Assisted Living Service Plan Downtime Form

PERSON DETAILS

Name: _____DOB: _____Gender: _____

Address: _____

Contact Number: _____ _____

Paris ID ___ _____ PHN: _____

HEADER DETAILS

Date Started _____ Time Started _____

End Date _____ End Time _____

Reason for Assessment: _____

Location:_____

Team: _____

Completed by _____

End Date _____End Time _____

Goal at time of assessment

Assisted Living Site

AL Provider Name: _____

Provider Address:

AL Acuity Level: ☐ Low ☐ Moderate ☐ High

Supportive Funding

Supportive Funding Required: ☐ Yes ☐ No

If **Yes**

Start Date: _____ End Date ___ _____

Re-assessment Date: _____

Approved Hours Per Day: _____

Created on: July 14, 2020

By Health Informatics: Advanced Clinical Systems – Community PARIS

Reason for Supportive Funding:

- ☐ Acute to Assisted Living Transition
- ☐ Assisted Living to Long Term Care Transition
- ☐ Support to End of Life
- ☐ Temporary Increase of Care Needs

Comments

Client Information

Select All that Apply

- ☐ Current MOST in Place Date: _____Location of the Form _____
- ☐ Blind/Poor Vision
- ☐ Wears Glasses
- ☐ Hearing Aide(s)
- ☐ Unable to Speak/Unclear Speech
- ☐ Dentures
- ☐ Palliative Care
- ☐ Other Specify: _____

Client Mobility Recommendation (CMR) Form ☐ Yes ☐ No

Equipment Checklist

- ☐ Transfer Belt
- ☐ Cane
- ☐ Walker
- ☐ Manual Wheelchair
- ☐ Power Wheelchair or Scooter
- ☐ Roho Cushion
- ☐ Roho Mattress
- ☐ Other Specify: _____

Specific Client Needs (TIP – Chronic Illness Management, Gender, Communication Issues, Approach, Palliative, etc)

Created on: July 14, 2020
By Health Informatics: Advanced Clinical Systems – Community PARIS

Languages and Communication

Language: _____
Interpreter Required: _____

Diagnosis/Clinical Impression

Diagnosis: _____ ☐ Primary DSM
Diagnosis: _____
Diagnosis: _____
Diagnosis: _____

Additional Diagnosis Details

Allergies

Allergy: _____ Severity: ☐ Mild ☐ Intermediate ☐ Severe ☐ Unknown
Reaction: _____ (If Anaphylactic: Alert required)
Allergy: _____ Severity: ☐ Mild ☐ Intermediate ☐ Severe ☐ Unknown
Reaction: _____ (If Anaphylactic: Alert required)
Allergy: _____ Severity: ☐ Mild ☐ Intermediate ☐ Severe ☐ Unknown
Reaction: _____ (If Anaphylactic: Alert required)
Allergy: _____ Severity: ☐ Mild ☐ Intermediate ☐ Severe ☐ Unknown
Reaction: _____ (If Anaphylactic: Alert required)

Assisted Living Services

Select All that Apply

☐ Assistance with Activities of Daily Living
☐ Assistance with Managing Medications
☐ Assistance with Safekeeping Money and other Personal Property
☐ Assistance with Managing Therapeutic Diets Supports
☐ Assistance with Behaviour Management Support
☐ Assistance with Programming (or Psychosocial) Support

Comments

Personal Care Services

Select All Services that Apply	Frequency	Average Minutes	Minutes Per Day
☐ Bathing/Shower	_____	_____(15)	_____
(TIP – includes bed bath, full body wash, hair wash and related subtasks)			
☐ Sponge Bath	_____	_____(15)	_____
(TIP – includes partial body wash and related subtasks)			
☐ Assist to Dress/Undress	_____	_____(10)	_____
☐ Personal Care/Hygiene	_____	_____(10)	_____

(TIP – includes face/hand wash, brush teeth, denture care, comb/brush hair, skin care and related subtasks)
☐ Other Specify: _____

Transfers

☐ Mechanical Lift
☐ Transfer Assist Device (TIP – Sara Stedy, Sit to Stand Lift, and Transfer Board, Transfer Pole etc)

