

# 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  5 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  none \_\_\_\_\_

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) \_\_\_\_\_ Member wears reading glasses, is able to read small print with her glasses \_\_\_\_\_

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) \_\_\_\_\_

None \_\_\_\_\_

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

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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/ADL 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

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

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.

If no assistance needed, enter "0".

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Upper body only- up to 15 minutes

Lower body only- up to 15 minutes

Full bath- up to 30 minutes

# days

total minutes

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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  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

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  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

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 up to 90 minutes per day

Incontinent     Bowel     Bladder     Both    # days    total minutes  
 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  
 If no assistance needed, enter "0":  
 Limited assist, 5 to 10 minutes  
 Extensive assist or higher, 15 minutes

\_\_\_\_\_    # days    total minutes  
 \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

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

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

If no assistance needed, enter "0".  
 Limited assist, 5-10 minutes per episode    # days    total minutes  
 Extensive assist or higher, 15 minutes per episode  
       

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

**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  
           

Justification of need

Bed linen changes associated with soiling only- Routine bed linen changes  
 are included in light housekeeping    10 minutes per occasion, limit 30 minutes/day    # days    total minutes  
       

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  
   

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	# of dinners	meal per week	total minutes
Dinner: 20 to 25 minutes			
Lunch: 10 to 15 minutes			
Breakfast: 10 to 15 minutes			

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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
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>

Justification of need

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 Minutes	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Total PCA hours	<input style="width: 100%;" type="text"/>

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.*

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

# Personal Care Assistant (PCA) Nursing Assessment Tool

Signature \_\_\_\_\_

Relationship to Member \_\_\_\_\_

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