




PROPOSED CARE GUIDE

MOCK-UP ver 14.0

SECTIONS


MOVING IN	2
Moving In Profile	2
Previous Routine	4
COGNITIVE STATUS AND BEHAVIOUR	5
PAIN	8
SAFETY/FALLS	9
COMMUNICATION	10
Communication	10
Hearing and Vision	10
NUTRITION	12
ACTIVITIES OF DAILY LIVING	16
Toileting	16
Dressing	18
Hygiene	19
Bathing	20
MOBILITY/TRANSFER	21
SKIN CONDITION	26
SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS	27
SOCIAL WELL-BEING	28
REGULAR PREFERRED ROUTINE	30
REFERENCE KEY TO MDS QUESTIONS	33

CARE GUIDE: MOVING IN MOCK-UP ver 14.0

Name	Date of Birth	ID	Date Approved	Approved By
				
Legend:	Pre-Screening Question	MDS Question	Bold italicized text displays on the Care Guide Printout	

MOVING IN PROFILE

1 ADMITTED FROM (AT ENTRY):

-  ☐ Ambulatory Health Service
- ☐ Inpatient Acute Care Service
- ☐ Inpatient Rehabilitation Service (General)
- ☐ Inpatient Continuing Care Service
- ☐ Residential Care Service (24-hour nursing care)
- ☐ Inpatient Psychiatry Service
- ☐ Other / Unclassified Service
- ☐ Inpatient Rehabilitation Service (Specialized)
- ☐ Home Care Service
- ☐ Residential Care Service (board and care)
- ☐ Private Home (no home care)

2 LIVED ALONE (prior to entry): Enter 0 = No, 1 = Yes, 9 = Unknown.



3 RESIDENTIAL HISTORY - Check all settings resident lived in during the 5 years prior to date of entry.

- ☐ Prior stay at this facility
- ☐ Prior stay in other similar level of care facility
- ☐ Prior stay in other board and care facility
- ☐ Prior stay in a psychiatric facility
- ☐ Prior stay in developmental disability facility
- ☐ NONE OF ABOVE

4 RESPONSIBILITY FOR PAYMENT - Check all that apply in LAST 30 DAYS.

- ☐ Provincial/territory government plan (for resident of province/territory)
- ☐ Other province/territory (resident of Canada)
- ☐ Federal government - Department of Veteran Affairs (DVA)
- ☐ Federal government - First Nations and Inuit Health Branch (FNIHB)
- ☐ Federal government - other (RCMP, Canadian Armed Forces, federal penitentiary inmate, refugee)
- ☐ Worker's compensation board (WCB/WSIB)
- ☐ Canadian resident, private insurance pay
- ☐ Canadian resident, public trustee pay
- ☐ Canadian resident, self pay
- ☐ Other country resident, self pay
- ☐ Responsibility for payment unknown/unavailable

CARE GUIDE: MOVING IN MOCK-UP ver 14.0

	Name	Date	
	Date of Birth	Date Approved	
	ID	Approved By	
Legend:	Pre-Screening Question	MDS Question	Bold italicized text displays on the Care Guide Printout

5 RESPONSIBILITY/LEGAL GUARDIAN - Check all that apply.

- ☐ Legal guardian
- ☐ Durable power of attorney/financial
- ☐ Other legal oversight
- ☐ Family member responsible
- ☐ Durable power of attorney/health care
- ☐ Resident responsible for self
- ☐ None of above

6 MENTAL HEALTH HISTORY - Does resident's record indicate any history of mental illness, or developmental disability problem?

- ☐ Yes
- ☐ No

7 CONDITIONS RELATED TO DEVELOPMENTAL DISABILITY STATUS - Check all conditions that are related to developmental disability.

- ☐ Not applicable - no developmental disability
- Developmental disability with organic condition:*
 - ☐ Down's syndrome
 - ☐ Autism
 - ☐ Epilepsy
 - ☐ Other organic condition related to developmental disability
 - ☐ Developmental disability with no organic condition

8 ADVANCED DIRECTIVES - For those items with supporting documentation in the medical record, check all that apply.

- ☐ Living will
- ☐ Do not resuscitate
- ☐ Do not hospitalize
- ☐ Organ donation
- ☐ Autopsy request
- ☐ Feeding restrictions
- ☐ Medication restrictions
- ☐ Other treatment restrictions
- ☐ None of above

CARE GUIDE: MOVING IN MOCK-UP ver 14.0

	Name	Date of Birth	Date	Date Approved
	ID			Approved By
Legend:	Pre-Screening Question	MDS Question		Bold italicized text displays on the Care Guide Printout

PREVIOUS ROUTINE

9 In year prior to date of entry to this facility, or year last in community if now being admitted from another facility. Check one response for each.

- 9a** Cycle of daily events (in year prior to admission):
- ☐ Stays up late at night (e.g. after 9 pm)
 - ☐ Naps regularly during the day (at least 1 hour)
 - ☐ Get out 1+ days a week
 - ☐ Stays busy with hobbies, reading, or fixed daily routine
 - ☐ Spends most of the time alone or watching TV
 - ☐ Moves independently indoors (with appliances, if used)
 - ☐ Use of tobacco products at least daily
 - ☐ (None of the Above)




- 9b** Eating patterns (in year prior to admission):
- ☐ Distinct Food Preferences
 - ☐ Eats between meals all or most days
 - ☐ Use of alcoholic beverage(s) at least weekly
 - ☐ (None of the Above)


- 9c** ADL patterns (in year prior to admission):
- ☐ In bedclothes much of the day
 - ☐ Wakens to toilet all or most nights
 - ☐ Has irregular bowel movement pattern
 - ☐ Showers for bathing
 - ☐ Bathes in PM
 - ☐ (None of the Above)

- 9d** Involvement patterns (in year prior to admission):
- ☐ Daily contact with relatives/close friends
 - ☐ Usually attends church, temple, synagogue (etc)
 - ☐ Finds strength in faith
 - ☐ Daily animal companion/presence
 - ☐ Involved in group activities
 - ☐ (None of the Above)


CARE GUIDE: COGNITIVE STATUS & BEHAVIOUR MOCK-UP ver 14.0


	Name	Date	
	Date of Birth	Date Approved	
	ID	Approved By	


Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

1  **COMATOSE** - Persistent vegetative state or no discernible consciousness ☐ Yes ☐ No


2  **COGNITIVE SKILLS FOR DAILY DECISION MAKING** - Made decisions regarding tasks of daily life.


