

## CARE4 MODULE NAME: PCS and EDM

### Updates to ADLs and to key Physical Assessments

#### Overview:

The ADL intervention has been updated to better capture patient's needs & abilities as well as the care provided to them by the team.

See print screens below for the updates made to the **ADL Activities & Care for Daily Living** intervention.

Physical Assessment interventions have been tweaked to focus on findings and remove items related to care provided.

#### Changes to ADL Activities & Care for Daily Living

- Mobility
- Hygiene
- Elimination
- Rest and Comfort

Mobility – Transfer Needs and Care updated to include Transfer of patient.

Mobility – Ambulation updated to include distance ambulated by patient.

ADL.MOBIL.01		
<input type="checkbox"/> Mobility Needs and Care Provided		
<input type="checkbox"/> Transfer Needs and Care		
If staff assistance is required beyond 35lbs/16kg then either the staff member should get equipment or more staff to assist with the patient handling task.		
Transfer of Patient	<input type="checkbox"/> Bed to Chair <input type="checkbox"/> Chair to Bed <input type="checkbox"/> Bed to Wheelchair <input type="checkbox"/> Wheelchair to Bed	<input type="checkbox"/> Bed to Geri Chair <input type="checkbox"/> Geri Chair to Bed <input type="checkbox"/> Bed to Stretcher <input type="checkbox"/> Stretcher to Bed
Transfer Ability	<input type="radio"/> Independent <input type="radio"/> Supervision/Cueing <input type="radio"/> Set Up	<input type="radio"/> Partial Assistance <input type="radio"/> Total Assistance <input type="radio"/> Declined
Assistance Needed With Transfers	<input type="checkbox"/> None <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Set Up <input type="checkbox"/> Assist x1	<input type="checkbox"/> Assist x2 <input type="checkbox"/> Assist x3 or More <input type="checkbox"/> Assistive Device(s) <input type="checkbox"/> Declined
Transfer Devices Needed and/or Used	<input type="radio"/> Cane <input type="radio"/> Crutches <input type="radio"/> Mechanical Lift <input type="radio"/> Pivot Disc <input type="radio"/> Other:	<input type="radio"/> Sit Stand Transfer Device <input type="radio"/> Transfer Board <input type="radio"/> Transfer Pole <input type="radio"/> Walker
<input type="checkbox"/> Sitting Activity		
Sitting Up	<input type="radio"/> Chair <input type="radio"/> Dangling at Bedside <input type="radio"/> Recliner	<input type="radio"/> Wheelchair <input type="radio"/> Wheelchair Electric
Minutes Patient Sitting Up		
Hours Patient Sitting Up		
Patient Tolerance of Sitting Up	<input type="radio"/> Good <input type="radio"/> Fair	<input type="radio"/> Poor <input type="radio"/> Unable to Tolerate

<input type="checkbox"/> Ambulation	
Distance Ambulated by Patient	
Problems Seen when Patient Ambulates	<input type="checkbox"/> Balance Problems <input type="checkbox"/> Gait and Balance Satisfactory <input type="checkbox"/> Pain With Ambulation <input type="checkbox"/> Side Stepping <input type="checkbox"/> SOB on Exertion <input type="checkbox"/> Stumbling on Ambulation <input type="checkbox"/> Swaying on Ambulation <input type="checkbox"/> Unsteady Gait <input type="checkbox"/> Weakness in Legs
Patient Tolerance of Ambulation	<input type="radio"/> Good <input type="radio"/> Poor <input type="radio"/> Fair <input type="radio"/> Unable to Tolerate
Ambulation Ability	<input type="radio"/> Independent <input type="radio"/> Partial Assistance <input type="radio"/> Supervision/Cueing <input type="radio"/> Total Assistance <input type="radio"/> Set Up <input type="radio"/> Declined
Assistance Needed With Ambulation	<input type="checkbox"/> Independent <input type="checkbox"/> Assist x2 <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Assist x3 or More <input type="checkbox"/> Set Up <input type="checkbox"/> Assistive Device(s) <input type="checkbox"/> Assist x1 <input type="checkbox"/> Declined
Ambulation Devices Used By Patient	<input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Crutches <input type="checkbox"/> Gait Belt <input type="checkbox"/> Non Skid Footwear or Sock <input type="checkbox"/> Prosthesis <input type="checkbox"/> Rollator <input type="checkbox"/> Scooter (Knee)

Hygiene – Order of information entry adjusted to align with flow of documentation.

