: _____
Address: _____
_____
Schedule: ☐S ☐M ☐T ☐W ☐Th ☐F ☐S
Primary transport: _____
Alternative transport: _____
Meal prep required: _____
Physician managing: _____

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Signatures of Interdisciplinary Team Members Contributing to Baseline Care Plan

_____	_____	_____
_____	_____	_____
_____	_____	_____

Written Summary of Baseline Care Plan

Resident: _____ MR#: _____ Admission Date: _____ Allergies: _____ Code Status: _____

Completion Dates		
Admit date: _____	Baseline care plan completion date: _____	Date reviewed with resident/representative: _____
Completion Signatures		
Staff signature: _____	Resident signature: _____	Representative signature: _____

Updates to Baseline Care Plan

Date: _____ _____ Signature: _____
Date: _____ _____ Signature: _____
Date: _____ _____ Signature: _____

☐ Baseline care plan discontinued due to completion of comprehensive care plan
Signature: _____ Date: _____