Unique Health Care LLC

CLIENT CARE PLAN (HHA)

Client Name: _____ **Admit Date:**_____

Date of Birth: _____ **Allergies:**_____ **Diagnosis:** _____

Client History/Condition: _____

CODE STATUS: ☐ **FULL RESUSCITATION** ☐ **NO CODE**

	Type of Service	Frequency	Instructions/Comments
Assistance	**PERSONAL CARE SERVICES**		
□Reminders □ Standby □ Total Assist	Bath Type □ Tub □ Shower		
□Reminders □ Standby □ Total Assist	Dressing		
□Reminders □ Standby □ Total Assist	Hair care/Shampoo		
□Reminders □ Standby □ Total Assist	☐ Oral Hygiene ☐ Dentures		
□Reminders □ Standby □ Total Assist	☐ Skin Care ☐ Cast Care		
□Reminders □ Standby □ Total Assist	Fingernail/Foot Care		
□Reminders □ Standby □ Total Assist	Shave		
	Other (specify)		
□Reminders □ Standby □ Total Assist	Non-Sterile Dressing Changes		
	Vital Signs: T P R Blood Pressure		
□ Reminders □ Administration □ Standby □ Total Assist	**Medications**		
□Reminders □ Standby □ Total Assist	**Other (specify):**		

	Type of Service	Frequency	Instructions/Comments
□Reminders □ Standby □ Total Assist	Other (specify):		
Assistance	**B. ACTIVITIES**		
	☐ Bed Rest ☐ BRP		
□Reminders □ Standby □ Total Assist	Up in Chair		
□Reminders □ Standby □ Total Assist	Ambulation: ☐ Assist ☐ Indep. ☐ Stand-by		
□Reminders □ Standby □ Total Assist	☐ Walker ☐ Wheelchair ☐ Cane ☐ Crutches ☐ Other		
□Reminders □ Standby □ Total Assist	Transfer: ☐ Assist ☐ Indep. ☐ Stand-by		
□Reminders □ Standby □ Total Assist	Range of Motion		
□Reminders □ Standby □ Total Assist	Turn/Reposition		
□Reminders □ Standby □ Total Assist	Assist with Special Equipment		
□Reminders □ Standby □ Total Assist	Other (specify):		
C. DIET AND NUTRITION		**Frequency**	**Instructions/Comments**
	Meal Preparation		
	Diet (specify)		
	Assist with Meal Set-up		
	Feeding: ☐ Total ☐ Assist ☐ Indep.		
	Encourage Fluids: cc/day		
	Restrict Fluids		

Assistance	D. ELIMINATION	Frequency	Instructions/Comments
See delegated task	Catheter Care - Type :		
See delegated task	Urine Testing/I & O		
See delegated task	Ostomy care - Type:		
See delegated task	Enema - Type:		
□Reminders □ Standby □ Total Assist	Toileting:		
	Incontinence/Diapers		
	Peri-Care/Skin Care Needs		
E. HOME MANAGEMENT		**Frequency**	**Instructions/Comments**
	Infection Control		
	Clean Rooms: ☐ Bathroom ☐ Bedroom ☐ Kitchen ☐ Other:		
	Clean Equipment - List:		
	Type of Cleaning		
	Client's Laundry		
	Shopping/Errands		
F. COMMUNICATION		**Frequency**	**Instructions/Comments**
	Complete Documentation		
	Report Changes in Client Condition to RN		
	Follow Care Plan and report if changes needed **Other (specify):**		
G. OTHER DUTIES (SPECIFY)		**Frequency**	**Instructions/Comments**

D. DELEGATED TASK/TREATMENT AND/OR THERAPY Frequency			Instructions/Comments
□Reminders □ Standby □ Total Assist	**Specify** —		See protocol/delegated task instruction form for specific instruction
□Reminders □ Standby □ Total Assist			
□Reminders □ Standby □ Total Assist			
□Reminders □ Standby □ Total Assist			

RN CONTACT INFORMATION: 651.500.4050

AIDE/PCA CARE PLAN PAGE TWO

Expected Outcome/Goals:_____

_____

_____

_____

Plan of Care Developed in Consultation with:

☐ Client ☐ Family/Significant Others ☐ Physician ☐ Other:_____

_____

Client/Client Representative Signature Date:

RN Signature **Date**

Plan of Care Review/Update (minimally every 90 days):

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____