ADL.HYGIENE.01	
<input type="checkbox"/> ADL Hygiene Needs and Care Provided	
<input type="checkbox"/> Hygiene Needs and Care Provided	
Hygiene Care Done or Provided	<input type="checkbox"/> Denture Care <input type="checkbox"/> Eyeglasses Cleaned and Applied <input type="checkbox"/> Hair Brushed <input type="checkbox"/> Handwashing <input type="checkbox"/> Hearing Aids Inserted and Operating Confirmed <input type="checkbox"/> Lips Moisturized <input type="checkbox"/> Make-Up Applied <input type="checkbox"/> Mouth Swabbed <input type="checkbox"/> Mouth Swabbed and Suctioned <input type="checkbox"/> Oral Rinse Done <input type="checkbox"/> Shaved <input type="checkbox"/> Skin Care Cream Applied <input type="checkbox"/> Teeth Brushed <input type="checkbox"/> Toenail Care Done
Hygiene Ability	<input type="radio"/> Independent <input type="radio"/> Partial Assistance <input type="radio"/> Supervision/Cueing <input type="radio"/> Total Assistance <input type="radio"/> Set Up <input type="radio"/> Declined
Assistance Needed With Hygiene	<input type="checkbox"/> None <input type="checkbox"/> Assist x2 <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Assist x3 or More <input type="checkbox"/> Set Up <input type="checkbox"/> Assistive Device(s) <input type="checkbox"/> Assist x1 <input type="checkbox"/> Declined

## Hygiene – Bathing Needs and Care Provided updated to include Bathing Completed.

Bathing Needs and Care Provided	
Bathing Completed	<input type="radio"/> Basin <input type="radio"/> Bed Bath <input type="radio"/> Shower <input type="radio"/> Tub <input type="radio"/> Other:
Bathing Ability	<input type="radio"/> Independent <input type="radio"/> Declined <input type="radio"/> Supervision/Cueing <input type="radio"/> Set Up <input type="radio"/> Partial Assistance Needed <input type="radio"/> Total Assistance Needed
Assistance Needed With Bathing	<input type="checkbox"/> None <input type="checkbox"/> Assist x2 <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Assist x3 or More <input type="checkbox"/> Set Up <input type="checkbox"/> Assistive Device(s) <input type="checkbox"/> Assist x1 <input type="checkbox"/> Declined
Bathing Adaptive Devices	<input type="radio"/> Grab Bars <input type="radio"/> Shower Chair <input type="radio"/> Transfer Bench <input type="radio"/> Tub Chair or Bench
Bath Set Up or Bath Location	<input type="checkbox"/> Accessible Shower Room <input type="checkbox"/> Other <input type="checkbox"/> Basin <input type="checkbox"/> Bathroom Shower <input type="checkbox"/> Chair <input type="checkbox"/> Commode <input type="checkbox"/> Seated at Edge of Bed <input type="checkbox"/> Seated at Sink <input type="checkbox"/> Standing at Sink
Other Set Up or Location For Bathing	

## Hygiene - Perineal and Urinary Catheter Care Provided updated to include Perineal Care.

Perineal and Urinary Catheter Care Provided	
Perineal Care	<input type="radio"/> Perineal Care Completed by Patient <input type="radio"/> Perineal Care Completed <input type="radio"/> Catheter Care Completed by Patient <input type="radio"/> Catheter Care Completed <input type="radio"/> Other:
Perineal/Catheter Care Ability	<input type="checkbox"/> Independent <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Cueing and or Stand By Needed <input type="checkbox"/> Partial Assistance <input type="checkbox"/> Total Assistance
Assistance Needed With Perineal/Catheter Care	<input type="checkbox"/> None <input type="checkbox"/> Assist x2 <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Assist x3 or More <input type="checkbox"/> Set Up <input type="checkbox"/> Assistive Device(s) <input type="checkbox"/> Assist x1 <input type="checkbox"/> Declined

Elimination – Bowel Elimination updated to include additional Bowel Movement information for all staff providing care to document on to avoid the potential of duplicate documentation.