-  ☐ **INDEPENDENT** - decisions consistent and reasonable
- ☐ **MODIFIED INDEPENDENCE** - some difficulty in new situations only
- ☐ **MODERATELY IMPAIRED** - decisions poor; cues or supervision required
- ☐ **SEVERELY IMPAIRED** - never/rarely made decisions


3  Behaviour - Check all that apply.


-  ☐ ***No issues***
- ☐ ***Can be physically aggressive***
- ☐ ***Can be verbally aggressive***
- ☐ ***Often agitated***
- ☐ ***Socially inappropriate***
- ☐ ***Refuses/ resists care***
- ☐ Other
- } Complete Describe what triggers the behaviour

If other, specify:


 Describe what triggers the behaviour:


4-8  **BEHAVIOURAL SYMPTOMS** - Code for behaviour in LAST 7 DAYS.


4a  **WANDERING** (moved with no rational purpose, seemingly oblivious to needs or safety)


 Behavioural symptom frequency in last 7 days:


- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

4b  Behavioural symptom alterability in last 7 days:

-  ☐ Behaviour not present - OR - behaviour was easily altered
- ☐ Behaviour was not easily altered




4c  Wandering - Check all that apply:

-  ☐ ***One to one if off unit***
- ☐ ***Resident has a wandering alert system***
- ☐ (None of Above)


 Wandering description/comments:

CARE GUIDE: COGNITIVE STATUS & BEHAVIOUR MOCK-UP ver 14.0

Name	Date
Date of Birth	Date Approved
ID	Approved By


Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

5a VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS (others were threatened, screamed at, cursed at)

 Behavioural symptom frequency in last 7 days:


- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

5b Behavioural symptom alterability in last 7 days:

 ☐ Behaviour not present - OR - behaviour was easily altered


☐ Behaviour was not easily altered

6a PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)

 Behavioural symptom frequency in last 7 days:

- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

6b Behavioural symptom alterability in last 7 days:

 ☐ Behaviour not present - OR - behaviour was easily altered


☐ Behaviour was not easily altered

7a SOCIALLY INAPPROPRIATE OR DISRUPTIVE BEHAVIOURAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others' belongings)

Behavioural symptom frequency in last 7 days:


- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily

7b Behavioural symptom alterability in last 7 days:

 ☐ Behaviour not present - OR - behaviour was easily altered


☐ Behaviour was not easily altered

8a RESISTS CARE (resisted taking meds or injections, ADL assistance, or eating)

 Behavioural symptom frequency in last 7 days:




- ☐ Behaviour not exhibited in last 7 days
- ☐ Behaviour of this type occurred on 1 to 3 days in last 7 days
- ☐ Behaviour of this type occurred 4 to 6 days, but less than daily
- ☐ Behaviour of this type occurred daily



8b Behavioural symptom alterability in last 7 days:


 ☐ Behaviour not present - OR - behaviour was easily altered

☐ Behaviour was not easily altered

CARE GUIDE: COGNITIVE STATUS & BEHAVIOUR MOCK-UP ver 14.0

	Name	Date
	Date of Birth	Date Approved
	ID	Approved By
Legend:	 Pre-Screening Question	 MDS Question
		 Bold italicized text displays on the Care Guide Printout

 Behaviour plan: 




 INTERVENTION PROGRAMS FOR MOOD, BEHAVIOUR, COGNITIVE LOSS - Check all interventions or strategies used in the LAST 7 DAYS, no matter where received.


- ☐ Special behaviour symptom evaluation program
- ☐ Evaluation by a licensed mental health specialist in LAST 90 DAYS
- ☐ Group therapy
- ☐ Resident-specific deliberate changes in the environment to address mood or behaviour patterns (e.g. providing bureau in which to rummage)
- ☐ Reorientation (e.g. cueing)
- ☐ NONE OF ABOVE

CARE GUIDE: PAIN MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By


Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

 **1** PAIN SYMPTOMS: Code the highest frequency with which resident complains or shows evidence of pain in the last



 7 days.

- ☐ No Pain
☐ Pain less than daily
☐ Pain daily
- } Complete Intensity of pain, Pain Site


 Intensity of pain in the last 7 days:

-  ☐ Mild pain
☐ Moderate pain
☐ Times when pain is horrible or excruciating

 PAIN SITE: If pain present, check all sites that apply in the last 7 days.

-  ☐ **Back pain**
 ☐ **Bone pain**
☐ **Chest pain** while doing usual activities
☐ **Headache**
☐ **Hip pain**
☐ Incisional pain
☐ **Joint pain** (other than hip)
☐ Soft tissue pain (e.g. lesion, muscle)
☐ **Stomach pain**
☐ Other


Specify:

 **2** Describe how the resident prefers to manage pain (incl. non-medical techniques)?


CARE GUIDE: SAFETY/FALLS MOCK-UP ver 14.0

Name
Date of Birth
ID


Date
Date Approved
Approved By


Legend:  Pre-Screening Question


 MDS Question

 Bold italicized text displays on the Care Guide Printout

FALLS


 **1** ACCIDENTS - Check all that apply:

-  ☐ Fell in past 30 days
☐ Fell in past 31-180 days
☐ Hip fracture in last 180 days
☐ Other fracture in last 180 days
☐ (None of the Above)

 **2** Interventions for falls - Check all that apply. Complete Physical Restraint Protocol if restraints used.

- ☐ **Wheelchair Tilted**
☐ **Seat belt** Seat belt Type: ☐ **Front fastening** ☐ **Pen release** ☐ **Other** If other, specify:
☐ **Wheelchair with full lap tray**
☐ **Low bed**
☐ **Bed rail(s)** Up: ☐ **Top left** ☐ **Top right** ☐ **Bottom left** ☐ **Bottom right**
☐ **Bed Alarm**
☐ **Wheelchair Alarm**
☐ **Hip Protector** Specify:
☐ **Fall Mat** When: ☐ **Day** ☐ **Night** ☐ **Both**
Side: ☐ **Left side** ☐ **Right side** ☐ **Both sides**
☐ **Special toilet plan**
☐ Other Specify any other interventions:
☐ (None of the Above)

SAFETY

 **3** Specify other safety needs:

CARE GUIDE: COMMUNICATION MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question

 MDS Question





Bold italicized text displays on the Care Guide Printout

COMMUNICATION



1 MODES OF EXPRESSION - Check all used by resident to make needs known.

Makes needs known by...

-  ☐ Speech
-  ☐ ***Writing messages*** to express or clarify needs
- ☐ American sign language or Braille
- ☐ ***Signs, gestures, or sounds***
- ☐ ***Communication board***
- ☐ Other
- ☐ None of the Above

If other, specify:

2 SPEECH CLARITY (Code for speech in last 7 days):

-  ☐ CLEAR SPEECH - distinct, intelligible words
-  ☐ UNCLEAR SPEECH - slurred, mumbled words
- ☐ NO SPEECH - absence of spoken words

speech clear

speech unclear

no speech

3 Language(s) spoken: ☐ ***English*** ☐ ***Cantonese*** ☐ ***Mandarin*** ☐ ***Punjabi*** ☐ Other

If other, specify:



Speaks...

