Adult Day Care Assessment and Planning System
MUST BE COMPLETED BY A REGISTERED NURSE
Please Read Guidelines for Completing the ADCAPS before Completing this Assessment

Participant Name: _____ Assessment Date: _____

DOB: _____ Male: ☐ Female: ☐ Primary Language: _____

ALLERGIES:
(DRUG) _____

(FOOD) _____

(ENVIRONMENTAL) _____

Current Medical Diagnoses: _____

Past Medical HX: _____

Past Mental Health HX: _____

Surgeries/ Procedures: _____

Identify any changes over within the past 90days:
☐ Diagnosis ☐ Medications ☐ Health Status ☐ Hospitalization ☐ Falls ☐ Incidents ☐ Emergent Care Visits ☐ Other
If there is a significant change from previous ADCAPS please document: Wt: _____
Within the last 90 days, if so document (comments):

_____

GENERAL HEALTH
Temperature: _____ Pulse: _____ Respiration: _____ Blood Pressure: _____
Current Weight: _____ (last wt. taken during physician's visit, by HCP, or RN) Date: _____
Height: _____

Diet / Nutrition: ☐ Regular ☐ No Added Salt ☐ Pureed ☐ Diabetic/No Concentrated Sweets ☐ Mechanical Soft

☐ Other Fluid: ☐ Unlimited ☐ Restricted ☐ Amount: _____

Comments: Describe Changes Including lab and diagnostic tests, if available:

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NEUROLOGICAL

Cognitive functioning:
☐ Alert/oriented ☐ Person ☐ Place ☐ Time
☐ Requires prompting (cueing, repetition, reminders)
☐ Memory deficit: failure to recognize familiar persons/places inability to recall events of past 24 hours, significant memory loss so that supervision is required.
☐ Impaired decision-making: failure to perform usual ADL's or IADL's, inability to appropriately stop activities, jeopardizes safety through actions, or fails to chose correct clothing for the season.

Speech:
☐ Clear and understandable
☐ Slurred/garbled
☐ Aphasic

Pupils:
☐ Equal
☐ Unequal

Extremities:
RUE: ☐ Strong ☐ Weak ☐ Tremors ☐ No movement
LUE: ☐ Strong ☐ Weak ☐ Tremors ☐ No movement
RLE: ☐ Strong ☐ Weak ☐ Tremors ☐ No movement
LLE: ☐ Strong ☐ Weak ☐ Tremors ☐ No movement

☐ Paralysis: If so explain:

☐ Numbness/Tingling: If so explain:

☐ Contractures: If so explain:

☐ History of Seizures: If so explain:

Comments:

SENSORY

Vision:
☐ Normal vision (can see medication labels or newsprint)
☐ Partially impaired (can see objects in path, but cannot read medication labels)
☐ Severely impaired (cannot locate objects, needs aids for vision)
☐ Corrective Lenses ☐ Yes ☐ No
☐ Glasses
☐ Contacts
☐ Blind

Hearing
☐ Normal (can hear normal conversational tones)
☐ Partially impaired (cannot hear normal conversational tones)
☐ Severely impaired (needs aids for hearing)
☐ Utilizes a hearing device
☐ Neuropathy (loss of sensation)
☐ Location:

Comments:

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CARDIOVASCULAR

BP: _____ (treatments/ medications)

Apical Pulse:

☐ Regular _____ (treatments/ medications)

☐ Irregular _____ (treatments/ medications)

Heart Sounds

S1 ☐ S2 ☐ S3 ☐ S4 ☐

Comments (200 char. Max)

Document Abnormal Auscultation:

_____

_____

_____

_____

Edema:

RUE: ☐ Non-pitting ☐ Pitting

LUE: ☐ Non-pitting ☐ Pitting

RLE: ☐ Non-pitting ☐ Pitting

LLE: ☐ Non-pitting ☐ Pitting

Comments:

RESPIRATORY

Breath Sounds:

☐ Clear ☐ Crackles ☐ Cough ☐ Wheezing

☐ Other: _____

Is the person noticeably short of breath?