Bowel Elimination	
Bowel Movement	<input type="radio"/> Yes <input type="radio"/> No Comment:
Bowel Movement	<input type="radio"/> Observed <input type="radio"/> Reported by Pt or Significant Other <input type="radio"/> Other:
Bristol Stool Chart	<input type="radio"/> Type 1 Separate Lumps <input type="radio"/> Type 2 Lumpy <input type="radio"/> Type 3 Cracked Sausage <input type="radio"/> Type 4 Smooth Sausage <input type="radio"/> Type 5 Soft Blobs <input type="radio"/> Type 6 Mushy Pieces <input type="radio"/> Type 7 Entirely Liquid
Stool Size	<input type="radio"/> Scant/Smear <input type="radio"/> Medium <input type="radio"/> Copious <input type="radio"/> Small <input type="radio"/> Large
Incontinence of Stool	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Large <input type="radio"/> Scant <input type="radio"/> Moderate <input type="radio"/> Copious
Stool Colour	<input type="checkbox"/> Brown <input type="checkbox"/> Dark Red Blood <input type="checkbox"/> Black <input type="checkbox"/> Gray <input type="checkbox"/> Blood Tinged <input type="checkbox"/> Green <input type="checkbox"/> Bright Red Blood <input type="checkbox"/> White <input type="checkbox"/> Clay Coloured <input type="checkbox"/> Yellow
Other Stool Colour	

Elimination – Urinary Elimination added from the Physical Assessment intervention so all elimination is documented in the same location.

Urinary Elimination	
Urination	<input type="radio"/> Observed <input type="radio"/> Reported by Pt or Significant Other <input type="radio"/> Other:
Incontinence of Urine	<input type="radio"/> None <input type="radio"/> Small <input type="radio"/> Large <input type="radio"/> Scant <input type="radio"/> Moderate <input type="radio"/> Copious
Clarity of Urine	<input type="checkbox"/> Clear <input type="checkbox"/> Stones or Calculi <input type="checkbox"/> Clots <input type="checkbox"/> Cloudy <input type="checkbox"/> Concentrated or Thick <input type="checkbox"/> Mucous <input type="checkbox"/> Purulent <input type="checkbox"/> Sediment Present
Colour of Urine	<input type="radio"/> Straw or Pale Yellow <input type="radio"/> Indigo <input type="radio"/> Amber <input type="radio"/> Orange <input type="radio"/> Bright Red <input type="radio"/> Pink <input type="radio"/> Brown <input type="radio"/> Red <input type="radio"/> Dark Red <input type="radio"/> Tea Colour <input type="radio"/> Green
Odour of Urine	<input type="radio"/> No Odour <input type="radio"/> Fruity <input type="radio"/> Fecal <input type="radio"/> Sulphur <input type="radio"/> Ammonia <input type="radio"/> Foul <input type="radio"/> Strong <input type="radio"/> Sweet
<input type="checkbox"/> Care Related to Elimination	
Peri Care Done	<input type="radio"/> Yes <input type="radio"/> No Comment:
Other	

## Rest and Comfort – Turning and Repositioning updated to include Patient Turned and Skin Care Given with Turn.

**ADL.TURNSL.01**

Turning Rest Comfort

Turning and Repositioning

Patient Turned and Positioned Skin Care Given with Turn	<input type="checkbox"/> Right Side <input type="checkbox"/> Left Side <input type="checkbox"/> On Back <input type="checkbox"/> Head of Bed Elevated <input type="checkbox"/> Prone	<input type="checkbox"/> Sim's Position <input type="checkbox"/> Fowler's <input type="checkbox"/> Semi Fowler's <input type="checkbox"/> Tripod <input type="checkbox"/> Trendelenburg
Turning and Repositioning Ability	<input type="radio"/> Independent <input type="radio"/> Supervision/Cueing <input type="radio"/> Set Up	<input type="radio"/> Partial Assistance <input type="radio"/> Total Assistance <input type="radio"/> Declined
Assistance Needed With Turning and Repositioning	<input type="checkbox"/> None <input type="checkbox"/> Supervision/Cueing <input type="checkbox"/> Set Up <input type="checkbox"/> Assist x1	<input type="checkbox"/> Assist x2 <input type="checkbox"/> Assist x3 or More <input type="checkbox"/> Assistive Device(s) <input type="checkbox"/> Declined

Sleep

Observation on Patient's Sleep During This Shift	<input type="radio"/> Appeared to be Sleeping During Rounds <input type="radio"/> Appeared to Sleep Between Care <input type="radio"/> Awake on Rounds <input type="radio"/> Restless Most of Shift <input type="radio"/> Slept Intermittently <input type="radio"/> Slept Short Period (Nap) <input type="radio"/> Other:
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