4 Language(s) understood: ☐ ***English*** ☐ ***Cantonese*** ☐ ***Mandarin*** ☐ ***Punjabi*** ☐ Other

If other, specify:

Understands...

5 MAKING SELF UNDERSTOOD (Expressing information content - however able):

-  ☐ Understood
-  ☐ Usually understood - difficulty finding words or finishing thoughts
- ☐ Sometimes understood - ability is limited to making concrete requests
- ☐ Rarely or never understood



makes self understood

usually makes self understood

sometimes makes self understood

rarely or never understood

6 ABILITY TO UNDERSTAND OTHERS (Understanding verbal information content - however able):

-  ☐ Understands
-  ☐ Usually understands - may miss some part or intent of message
- ☐ Sometimes understands - responds adequately to simple, direct communication
- ☐ Rarely or never understands

Understands others



Usually understands

Sometimes understands

Rarely or never understands




HEARING AND VISION

7 HEARING (With hearing appliance, if used):

-  ☐ ***HEARS ADEQUATELY*** - normal talk, TV, phone
-  ☐ ***MINIMAL DIFFICULTY*** - when not in quiet setting
- ☐ ***HEARS IN SPECIAL SITUATIONS ONLY*** - speaker has to adjust tonal quality and speak distinctly
- ☐ ***HIGHLY IMPAIRED*** (absence of useful hearing)

CARE GUIDE: COMMUNICATION MOCK-UP ver 14.0

Name	Date of Birth	ID	Date	Date Approved	Approved By
------	---------------	----	------	---------------	-------------

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

8 If hearing impaired, indicate:

- ☐ ***Impaired right ear***
- ☐ ***Impaired left ear***
- ☐ ***Impaired both ears***
- ☐ Not applicable

9 COMMUNICATION DEVICES/TECHNIQUES - Check all that apply last 7 days.

- ☐ ***Hearing aid, present & used***
- ☐ ***Hearing aid, present & not used regularly***
- ☐ ***Other receptive communication techniques used*** (e.g. lip reading)
- ☐ (None of the Above)

Specify other hearing specifics:

10 VISION (Ability to see in adequate light/ with glasses if used)

- ☐ ADEQUATE - sees fine details including regular print in newspapers/books
- ☐ IMPAIRED - sees large print, but not regular print in newspaper/books
- ☐ MODERATELY IMPAIRED - limited vision; not able to see newspaper headlines, but can identify objects
- ☐ HIGHLY IMPAIRED - object identification in question, but eyes appear to follow objects
- ☐ SEVERELY IMPAIRED - no vision or sees only light, color, shapes; eyes do not appear to follow objects

sees regular print

sees large print

can identify objects only

appears to follow objects only

no vision

11 If visually impaired, indicate:

- ☐ ***Impaired right eye***
- ☐ ***Impaired left eye***
- ☐ ***Impaired both eyes***
- ☐ ***Prosthesis right eye***
- ☐ ***Prosthesis left eye***
- ☐ ***Prosthesis both eyes***
- ☐ Not applicable

12 VISUAL APPLIANCES - Glasses; contact lens; magnifying glass: ☐ Yes ☐ No




Comments:

13 Glasses: ☐ ***glasses for reading only*** ☐ ***always wears glasses*** ☐ (None of the above)

CARE GUIDE: NUTRITION MOCK-UP ver 14.0


Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

NUTRITION


1 ORAL PROBLEMS - Check all that apply:

-  ☐ Chewing problem
☐ Swallowing problem
☐ Mouth pain
☐ (None of the Above)

2a HEIGHT (cm) (Record height in centimetres)



2b WEIGHT (kg) (Record weight in kilograms)

 Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).

3 WEIGHT CHANGE


3a Weight loss - 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS ☐ Yes ☐ No ☐ N/A

3b Weight gain - 5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS ☐ Yes ☐ No ☐ N/A

4 NUTRITIONAL PROBLEMS - Check all that apply in last 7 days.

- ☐ Complains about the taste of many foods
☐ Regular or repetitive complaints of hunger
☐ Leaves 25% or more of food uneaten at most meals
☐ None of the Above

5 NUTRITIONAL APPROACHES - Check all that apply in last 7 days.

-  ☐ Parenteral / IV } **Complete Parenteral or Enteral** ☐ Dietary supplement between meals
☐ Feeding tube } **Intake & avg fluid intake** ☐ Plate guard, stabilized built-up utensil, etc.
☐ Mechanically Altered Diet ☐ On a planned weight change program
☐ Syringe (oral feeding) ☐ None of the Above
☐ Therapeutic diet

PARENTERAL OR ENTERAL INTAKE

Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days.

- ☐ None ☐ 26% to 50% ☐ 76% - 100%
☐ 1% - 25% ☐ 51% to 75%




Code the average fluid intake per day by IV or tube in the last 7 days.

- ☐ None ☐ 1001 to 1500 cc/day
☐ 1 to 500 cc/day ☐ 1501 to 2000 cc/day
☐ 501 to 1000 cc/day ☐ 2001 or more cc/day

CARE GUIDE: NUTRITION MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout


6a EATING - How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube


 feeding, total parenteral nutrition). Code for **self-performance** over all shifts during last 7 days - not incl. set-up:

- ☐ Independent
- ☐ Supervision
- ☐ Limited assistance
- ☐ Extensive assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days


6b EATING - How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube

 feeding, total parenteral nutrition). Code for **most support provided** over all shifts during last 7 days:


-  ☐ No Setup or physical help from staff *independent*
- ☐ Setup help only *setup help only*
- ☐ One person physical assist *one person assist*
- ☐ Two + person physical assist *two + person assist*
- ☐ ADL activity did not occur entire 7 days

 **7** Eating/drinking techniques/setup – Check all that apply for dysphagia and other functional needs:

- ☐ *Eating at risk*
- ☐ *Teaspoon only*
- ☐ *No straws*
- ☐ *Drink from cup only*
- ☐ *Double swallow*
- ☐ *Pace eating*
- ☐ *Check for pocketing*
- ☐ *Watch/feel for swallow before next bite/sip*
- ☐ *Good mouth care*
- ☐ *Guiding hand*
- ☐ *Verbal cueing* Specify:
- ☐ None of the Above

 **8** Positioning techniques/setup – Check all that apply for dysphagia and other functional needs:


- ☐ *Chin down during swallow*
- ☐ *Minimize distraction*
- ☐ *Feed to:* ☐ *Left side of mouth* ☐ *Right side of mouth*
- ☐ *Place item to:* ☐ *Left side of resident* ☐ *Right side of resident*
- ☐ *Positioning bed/wheelchair* Specify:
- ☐ None of the Above