☐ Never

☐ Walking or climbing stairs

☐ Eating, talking, dressing

☐ At rest

Respiratory treatments utilized at home:
(if any of the treatments are checked must provide specifics in comments section)

☐ Oxygen (intermittent or continuous)

☐ Aerosol or nebulizer

☐ Ventilator (intermittent or continuous)

☐ CPAP or BIPAP

☐ None

Comments:

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Participant Name: _____

GENITOURINARY STATUS

- ☐ Catheter
- ☐ Continent
- ☐ Incontinent
- ☐ Urine frequency: _____
- ☐ Pain/Burning
- ☐ Discharge
- ☐ Distention/Retention
- ☐ Hesitancy
- ☐ Hematuria
- ☐ Has the participant been treated for a UTI over the past month?
- ☐ Ostomies
- ☐ Other:

Comments:

GASTROINTESTINAL STATUS

Bowel frequency:

- ☐ Continent
- ☐ Incontinent
- ☐ Diarrhea
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Ostomies
- ☐ Swallowing Issues:

_____

- ☐ Pain: ☐ abdominal ☐ epigastric
- ☐ Anorexia
- ☐ Other: _____

Bowel Sounds:

☐ ⊕ Positive ☐ ⊖Negative

Comments:

MUSCULOSKELETAL

- ☐ Steady gait
- ☐ Unsteady gait
- ☐ Altered balance
- ☐ Contracture(s)
- ☐ Impaired ROM

Yes ☐ No ☐ Has the participant had a history of falls (any in the past (3) three months?) If yes is selected please complete a fall risk assessment)

Comments:

Pain frequency:

- ☐ No Pain
- ☐ Less than daily
- ☐ Daily

If daily is checked please complete a pain rating scale

Sites(s):

Cause (if known):

Treatment(s):

Please document any limitation(s) due to pain in comments section:

Comments:

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MENTAL HEALTH

☐ Angry
☐ Agitated/hostile
☐ Depressed
☐ Flat affect
☐ Uncooperative
☐ Anxious
☐ Suicide Attempt (If checked complete the Frequency of Disruptive Behavior Symptoms and comment in the comments section)
- ☐ Insomnia
- ☐ Manic
- ☐ Self Injurious Behavior (If checked complete next section and comments)
- ☐ Disruptive Behavior that may be injurious to others (If checked complete next section Frequency of Disruptive Behavior Symptoms)

Frequency of Disruptive Behavior Symptoms (Reported or Observed) Any physical, verbal, or other disruptive/dangerous symptoms that are injurious to self or others or jeopardize personal safety.

☐ Never
☐ Less than once a month
☐ Once a month
☐ Several times each month
☐ Several times a week
☐ At least daily

Is the person receiving psychological/psychiatric services?

☐ Yes ☐ No

Comments:

SKIN INTEGRITY

General skin color: ☐ Normal ☐ Pale ☐ Red ☐ Irritation ☐ Rash ☐ Other:

Comments:

Skin Turgor: ☐ Good ☐ Fair ☐ Poor

Skin intact: ☐ Yes ☐ No (if no, complete next section)

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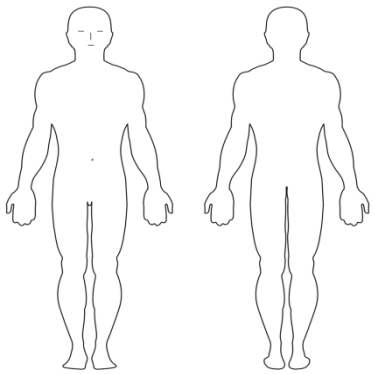
Pressure Ulcer Stages	**Number of Pressure Ulcers**
Stage 1: Redness of intact skin; warmth, edema, hardness, or discolored skin.	
Stage 2: Partial thickness skin loss of epidermis and/or dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as intact or open/ruptured serum-filled blister.	
Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bon, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of the tissue loss. May include undermining and tunneling.	
Stage 4: Full thickness skin loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.	
(1) Unstageable: Known or likely but unstageable due to non-removable dressing or device.	
(2) Unstageable: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.	
(3) Unstageable: Suspected deep tissue injury in evolution.	

Location of ulcers:



Using the above diagram or explain in the comments section, show the location of each pressure ulcer or wound. Include measurements ([length x width] record in centimeters), drainage, type and any other significant characteristics:
How to measure:
Pressure Ulcer Length: Longest length: “head-to-toe”
Pressure Ulcer Width: Width of same pressure ulcer; greatest width perpendicular to the length
Pressure Ulcer Depth: Depth of same pressure ulcer; from visible surface to the deepest area

Comments:

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ADLs and IADLs

Grooming:
Current ability to tend safely to personal hygiene needs (e.g.., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

☐ Able to groom self unaided, with or without the use of assistive devices or adapted methods.
☐ Grooming utensils must be placed within reach before able to complete grooming activities.
☐ Someone must assist the participant to groom self.
☐ Participant depends entirely upon someone else for grooming needs.

