Care Seniors LLC
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# AIDE/HOMEMAKER CARE PLAN

HOME HEALTH AIDE - HOMEMAKER

(Circle Service Provided)

| | | | |
|---|---|---|---|
| Patient Name ➤ | | Date of First Visit | |
| Team Leader Name | | Frequency | |
| Caregiver Name | | | |
| Diagnosis/Problems | | | |
| Client Address | | DOB | |
| | | Phone # | |

**ASSIGNMENTS**: Specify Q visits, frequency with day of week at patient request.

| VITAL SIGNS | FREQUENCY |
|---|---|
| Temperature | |
| BP | |
| Pulse | |
| Respiration | |

| | TOTAL SUPPORT | ASSIST | SELF CARE | FREQUENCY |
|---|---|---|---|---|
| **BATH** | | | | ☐ Every Visit OR: |
| Tub/Shower | | | | ☐ Every Visit OR: |
| Bed-Partial/Complete | | | | ☐ Every Visit OR: |
| Assist Bath-Chair | | | | ☐ Every Visit OR: |
| Shampoo Hair | | | | ☐ Every Visit OR: |
| Comb Hair | | | | ☐ Every Visit OR: |
| Mouth Care | | | | ☐ Every Visit OR: |
| Shave ☐ electric ☐ straight | | | | ☐ Every Visit OR: |
| Assist with Dressing | | | | ☐ Every Visit OR: |
| **HAND/FOOT CARE** | | | | |
| Clean/File Nails | | | | ☐ Every Visit OR: |
| Soak Feet | | | | ☐ Every Visit OR: |
| **ELIMINATION** | | | | |
| Perineal Care | | | | ☐ Every Visit OR: |
| External Cath Care | | | | |
| Measure Cath Output | | | | ☐ Every Visit OR: |
| Empty Drainage Bag | | | | ☐ Every Visit OR: |
| **SKIN CARE** | | | | |
| Moisturize Skin | | | | Every Visit OR: |
| **ACTIVITY** | | | | |
| Ambulation/Mobility | | | | Every Visit OR: |
| Walker/Wheelchair/Cane | | | | Every Visit OR: |
| Chair/Bed | | | | Every Visit OR: |
| Dangle/Commode | | | | Every Visit OR: |
| Exercise-per PT / OT / SLP | | | | Every Visit OR: |
| Reposition Patient | | | | Every Visit OR: |
| Other | | | | Every Visit OR: |
| **MEALS** | | | | |
| Prepare | | | | Every Visit OR: |
| Feed | | | | Every Visit OR: |
| Setup | | | | Every Visit OR: |
| Offer Oral Supplement | | | | Every Visit OR: |
| **HOUSEKEEPING** | | | | |
| Change Bed Linens | | | | Every Visit OR: |
| Make Bed | | | | Every Visit OR: |
| Straighten Room | | | | Every Visit OR: |
| Laundry | | | | Every Visit OR: |
| Shopping | | | | Every Visit OR: |

| PERTINENT INFORMATION | |
|---|---|
| ☐ | DNR |
| ☐ | Lives Alone |
| ☐ | Lives with other: |
| ☐ | Bed Bound |
| ☐ | Bed Rest BR P's |
| ☐ | Up as Tolerated |
| ☐ | Amputee (specify) |
| ☐ | Partial Weight Bearing |
| ☐ | Weight Bearing (R) |
| ☐ | Weight Bearing (L) |
| ☐ | Prone to Fracture |
| ☐ | Prosthesis (specify) |
| ☐ | Special Equipment |
| ☐ | Speech/Communication Deficit |
| ☐ | Vision Deficit |
| ☐ | Glasses |
| ☐ | Contacts |
| ☐ | Other |
| ☐ | Hearing Deficit |
| ☐ | Hearing Aid |
| ☐ | Dentures Upper |
| ☐ | Dentures Lower |
| ☐ | Dentures Partial |
| ☐ | Oriented x3 |
| ☐ | Alert |
| ☐ | Forgetful/Confused |
| ☐ | Diabetic |
| ☐ | Diabetic Diet |
| ☐ | Allergies (specify) |
| ☐ | |
| ☐ | **SAFETY** |
| ☐ | Hip Precautions |
| ☐ | Seizure Precautions |
| ☐ | Bleeding Precautions |
| ☐ | Fall Precautions |
| ☐ | Pain Medication |
| ☐ | $O_2$ |
| ☐ | 24 Hour Supervision |
| ☐ | Emergency Call System |
| ☐ | Other (specify) |
| ☐ | |
| ☐ | |
| ☐ | |

| | |
|---|---|
| **OTHER** | |
| **SPECIAL INSTRUCTIONS** | |
| **PARAMETERS/SPECIAL CONDITIONS TO REPORT TO RN/THERAPIST** | |

| Review Date/Signature | Review Date/Signature | Review Date/Signature | Review Date/Signature |
|---|---|---|---|
| | | | |

| RN/Therapist Signature | Date |
|---|---|
| ➤ | |