 **9** Specify any other eating/drinking details related to swallowing:

CARE GUIDE: NUTRITION MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By


Legend:  Pre-Screening Question

 MDS Question

 Bold italicized text displays on the Care Guide Printout

10 Diet Type - Check all that apply:

- ☐ ***Dysphagia***
- ☐ ***NPO***
- ☐ ***Diabetic*** Complete Diabetic instructions
- ☐ ***Low potassium***
- ☐ ***Low salt***
- ☐ ***Tube feed***
- ☐ ***Other*** If other, specify:
- ☐ None of the Above

 Diabetic instructions:

- ☐ ***Tell nurse right away if resident misses meal/eats poorly***
- ☐ ***Give prescribed nourishments***


11 Diet Texture - Check all that apply:

- ☐ ***Regular***
- ☐ ***Cut-up***
- ☐ ***Dental Soft***
- ☐ ***Minced***
- ☐ ***Pureed***
- ☐ ***Other*** If other, specify:
- ☐ None of the Above

12 Fluid Consistency - Check all that apply:


- ☐ ***Thick fluids***
- ☐ ***Thin fluids***

Eating comments:

 **13** Are there any foods resident cannot eat for religious reasons?

☐ Yes ☐ No

If yes, specify:

 **14** Does resident fast for religious reasons?




☐ Yes ☐ No


If yes, specify:


15 Teeth/Dentures - Check all that apply:

- | | | | |
|---|---------|---------------------------|--------------------------|
| <input type="checkbox"/> <i>Own teeth</i> | | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="checkbox"/> <i>Lower dentures</i> | } wears | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="checkbox"/> <i>Upper dentures</i> | | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="checkbox"/> <i>Lower partial dentures</i> | | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="checkbox"/> <i>Upper partial dentures</i> | | <input type="radio"/> Yes | <input type="radio"/> No |
| <input type="checkbox"/> <i>No teeth</i> | | | |

CARE GUIDE: NUTRITION MOCK-UP ver 14.0

	Name	Date
	Date of Birth	Date Approved
	ID	Approved By
Legend:	 Pre-Screening Question	 MDS Question
		 Bold italicized text displays on the Care Guide Printout

-  16 Colour of mouth care card
- ☐ ***Pink*** (with teeth)
 - ☐ ***Blue*** (teeth and dentures)
 - ☐ ***Green*** (dentures)
 - ☐ ***Red*** (unable to swallow)

 17 Comments related to oral care:

CARE GUIDE: ACTIVITIES OF DAILY LIVING MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question

 MDS Question



Bold italicized text displays on the Care Guide Printout

ACTIVITIES OF DAILY LIVING

TOILETING

1 BOWEL CONTINENCE - Control of bowel movement, with appliance or bowel continence programs, if used. Code for resident's performance over all shifts during last 14 days:

- ☐ **Continent** - Complete control
- ☐ **Usually continent** - incontinent episodes less than weekly
- ☐ **Occasionally incontinent** - once a week
- ☐ **Frequently incontinent** 2-3 times a week
- ☐ **Incontinent** - had inadequate control all (or almost all) of the time

2 BLADDER CONTINENCE - Code for resident's performance over all shifts. Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if employed:

- ☐ **Continent** - Complete control
- ☐ **Usually continent** - incontinent episodes once a week or less
- ☐ **Occasionally incontinent** - 2+ times a week but not daily
- ☐ **Frequently incontinent** - tended to be incontinent daily but some control present
- ☐ **Incontinent** - Had inadequate control. Multiple daily episodes

3 Day brief **Day...**

- ☐ **One-piece brief** Colour: ☐ **Yellow** ☐ **Green** ☐ **White** ☐ **Lavender** ☐ **Blue** ☐ **Beige**
- ☐ **Pad** Colour: ☐ **White** ☐ **Blue** ☐ **Yellow** ☐ **Green**
- ☐ **Mesh pant** Colour: ☐ **White** ☐ **Blue** ☐ **Brown** ☐ **Green** ☐ **Pink**
- ☐ **Underwear**

4 Night undergarment **Night...**

- ☐ **One-piece brief (green):** Size: ☐ **S** ☐ **M** ☐ **L** ☐ **XL**
- ☐ **Pad** Colour: ☐ **White** ☐ **Blue** ☐ **Yellow** ☐ **Green**
- ☐ **Mesh pant** Colour: ☐ **White** ☐ **Blue** ☐ **Brown** ☐ **Green** ☐ **Pink**
- ☐ **Underwear**

Comments:

5 APPLIANCES AND PROGRAMS - Check all that apply in last 14 days:




- ☐ Any **scheduled toileting plan**
- ☐ **Bladder retraining program**
- ☐ External (**condom**) **catheter**
- ☐ **Indwelling catheter**
- ☐ Intermittent catheter
- ☐ Does not use toilet room/commode/urinal
- ☐ Pads/briefs used
- ☐ Enemas/irrigation
- ☐ **Ostomy** present
- ☐ (None of the Above)

Specify appliances and programs if applicable (e.g. toileting plan):

CARE GUIDE: ACTIVITIES OF DAILY LIVING MOCK-UP ver 14.0

Name
Date of Birth
ID


Date
Date Approved
Approved By


Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

- 6a** TOILET USE - How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. Code for **self performance** over all shifts during last 7 days, not including setup.
- ☐ Independent
 - ☐ Supervision
 - ☐ Limited Assistance
 - ☐ Extensive Assistance
 - ☐ Total Dependence
 - ☐ Activity did not occur during entire 7 days


- 6b** TOILET USE - How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. Code for most **support provided** over all shifts during last 7 days.
- ☐ No Setup or physical help from staff *independent*
 - ☐ Setup help only *supervision*
 - ☐ One person physical assist } Complete type of transfer from BED TO TOILET/COMMODE,
 - ☐ Two+ persons physical assist } type of transfer from WHEELCHAIR TO TOILET/COMMODE
 - ☐ ADL activity did not occur entire 7 days


Toileting Comments:


-  Type of transfer from BED TO TOILET/COMMODE:
- ☐ One person minimal physical assist *one person minimal assist for transfer*
 - ☐ *Sit to stand lift*
 - ☐ *Mechanical total lift (floor based)*
 - ☐ *Ceiling lift*
- } Complete type of chair for toileting, type of transfer, type/colour of sling

-  Type of chair for toileting: *to...*
- ☐ *Toilet*
 - ☐ *Regular commode chair*
 - ☐ *Tilt commode chair*
 - ☐ *Extra wide chair*
 - ☐ *Broda commode chair*
 - ☐ Other

If other, specify:

-  Type of transfer:
- ☐ One person *with one person*
 - ☐ Two person *with two persons*