Comments:

Current Ability to Dress Body safely
(with or without dressing aids) Including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

☐ Able to get clothes out of closets and drawers put them on and remove them from the upper body without assistance.
☐ Able to dress upper body without assistance if clothing is laid out or handed to the participant.
☐ Someone must help the participant put on upper body clothing.
☐ Participant depends entirely upon another person to dress the upper body.

Comments:

Current Ability to Dress Lower Body safely:
(with or without dressing aids) Including undergarments, slacks, socks or nylons, shoes:

☐ Able to obtain, put on, and remove clothing and shoes without assistance.
☐ Able to dress lower body without assistance if clothing is laid out or handed to the participant.
☐ Someone must help the participant put on undergarments, slacks, socks or nylons, and shoes.
☐ Participant depends entirely upon another person to dress lower body.

Bathing:
Current ability to wash entire body safely. Excludes grooming (washing face, washing hands, and shampooing hair).

☐ Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
☐ With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower
☐ Able to bathe in shower or tub with the intermittent assistance of another person
  ☐ for intermittent supervision or encouragement of reminder, OR
  ☐ to get in and out of the shower or tub OR
  ☐ for washing difficult to reach areas
☐ Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
☐ Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
☐ Unable to use the shower or tub, but able to or participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
☐ Unable to participate effectively in bathing and is bathed totally by another person.

Comments:

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Participant Name: _____

Toilet Transferring:
Current ability to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.

☐ Able to get to and from the toilet and transfer independently with or without a device.
☐ When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
☐ Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance)
☐ Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
☐ Is totally dependent in toileting

Comments:

Transferring:
Current ability to move safely from bed to chair, or ability to turn and position self in bed If participant is bedfast.

☐ Able to independently transfer.
☐ Able to transfer with minimal human assistance or with use of an assistive device.
☐ Able to bear weight and pivot during the transfer process but unable to transfer self.
☐ Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
☐ Participant must have a (2) person transfer or mechanical lift transfer

Comments:

Toileting Hygiene:
Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

☐ Able to manage toileting hygiene and clothing management without assistance.
☐ Able to manage toileting, hygiene and clothing management without assistance if upplies/implements are laid out for the participant.
☐ Someone must help the participant to maintain toileting hygiene and/or adjust clothing.
☐ Participant depends entirely upon another person to maintain toileting hygiene.

Comments:

Ambulation Locomotion:
Current ability to walk safely:

☐ Able to walk safely once in a standing position
☐ Utilizes a wheelchair for mobility
☐ Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings e.g.., needs no human assistance or assistive device).
☐ With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
☐ Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
☐ Able to walk only with the supervision or assistance of another person at all times.
☐ Chair fast - unable to ambulate but is able to wheel self independently.
☐ Chair fast - unable to ambulate and is unable to wheel self.

Comments:

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Participant Name: _____

Feeding or Eating:

Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

☐ Able to independently feed self.
☐ Able to feed self independently but require:
- ☐ Meal set-up; OR
- ☐ Intermittent assistance or supervision from another person; OR
- ☐ A liquid pureed or ground meat diet.

☐ Unable to feed self and must be assisted or supervised throughout the meal/snack.
☐ Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
☐ Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
☐ Unable to take in nutrients orally or by tube feeding.

Comments:

ORAL HYGIENE:

Dentures: ☐ Yes ☐ No
Missing Teeth: ☐ Yes ☐ No

Comments:

Current Ability to Plan and Prepare Light Meals

(e.g., cereal, sandwich) or reheat delivered meals safely:

☐ Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
☐ Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past prior to this admission.
☐ Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
☐ Unable to prepare any light meals or reheat any delivered meals.

Comments:

Ability to Use Telephone:

Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

☐ Able to dial numbers and answer calls appropriately and as desired.
☐ Able to use a specially adapted telephone (e.g., large numbers on the dial, teletype phone for the deaf and call essential numbers.
☐ Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
☐ Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
☐ Unable to answer the telephone at all but can listen if assisted with equipment
☐ Totally unable to use the telephone.
☐ N/A - Participant does not have a telephone

Comments:

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Participant Name: _____

PSYCHOSOCIAL:

Behaviors observed
☐ Interacts easily with others
☐ Expresses interest in activities
☐ Diminished interest in most activities
☐ Difficulty engaging and interacting
☐ Uncooperative
☐ Any Symptoms of Physical Abuse or Neglect
☐ Wandering

Dementia Queuing: On the participant's current (day of assessment) level of alertness, orientation, comprehension, concentration and immediate memory for simple commands.

