Personal Care Assistant (PCA) Nursing Assessment Tool

Per **N.J.A.C. 10:60-3.5(a) 3: following the initial PCA nursing assessment,** the PCA nursing reassessment visit shall be provided at least once every six months, or more frequently if the member's condition warrants, to reevaluate the member's need for continued care.

Date of Assessment _____ Person completing assessment _____

Member Name _____ DOB _____ MEIN/MCO # _____

Primary language spoken by member _____ Primary language spoken by household _____

Are Interpreter services needed? ☐ Yes ☐ No If yes, what type of interpreter services were used for this assessment? _____

Type of assessment ☐ Initial ☐ 6 month Re-evaluation ☐ re-evaluation based on change in condition

Date of last assessment _____ Current number of hours approved _____

Legally Responsible Individual (LRI) _____ LRI relationship _____

LRI limitations

People in household and relationship to member

Primary Source of information: ☐ member ☐ other - specify relationship to member _____

Structural/Physical Barriers (check all that apply)

☐ None ☐ Stairs inside home used for daily living ☐ Stairs used in home for optional use ☐ Stairs for access to home

☐ elevator or stair glide ☐ narrow halls/doors restricting wheelchair ☐ Other _____

Mental Status (describe impairments) _____

Language Status (describe impairments) _____

Hearing and auditory comprehension (describe impairments) _____

Vision (describe impairments) _____

Mobility ☐ ambulates unassisted ☐ modified mobility with or without assistive device ☐ Non-ambulatory

Diagnoses and/or limitations resulting in need for PCA services:

Factors that directly impact level of function: ☐ mobility deficit ☐ cognitive/behavior ☐ endurance ☐ sensory deficit ☐ other:(Describe below)

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Address each area of the tool. If the member does not require any assistance in that area, fill in the box with a zero.

The presence of other people in the house, does not alone indicate available assistance. Informal supports is someone accepted by the member who is present, able and willing to perform task assistance on a continued basis

The times listed for each activity are guidelines. If the member requires more or less time, place the required time in the box and write an explanation why.

Parents or legal guardians are responsible for care under ages listed. List '0' in minutes when parent/guardian is responsible for care/assist. NOTE: The age limitations are based on standard developmental milestones. These are guidelines and may vary for children with developmental disabilities.

Cognitive

Decision Making Ability- the cumulative time for supervision required between ADL/IADL tasks (over 6 years old).

If no impairment, enter "0".

Minimally impaired- cuing in new or specific situations- 60 minutes per week

Moderately impaired- repeated reminders to initiate, perform or self direct activities-120 minutes per week

Severely impaired- never or rarely makes decisions, unable to initiate or self direct any activity- 180 minutes per week

total minutes: ____

ADLs

Ambulation/mobility assistance: the process of moving between locations, e.g. room to room
includes pushing a wheelchair, includes contact guard (over 2 yrs. old)

Up to 30 minutes/day: ____ # days: ____ total minutes: 0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (non-weight bearing support) ☐ Extensive/Max assist (weight bearing support) ☐ Total dependence

Justification of need: ____

Transferring- the movement from one stationary position to another includes chair to bed/tub.
Toileting transfer is included in toileting (over 2 yrs. Old)

Supervision/Limited Assist- up to 15 minutes/day

Extensive/Max Assist- up to 30 minutes/day

Mechanical lift/Non-wt bearing up to 45 minutes/day

____ # days: ____ total minutes: 0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (non-weight bearing support) ☐ Extensive/Max assist (weight bearing support) ☐ Total dependence

Justification of need: ____

Bathing (over 6 years old) - Bathing or washing the member in tub/shower/bed/chair.
Includes washing hair, drying hair and applying lotion.

Upper body only- up to 15 minutes

Lower body only- up to 15 minutes

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If no assistance needed, enter "0".

Full bath- up to 30 minutes | # days | total minutes: 0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (minimal physical assistance) ☐ Extensive/Max assist (hand-over-hand assist) ☐ Total dependence

Justification of need

Feeding/eating (over 4 yrs. old)- the process of getting food into the digestive system, excluding meal preparation

If no assistance needed, enter "0".