-  Type/colour of sling from bed to toilet/commode:
- ☐ *Regular Sling* Size ☐ *Gray (XS)* ☐ *Red (S)* ☐ *Yellow (M)* ☐ *Green (L)* ☐ *Blue (XL)*
 - ☐ *Toilet Sling* Size ☐ *Gray (XS)* ☐ *Red (S)* ☐ *Yellow (M)* ☐ *Green (L)* ☐ *Blue (XL)*
 - ☐ *Never use toilet sling*


 Transfers from bed to toilet/commode comments:


CARE GUIDE: ACTIVITIES OF DAILY LIVING MOCK-UP ver 14.0

Name
Date of Birth
ID


Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

-  Type of transfer from WHEELCHAIR TO TOILET/COMMUNE:
- ☐ One person minimal physical assist *one person minimal assist for transfer*
 - ☐ *Sit to stand lift*
 - ☐ *Mechanical total lift (floor based)*
 - ☐ *Ceiling lift*
- } Complete type of chair for toileting, type of transfer, type/colour of sling

-  Type of chair for toileting: *to...*
- ☐ *Toilet*
 - ☐ *Regular commode chair*
 - ☐ *Tilt commode chair*
 - ☐ *Extra wide chair*
 - ☐ *Broda commode chair*
 - ☐ Other

If other, specify:

-  Type of transfer:
- ☐ One person *with one person*
 - ☐ Two person *with two persons*


-  Type/colour of sling from wheelchair to toilet/commode:
- ☐ *Regular Sling* Size ☐ *Gray (XS)* ☐ *Red (S)* ☐ *Yellow (M)* ☐ *Green (L)* ☐ *Blue (XL)*
 - ☐ *Toilet Sling* Size ☐ *Gray (XS)* ☐ *Red (S)* ☐ *Yellow (M)* ☐ *Green (L)* ☐ *Blue (XL)*
 - ☐ *Never use toilet sling*

 Transfers from wheelchair to toilet/commode comments:

DRESSING

7a DRESSING - How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis. Code for **self performance** over all shifts during last 7 days, not including setup.




- ☐ Independent
- ☐ Supervision
- ☐ Limited assistance
- ☐ Extensive assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days

 **7b** DRESSING - How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis. Code for most **support provided** over all shifts during last 7 days.

- ☐ No Setup or physical help from staff *independent*
- ☐ Setup help only *set-up help only*
- ☐ One person physical assist *one person assist*
- ☐ Two + person physical assist *two+ person assist*
- ☐ ADL activity did not occur entire 7 days

Dressing Comments (e.g. cueing):

CARE GUIDE: ACTIVITIES OF DAILY LIVING MOCK-UP ver 14.0

Name	Date of Birth	ID	Date	Date Approved	Approved By
Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout					

8 Splints ☐ Yes ☐ No Specify type:
Specify wearing schedule:

9 Prosthesis ☐ Yes ☐ No Specify:

10 Braces ☐ Yes ☐ No Specify:

11 Adaptive/Easy clothing ☐ Yes ☐ No If yes, ☐ Top ☐ Bottom ☐ Dress
Comments:

12 Personal laundry done by:
☐ Care home
☐ Family
☐ Other
 If other, specify:

HYGIENE

13a PERSONAL HYGIENE - How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing/drying face, hands, and perineum (EXCLUDE baths and showers). Code for **self performance** over all shifts during last 7 days, not including setup.




☐ Independent
☐ Supervision
☐ Limited assistance
☐ Extensive assistance
☐ Total dependence
☐ Activity did not occur during entire 7 days

13b PERSONAL HYGIENE - How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing/drying face, hands, and perineum (EXCLUDE baths and showers). Code for most **support provided** over all shifts during last 7 days.

☐ No setup or physical help from staff *independent*
☐ Setup help only *set-up help only*
☐ One person physical assist *one person assist*
☐ Two+ persons physical assist *two+ person assist*
☐ ADL activity itself did not occur during entire 7 days

Hygiene Comments:

CARE GUIDE: ACTIVITIES OF DAILY LIVING MOCK-UP ver 14.0

Name	Date of Birth	ID	Date	Date Approved	Approved By
Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout					

BATHING

14a BATHING - How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (Exclude washing of back and hair). Code for most dependent in **self-performance**.

- ☐ Independent
- ☐ Supervision
- ☐ Physical help limited to transfer only
- ☐ Physical help in part of bathing activity
- ☐ Total dependence
- ☐ Bathing did not occur during entire 7 days

14b BATHING - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (Exclude washing of back and hair). Code for **most support** provided over all shifts during last 7 days.

- ☐ No setup or physical help from staff *independent*
- ☐ Setup help only *supervision*
- ☐ One person physical assist } Complete type of transfer
- ☐ Two+ persons physical assist } for bathing
- ☐ ADL activity itself did not occur during entire 7 days

Bathing Comments:

- Type of transfer for bathing:
- ☐ One person minimal physical assist *one person minimal assist for transfer*
 - ☐ *Sit to stand lift*
 - ☐ *Mechanical total lift (floor based)*
 - ☐ *Ceiling lift*
- } Complete type of transfer, type/colour of sling for bathing

- Type of transfer:
- ☐ One person *with one person*
 - ☐ Two person *with two persons*

- Type/colour of sling for bathing:
- ☐ *Regular Sling* Size ☐ Gray (XS) ☐ Red (S) ☐ Yellow (M) ☐ Green (L) ☐ Blue (XL)
 - ☐ *Toilet Sling* Size ☐ Gray (XS) ☐ Red (S) ☐ Yellow (M) ☐ Green (L) ☐ Blue (XL)
 - ☐ *Never use Toilet Sling*

- 15** Bath type - Check all that apply:
- ☐ *Tub bath*
 - ☐ *Bed bath*
 - ☐ *Shower* Complete type of chair for bathing

- Type of chair for bathing:
- ☐ *Regular shower chair*
 - ☐ *Tilt shower chair*
 - ☐ *Extra wide shower chair*
 - ☐ *Broda shower chair*

CARE GUIDE: MOBILITY/TRANSFER MOCK-UP ver 14.0

	Name	Date	
	Date of Birth	Date Approved	
	ID	Approved By	
Legend:	Pre-Screening Question	MDS Question	Bold italicized text displays on the Care Guide Printout

MOBILITY / TRANSFER

1a BED MOBILITY - How resident moves to and from lying position, turns side to side and positions body while in bed.

Code for **self performance** over all shifts during last 7 days, not including setup.

- ☐ Independent
- ☐ Supervision
- ☐ Limited Assistance
- ☐ Extensive Assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days

1b BED MOBILITY - How resident moves to and from lying position, turns side to side and positions body while in bed.

Code for most **support provided** over all shifts during last 7 days.