Equipment Requiredfor Personal Care Services

☐ Shower Chair
☐ Bath Bench
☐ Hospital Bed
☐ Other Specify: _____

Comments

Toileting Services

Select All Services that Apply	Frequency	Average Minutes	Minutes Per Day
☐ Continence Product Support	_____	_____(10)	_____
(TIP –includes peri care, skin care and related subtasks)			
☐ Assist Cue to Toilet	_____	_____(10)	_____
☐ Empty/Clean Commode, Bedpan, Urinal	_____	_____(5)	_____
☐ Catheter/Ostomy Care	_____	_____(5)	_____
(TIP – includes emptying, cleaning, changing bag and related subtasks)			
☐ Other Specify: _____			

Transfers

☐ Mechanical Lift

☐ Transfer Assist Device (TIP – Sara Stedy, Sit to Stand Lift, and Transfer Board, Transfer Pole etc)

Equipment Requiredfor Toileting Services

☐ Hospital Bed

☐ Bedpan/ Urinal

☐ Commode

☐ Raised Toilet Seat

☐ Toilet Safety Frame

☐ Other Specify: _____

Comments

Assignable/Delegable Services

Select All Services that Apply	Frequency	Average Minutes	Minutes Per Day
☐ Compression Stockings	_____	_____(5)	_____
☐ Med - Oral/Blisterpack	_____	_____(5)	_____
☐ Med – RX Topical Cream	_____	_____(5)	_____
Other			
☐ Catheter Care	_____	_____(5)	_____
☐ Exercise DOT from a Physiotherapist	_____	_____(10)	_____
☐ Med – Alcohol/Cannabis	_____	_____(5)	_____
☐ Med – Ear Drops	_____	_____(5)	_____

Created on: July 14, 2020
By Health Informatics: Advanced Clinical Systems – Community PARIS

☐ Med – Eye Drops/Ointment	_____	_____(5)	_____
☐ Med – Inhaled	_____	_____(5)	_____
☐ Med – Liquid Oral	_____	_____(5)	_____
☐ Med – Nasal Spray	_____	_____(5)	_____
☐ Med – Nebulizer	_____	_____(5)	_____
☐ Med – Patches	_____	_____(5)	_____
☐ Med – Rectal Suppository	_____	_____(5)	_____
☐ Med – RX Shampoo	_____	_____(5)	_____
☐ Ostomy Care	_____	_____(5)	_____
☐ O2 Equipment Maintenance	_____	_____(5)	_____

Comments

Nursing Services

Select All Services that Apply	Frequency	Average Minutes	Minutes Per Day
☐ Blood Glucose Reading – Observe/Take	_____	_____(5)	_____
☐ Catheter Change	_____	_____(15)	_____
☐ Chronic Illness Management Teaching	_____	_____(5)	_____
☐ Feeding Tube Care	_____	_____(5)	_____
☐ Med – Insulin	_____	_____(5)	_____
☐ Med – Microlax Enema	_____	_____(5)	_____
☐ Med – Rectal Suppository	_____	_____(5)	_____
☐ Wound Care	_____	_____(5)	_____
☐ Other Specify _____	_____	_____(5)	_____
☐ Other Specify _____	_____	_____(5)	_____
☐ Other Specify _____	_____	_____(5)	_____
☐ Other Specify _____	_____	_____(5)	_____

Comments

Nutrition Services			
Select All Services that Apply	**Frequency**	**Average Minutes**	**Minutes Per Day**
☐ Assist/Feed	_____	_____(15)	_____
☐ Meal Reminders/Escorts	_____	_____(5)	_____
☐ Meal Support (by exception)	_____	_____(10)	_____
(TIP – includes tray service, minor meal prep by exception based on care needs etc)			
☐ Setup/Encourage	_____	_____(10)	_____
☐ Other Specify _____	_____	_____(5)	_____

Comments

Additional Support Services			
Select All Services that Apply	**Frequency**	**Average Minutes**	**Minutes Per Day**
☐ Arrange Medical Appt/Transportation	_____	_____(5)	_____
☐ Assist to Ambulate	_____	_____(5)	_____
☐ Behaviour Support	_____	_____(5)	_____
☐ Laundry by care exception	_____	_____(15)	_____
(TIP – 15 mins for each load of laundry)			
☐ Memory Care	_____	_____(5)	_____
☐ Recreation Therapy	_____	_____(5)	_____
☐ Safety Checks	_____	_____(5)	_____
☐ SAIL/Falls Prevention Program	_____	_____(5)	_____
☐ Other Specify _____	_____	_____(5)	_____

Comments

**Total Care Time (per Month) will be auto calculated on Entry in to Paris