☐ Alert/oriented, able to focus and shift attention, comprehends and recalls task directions.
☐ Required prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
☐ Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
☐ Requires considerable assistance in routine shift attention and recall directions more than half the time.
☐ Totally dependent due to disturbances such as constant disorientation or delirium.

Comments:

Cognitive, behavioral, and psychiatric symptoms that are demonstrated at least once a week(Reported or Observed) (Mark all that apply):

☐ Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required.
☐ Impaired decision-making: failure to perform usual ADL's or IADL's, inability to appropriately stop activities, jeopardizes safety through actions.
☐ Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
☐ Physical aggression: aggressive combative to self and others (e.g. hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
☐ Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions).
☐ Delusional, hallucinatory, or paranoid behavior.
☐ None of the above behaviors demonstrated.

Comments:

Treatments:

Participant Name: _____

Transportation:

Does the participant have a physical or medical condition that would require special accommodations or an escort if the participant is in transit greater than 60 minutes?

☐ Yes ☐ No

If yes, explain:

Comments:

Social Services:

Does this assessment identify any social, emotional, or mental health needs per 10.12.04.15 A (4)?

☐ Yes ☐ No

(If yes) A referral must be made to a social worker:

Comments:

Medications:

☐ The participant is not taking any medications.

☐ The participant is not taking any high risk drugs

☐ Yes ☐ No ☐ N/A If taking high risk medication is the participant/caregiver fully knowledgeable about special precautions associated with high-risk medications.

☐ Yes ☐ No Since the previous ADCAPS assessment, was the participant/caregiver instructed by the registered nurse or other health care provider to monitor the effectiveness of drug therapy, drug reactions, side effects, and how and when to report problems that may occur?

☐ Yes ☐ No ☐ N/A Attached is a copy of the current Medication Orders.

(Medication orders may be attached to ADCAPS if utilizing a paper document; if utilizing a computerized document it may be scanned)

☐ Yes ☐ No ☐ N/A Medication orders have been reviewed?

☐ Yes ☐ No ☐ N/A Any changes in Medication orders since the previous ADCAPS?

☐ Yes ☐ No ☐ N/A Has the participant/caregiver received instruction on special precautions for all high risk medications (such as hypoglycemic, anticoagulants, etc.) and how and when to report problems that may occur.

☐ Yes ☐ No ☐ N/A Is lab monitoring required related to medication or diagnosis (hypoglycemic, anticoagulant, psychotropic, seizure, etc.?

☐ Yes ☐ No ☐ N/A Has the center made arrangements to obtain these labs? (If no please explain in the Comments section)

☐ Yes ☐ No ☐ N/A Has the center's registered nurse reviewed the labs?

☐ Yes ☐ No ☐ N/A Are vital signs required related to a medication or diagnosis?

☐ Yes ☐ No ☐ N/A Are there any treatments?

☐ Yes ☐ No ☐ N/A If so are treatment orders current?

☐ Yes ☐ No ☐ N/A If there were clinically significant medication issue since the last ADCAPS, was a physician or the physician-designee contacted to resolve the clinically significant medication issue, including reconciliation?

Please make (comments) on page thirteen, if needed:

Participant Name: _____

Management of Oral Medications: Participants current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals.
Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)

☐ Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
☐ Able to take medication(s) at the correct times if:
(a) Individual dosages are prepared in advance by another person; OR
(b) Another person develops a drug diary or chart.
☐ Able to take medications(s) at the correct times if given reminders by another person at the appropriate times.
☐ Unable to take medications unless administered by another person.
☐ N/A No oral medications prescribed.

Comments:

Management of Injectable Medications: Participants current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

☐ Able to independently take the correct medication(s) and proper dosage(s) at correct times.
☐ Able to take injectable medications(s) at correct times if:
(a) individual syringes are prepared in advance by another person; OR
(b) another person develops a drug diary or chart.
☐ Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection.
☐ Unable to take injectable medication unless administered by another person.
☐ N/A No injectable medications prescribed.

Comments:

Activities:

☐ Yes ☐ No ☐ N/A Does the participant have an individualized planned program of daily activities that are age appropriate and culturally relevant that meets the participant's specific needs and preferences?
☐ Yes ☐ No ☐ N/A Does the center have a weekly or monthly calendar of activities that include physical exercise, rest, social interaction, personal care, if needed and mental stimulation that meet the needs of this participant?

Comments:

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Participant Name: _____

COMMENTS SECTION: (Any additional comments or to further comments from an assessment area please document below)

Date: _____

Printed Signature: _____

Signature of Registered Nurse: _____