- ☐ No Setup or physical help from staff *independent*
- ☐ Setup help only *supervision*
- ☐ One person physical assist *one person assist*
- ☐ Two+ persons physical assist *two+ person assist*
- ☐ ADL activity did not occur entire 7 days

Bed Mobility Comments:

2a *Green positioning sling* ☐ Yes ☐ No

2b *Sliding sheet* ☐ Yes ☐ No

Comments:

3 MODES OF TRANSFER (Check all that apply during last 7 days):

- ☐ Bedfast all or most of time
- ☐ Bed rails used for bed mobility or transfer
- ☐ Lifted manually
- ☐ Lifted mechanically
- ☐ Transfer aid (e.g. slide board, trapeze, cane, walker, brace)
- ☐ (None of the Above)

Specify:




4a TRANSFER - How resident moves between surfaces - to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet). Code for **self performance** over all shifts during last 7 days, not including setup.

- ☐ Independent
- ☐ Supervision
- ☐ Limited Assistance
- ☐ Extensive Assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days


CARE GUIDE: MOBILITY/TRANSFER MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout


4b TRANSFER - How resident moves between surfaces - to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet). Code for most **support provided** over all shifts during last 7 days.

-  ☐ No Setup or physical help from staff ***independent***
☐ Setup help only ***supervision***
☐ One person physical assist } Complete type of transfer from
☐ Two+ persons physical assist } bed to w/c
☐ ADL activity did not occur entire 7 days


Transfer Comments:

 Type of transfer from BED TO WHEELCHAIR:


-  ☐ One person minimal physical assist ***one person minimal assist***
☐ ***Sit to stand lift***
☐ ***Mechanical total lift (floor based)*** } Complete type of transfer, type/colour of sling for transfer
☐ ***Ceiling lift***

 Type of transfer:

- ☐ One person ***with one person***
☐ Two person ***with two persons***

 Type/colour of sling for transfer:

- ☐ ***Regular Sling*** Size ☐ ***Gray (XS)*** ☐ ***Red (S)*** ☐ ***Yellow (M)*** ☐ ***Green (L)*** ☐ ***Blue (XL)***
☐ ***Toilet Sling*** Size ☐ ***Gray (XS)*** ☐ ***Red (S)*** ☐ ***Yellow (M)*** ☐ ***Green (L)*** ☐ ***Blue (XL)***
☐ ***Never use toilet sling***

 Transfer from bed to wheelchair comments:

5a LOCOMOTION ON UNIT - How resident moves between locations in own room and adjacent corridor on same floor.

If in wheelchair, self-sufficiency once in chair. Code for **self performance** over all shifts during last 7 days, not including setup.

- ☐ Independent
☐ Supervision
☐ Limited Assistance
☐ Extensive Assistance
☐ Total dependence
☐ Activity did not occur during entire 7 days

5b LOCOMOTION ON UNIT - How resident moves between locations in own room and adjacent corridor on same floor.




If in wheelchair, self-sufficiency once in chair. Code for most **support provided** over all shifts during last 7 days.

- ☐ No Setup or physical help from staff
☐ Setup help only
☐ One person physical assist
☐ Two+ persons physical assist
☐ ADL activity did not occur entire 7 days




CARE GUIDE: MOBILITY/TRANSFER MOCK-UP ver 14.0


Name
Date of Birth
ID


Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

6 MODES OF LOCOMOTION - Check all that apply during last 7 days:


-  ☐ Cane/walker/crutch
 ☐ Wheeled - self
 ☐ Other person wheeled
☐ Wheelchair primary mode of locomotion
☐ (None of the Above)
- } Complete type of w/c, foot pedals, w/c cushions, w/c comments

 Type of wheelchair:


-  ☐ **Powered Wheelchair**
☐ **Geri-Chair**
☐ **Tilt-in-space wheelchair**
☐ **Standard Manual Wheelchair**
☐ Other
- } ☐ **Foot propel** ☐ **Hand propel**

If other, specify:


-  **Foot Pedals** ☐ Yes **Foot pedals** ☐ No **No foot pedals**
 If yes, ☐ **Left side** ☐ **Right side** ☐ **Both sides**

-  Wheelchair Cushions ☐ Air ☐ Gel ☐ Foam ☐ Other **air cushion, gel cushion**
 If other, specify: **foam cushion, other cushion**

 Wheelchair comments:

 Walking - Check all that apply:


- ☐ **Does not walk**
☐ **Independent**
☐ **Walks with rehab lead**
☐ **Walks with family**
☐ **Walks with RCA**

 Type of mobility aid(s):

- ☐ **Cane**
☐ **Walker** ☐ **2-wheeled** ☐ **4-wheeled** ☐ **Platform**
☐ **Other**
☐ Not Applicable

If other, specify:




 **Maximum walking distance:**

 Type of footwear:

wears...

 Walking comments:

CARE GUIDE: MOBILITY/TRANSFER MOCK-UP ver 14.0

Name	Date of Birth	ID	Date	Date Approved	Approved By
Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout					

- 8a** LOCOMOTION OFF UNIT - How resident moves to and returns from off unit locations (e.g. areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair. Code for **self performance** over all shifts during last 7 days, not including setup.
- ☐ Independent
 - ☐ Supervision
 - ☐ Limited Assistance
 - ☐ Extensive Assistance
 - ☐ Total dependence
 - ☐ Activity did not occur during entire 7 days
- 8b** LOCOMOTION OFF UNIT - How resident moves to and returns from off unit locations (e.g. areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair. Code for most **support provided** over all shifts during last 7 days.
- ☐ No Setup or physical help from staff
 - ☐ Setup help only
 - ☐ One person physical assist
 - ☐ Two+ persons physical assist
 - ☐ ADL activity did not occur entire 7 days
- 9a** WALK IN ROOM - How resident walks between locations in own room. Code for **self performance** over all shifts during last 7 days, not including setup.
- ☐ Independent
 - ☐ Supervision
 - ☐ Limited Assistance
 - ☐ Extensive Assistance
 - ☐ Total dependence
 - ☐ Activity did not occur during entire 7 days
- 9b** WALK IN ROOM - How resident walks between locations in own room. Code for most **support provided** over all shifts during last 7 days.
- ☐ No Setup or physical help from staff
 - ☐ Setup help only
 - ☐ One person physical assist
 - ☐ Two+ persons physical assist
 - ☐ ADL activity did not occur entire 7 days

CARE GUIDE: MOBILITY/TRANSFER MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:



Pre-Screening Question



MDS Question



Bold italicized text displays on the Care Guide Printout

10a

WALK IN CORRIDOR - How resident walks in corridor on unit. Code for **self performance** over all shifts during last 7 days, not including setup.