10-20 minutes per meal | # of meals per week | total minutes: 0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (minimal physical assistance) ☐ Extensive/Max assist (hand-over-hand assist) ☐ Total dependence

Justification of need

Positioning (bed/chair): adjusting or changing member's position in a chair or bed

If no assistance needed, enter "0".

5 minutes per episode, limit 6 episodes per day | # days | total minutes: 0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (min. assist from caregiver) ☐ Extensive/Max assist (min. assist from member) ☐ Total dependence

Justification of need

Toileting- bowel and bladder elimination (over 5 yrs. old), including use of commode, emptying appliances, cleansing and adjusting clothing. This includes time transferring to commode or toilet.

5-10 minutes per occurrence if continent
15-20 minutes per occurrence if incontinent

Continent: ☐ Yes ☐ No

If incontinent: ☐ Bowel ☐ Bladder ☐ Both

(up to 90 minutes) | # days | total minutes: 0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (non-weight bearing support) ☐ Extensive/Max assist (weight bearing support) ☐ Total dependence

Justification of need

Personal Hygiene/grooming (over 5 yrs. old): combing brushing hair, shaving, brushing teeth, nail care

Limited assist, 5 to 10 minutes

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If no assistance needed, enter "0".

Extensive assist or higher, 15 minutes

	# days	total minutes
		0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (minimal physical assistance) ☐ Extensive/Max assist (hand-over-hand assist) ☐ Total dependence

Justification of need

Dressing and adaptive equipment (dressing over 5 yrs. old)

Limited assist, 5-10 minutes per episode
Extensive assist or higher, 15 minutes per episode

If no assistance needed, enter "0".

	# days	total minutes
		0

☐ no assist ☐ Supervision (oversight/cuing) ☐ Limited Assistance (minimal assistance from caregiver) ☐ Extensive/Max assist (min. assist from member) ☐ Total dependence

Justification of need

IADLs - If no assistance is needed, enter 0 in sections below.

Housekeeping- services are integral to personal care and include changing bed linens, vacuuming, keeping personal space clean (Over 18 yrs. old)

120 minutes per week / household size	household size	total minutes
120	0	0

Justification of need

Soiled bed linen changes.
Routine bed linen changes are included in housekeeping.

10 minutes per occasion, limit 30 minutes/day

	# days	total minutes
		0

Justification of need

Shopping for groceries and incidentals: grooming and household cleaning supplies, etc. (does include travel time) (Over 18 yrs. old)

up to 60 minutes per week

	total minutes
	0

Justification of need

Meal Preparation- includes meal planning, storing, preparing, serving and clean up
(Over 18 yrs. old unless special preparation is required.)

	# of minutes		meals per week	total minutes
Dinner: 20 to 25 minutes		# of dinners		0

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Lunch: 10 to 15 minutes		# of Lunches		0
Breakfast: 10 to 15 minutes		# of breakfasts		0

Justification of need

Laundry
(over 18 yrs. old)

45 minutes/week in home washer
75 minutes/week out of home washer

	max 1	total minutes
	1	0

Justification of need

Total Minutes 0

For PCA assessments that are performed as a reassessment or due to change in condition, the number of approved hours is:

☐ Unchanged ☐ Increased ☐ Reduced

Total PCA hours 0.00

Nursing Summary (be sure to include any changes in the member's condition that warrant a change in his/her service hours):

This certifies that I, a registered professional nurse, have evaluated the functional, social and environmental status of this member in their home on the date below. This form provides an accurate description of this member and the need for services.

_____ ***, RN*** _____

Printed Name ***Date***

_____ _____

Signature ***Agency***

The below signature confirms that the member or his/her authorized representative participated in this nursing assessment but does NOT certify agreement with the determination.

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_____	_____
Printed Name	***Date***
_____	_____
Signature	***Relationship to Member***