- ☐ Independent
- ☐ Supervision
- ☐ Limited Assistance
- ☐ Extensive Assistance
- ☐ Total dependence
- ☐ Activity did not occur during entire 7 days

10b




WALK IN CORRIDOR - How resident walks in corridor on unit. Code for most **support provided** over all shifts during last 7 days.

- ☐ No Setup or physical help from staff
- ☐ Setup help only
- ☐ One person physical assist
- ☐ Two+ persons physical assist
- ☐ ADL activity did not occur entire 7 days

CARE GUIDE: SKIN CONDITION MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

SKIN CONDITION

1 OTHER SKIN PROBLEMS OR LESIONS PRESENT - Check all that apply during last 7 days:

- ☐ Abrasions, bruises
- ☐ Burns (second or third degree burns)
- ☐ Open lesions other than ulcers, rashes, cuts (e.g. cancer lesions)
- ☐ Rashes - e.g. intertrigo, eczema, drug/heat rash, herpes zoster
- ☐ Skin desensitized to pain or pressure
- ☐ Skin tears or cuts (other than surgery)
- ☐ Surgical wounds
- ☐ (None of the Above)

2 Location of skin problems:

3 SKIN TREATMENTS - Check all that apply during last 7 days:

- ☐ Pressure relieving device(s) for chair
- ☐ Pressure relieving device(s) for bed Describe:
- ☐ Turning/repositioning program Describe:
- ☐ Nutrition or hydration intervention to manage skin problems
- ☐ Ulcer care
- ☐ Surgical wound care
- ☐ Application of dressings (with or without topical medications other than to feet) Describe:
- ☐ Application of ointments/medications (other than to feet) Describe:
- ☐ Other preventive or protective skin care (other than to feet) Describe:
- ☐ (None of the Above)

If other, specify:

4 ULCERS due to any cause (record the number of ulcers at each ulcer stage-regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during the last 7 days. Code 9 = 9 or more (REQUIRES FULL BODY EXAM).

4a Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when the pressure is relieved.

 0 1 2 3 4 5 6 7 8 9

4b Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

 0 1 2 3 4 5 6 7 8 9

4c Stage 3: A full thickness of skin is lost, exposing subcutaneous tissues-presenting as a deep crater with or without undermining adjacent tissue.

 0 1 2 3 4 5 6 7

4d Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

 0 1 2 3 4 5 6 7




5 HISTORY OF RESOLVED PRESSURE ULCERS

Resident had a pressure ulcer that was resolved or cured in the last 90 days:

☐ Yes ☐ No





If yes, specify date resolved:

CARE GUIDE: SPECIAL TREATMENTS AND PROGRAMS MOCK-UP ver 14.0

Name	Date of Birth	ID	Date Approved	Approved By
Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout				

SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS

1 SPECIAL CARE - (Check treatments received in LAST 14 DAYS.)

 <input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Radiation
 <input type="checkbox"/> Dialysis Enter dialysis schedule on Daily Schedule.	<input type="checkbox"/> Suctioning
<input type="checkbox"/> IV medication	<input type="checkbox"/> Trach. Care
<input type="checkbox"/> Intake/output	<input type="checkbox"/> Transfusions
<input type="checkbox"/> Monitoring acute medical condition	<input type="checkbox"/> Ventilator or respirator
<input type="checkbox"/> Ostomy care	<input type="checkbox"/> NONE OF ABOVE
 <input type="checkbox"/> Oxygen therapy	
 Comments:	<input type="text"/>

2 Substance abuse - Check all that apply:

☐ Drug/Alcohol
☐ Smoking
☐ Not applicable

Comments:




3 SPECIAL CARE - (Check programs received in LAST 14 DAYS.)

☐ Alcohol or drug treatment program
☐ Alzheimer's or dementia special care unit
☐ Hospice care
☐ Pediatric care
☐ Respite care
☐ Training in skills to required return to the community
 (e.g. taking medications, housework, shopping, transportation, ADLs)
☐ NONE OF ABOVE

 Comments:

CARE GUIDE: SOCIAL WELL-BEING MOCK-UP ver 14.0

Name	Date
Date of Birth	Date Approved
ID	Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

SOCIAL WELL-BEING


 Resident likes to be called:

 2. Neighbourhood:

3 SENSE OF INITIATIVE/INVOLVEMENT - Check all that apply.


- ☐ At ease interacting with others
- ☐ At ease doing planned or structured activities
- ☐ At ease doing self-initiated activities
- ☐ Establishes own goals
- ☐ Pursues involvement in life of facility (e.g. makes and keeps friends; involved in group activities; responds positively to new activities; assists at religious services)
- ☐ Accepts invitations into most group activities
- ☐ NONE OF ABOVE


4 UNSETTLED RELATIONSHIPS - Check all that apply.

-  ☐ Covert/open conflict with or repeated criticism of staff
- ☐ Unhappy with roommate
- ☐ Unhappy with residents other than roommate
- ☐ Openly expresses conflict/anger with family/friends
- ☐ Absence of personal contact with family or friends
- ☐ Recent loss of close family member or friend
- ☐ Does not adjust easily to change in routines
- ☐ NONE OF ABOVE

5 PAST ROLES

- ☐ Strong identification with past roles and life status
- ☐ Expresses sadness, anger or empty feeling over lost roles or status
- ☐ Resident perceives that daily life (customary routine, activities) is very different from prior pattern in the community
- ☐ NONE OF ABOVE

 6 Psychosocial/Cultural History:




 7 Companion / Family Support (incl. pets):

 8 Religious Practices / Beliefs:

9 Are there any cultural routines/practices that we need to be aware of?

 10 What is important for you to know about the resident?

CARE GUIDE: SOCIAL WELL-BEING MOCK-UP ver 14.0

	Name	Date
	Date of Birth	Date Approved
	ID	Approved By
Legend:	 Pre-Screening Question	 MDS Question
		 Bold italicized text displays on the Care Guide Printout
11 Life events:	<div></div>	
12 Activities & interests in the past:	<div></div>	

CARE GUIDE: REGULAR PREFERRED ROUTINE MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question

 MDS Question



Bold italicized text displays on the Care Guide Printout

REGULAR PREFERRED ROUTINE



Usual out of bed schedule - Check all that apply:

- ☐ *Up before breakfast*
- ☐ *Up after breakfast*
- ☐ *Naps after breakfast*
- ☐ *Up before lunch*
- ☐ *Up after lunch*
- ☐ *Naps after lunch*
- ☐ *Up before dinner*
- ☐ *Up all day*
- ☐ Other

If other, specify:



Usual bed time:



Sleeps through the night: ☐ Yes ☐ No

does not sleep through the night



If no, specify:



Bath/shower schedule - Check all that apply:

- | | | |
|---|----------------------------|--------------------------------|
| <input type="checkbox"/> <i>Sunday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |
| <input type="checkbox"/> <i>Monday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |
| <input type="checkbox"/> <i>Tuesday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |
| <input type="checkbox"/> <i>Wednesday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |
| <input type="checkbox"/> <i>Thursday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |
| <input type="checkbox"/> <i>Friday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |
| <input type="checkbox"/> <i>Saturday</i> | <input type="radio"/> Days | <input type="radio"/> Evenings |



Bath comments

(e.g. special soaps, lotions,
hair washing instructions, etc):



Nail care on bath day provided by RCA:

- ☐ *Cut fingernails*
- ☐ *Cut toenails*
- ☐ (None of Above)



Breakfast location:




- ☐ *In bed*
- ☐ *Up in room*
- ☐ *In dining area*

If other, specify:

CARE GUIDE: REGULAR PREFERRED ROUTINE MOCK-UP ver 14.0

Name
Date of Birth
ID

Date
Date Approved
Approved By

Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout

8 Lunch location:

☐ *In bed*

☐ *Up in room*

☐ *In dining area*

If other, specify:

9 Supper location:

☐ *In bed*

☐ *Up in room*

☐ *In dining area*

If other, specify:

10 GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities) - Check all PREFERENCES whether or not activity is currently available to resident.

<input type="checkbox"/> <i>Cards, other games</i>	<input type="checkbox"/> <i>Walk/wheeling outdoors</i>
<input type="checkbox"/> <i>Crafts or arts</i>	<input type="checkbox"/> <i>Watching TV</i>
<input type="checkbox"/> <i>Exercise or sports</i>	<input type="checkbox"/> <i>Gardening or plants</i>
<input type="checkbox"/> <i>Music</i>	<input type="checkbox"/> <i>Talking or conversing</i>
<input type="checkbox"/> <i>Reading, writing</i>	<input type="checkbox"/> <i>Helping others</i>
<input type="checkbox"/> <i>Spiritual or religious activities</i>	<input type="checkbox"/> NONE OF ABOVE
<input type="checkbox"/> <i>Trips or shopping</i>	

Comments:

11 PREFERRED ACTIVITY SETTINGS - Check all settings in which activities are preferred.

☐ *Own room*

☐ *Day or activity room*

☐ *Inside facility/off unit*




☐ *Outside facility*

☐ NONE OF ABOVE

12 Daily Schedule (incl. dialysis schedule if appl.):

<input type="checkbox"/> Sunday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	
<input type="checkbox"/> Monday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	
<input type="checkbox"/> Tuesday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	

CARE GUIDE: REGULAR PREFERRED ROUTINE MOCK-UP ver 14.0

Name		Date
Date of Birth	Date Approved	Approved By
ID		
Legend:  Pre-Screening Question  MDS Question  Bold italicized text displays on the Care Guide Printout		
<input type="checkbox"/> Wednesday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	
<input type="checkbox"/> Thursday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	
<input type="checkbox"/> Friday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	
<input type="checkbox"/> Saturday	<input type="radio"/> 7am - 3pm	
	<input type="radio"/> 3pm - 11pm	

CARE GUIDE REFERENCE KEY

Mock-Up ver 14.0

MDS Residential Care	Care Guide Question	
MOVING IN		
Moving In Profile		
AB2a	1	Admitted From
AB3	2	Lived Alone
AB5	3	Residential History
A7	4	Responsibility for Payment
A9	5	Responsibility/ Legal Guardian
AB9	6	Mental Health History
AB10	7	Conditions Related to Developmental Disability Status
A10	8	Advanced Directives
Previous Routine		
AC1	9a	Cycle of Daily Events
AC1	9b	Eating Patterns
AC1	9c	ADL Patterns
AC1	9d	Involvement Patterns
COGNITIVE STATUS & BEHAVIOUR		
B1	1	Comatose
B4	2	Cognitive Skills
E4	4-8	Behavioural Symptoms
P2	10	Intervention Programs for Mood, Behaviour, Cognitive Loss
PAIN		
J2a	1	Pain Symptoms - frequency
J2b		Pain Symptoms - intensity
J3		Pain Site
FALLS		
J4	1	Accidents
COMMUNICATION		
C3	1	Modes of Expression
C5	2	Speech Clarity
C4	5	Making Self Understood
C6	6	Ability to Understand Others
Hearing and Vision		
C1	7	Hearing
C2	9	Communication Devices
D1	10	Vision
D3	12	Visual Appliances

MDS Residential Care		Care Guide Question
NUTRITION		
K1	1	Oral Problems
K2a	2a	Height
K2b	2b	Weight
K3a	3a	Weight loss
K3b	3b	Weight gain
K4	4	Nutritional Problems
K5	5	Nutritional Approaches
K6a		Parenteral or Enteral Intake
K6b		Parenteral or Enteral Intake
G1ha	6a	Eating - self performance
G1hb	6b	Eating - support provided
ACTIVITIES OF DAILY LIVING		
Toileting		
H1a	1	Bowel Continence
H1b	2	Bladder Continence
H3	5	Appliances and Programs
G1ia	6a	Toilet Use - self performance
G1ib	6b	Toilet Use - support provided
Dressing		
G1ga	7a	Dressing - self performance
G1gb	7b	Dressing - support provided
Hygiene		
G1ja	13a	Personal Hygiene - self performance
G1jb	13b	Personal Hygiene - support provided
Bathing		
G2a	14a	Bathing - self performance
G2b	14b	Bathing - support provided
MOBILITY/TRANSFER		
G1aa	1a	Bed Mobility - self performance
G1ab	1b	Bed Mobility - support provided
G6	3	Modes of Transfer
G1ba	4a	Transfer - self performance
G1bb	4b	Transfer - support provided
G1ea	5a	Locomotion on Unit - self performance
G1eb	5b	Locomotion on Unit - support provided
G5	6	Modes of Locomotion
G1fa	8a	Locomotion off Unit - self performance
G1fb	8b	Locomotion off Unit - support provided
G1ca	9a	Walk in Room - self performance
G1cb	9b	Walk in Room - support provided
G1da	10a	Walk in Corridor - self performance
G1db	10b	Walk in Corridor - support provided
SKIN CONDITION		
M4	1	Other Skin Problems
M5	3	Skin Treatments
M1	4	Ulcers
M3	5	History of Resolved Pressure Ulcers
SPECIAL TREATMENTS,PROCEDURES AND PROGRAMS		
P1a	1	Special Care - Treatments
P1a	3	Special Care - Programs

MDS Residential Care		Care Guide Question
SOCIAL WELL-BEING		
F1	3	Sense of Initiative/Involvement
F2	4	Unsettled Relationships
F3	5	Past Roles
REGULAR PREFERRED ROUTINE		
N4	10	General Activity Preferences
N3	11	Preferred Activity Settings