**Amani Health Care Services, LLC**

**1705 Southcross Drive West, Suite 105, Burnsville, MN 55306**

**952 - 683 - 1628**

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## PCA CARE PLAN Date:

**Client Name:** _____

**Address:** _____

**Telephone number:** _____

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

**Allergies:** _____

**Frequency of Visits/Shifts:** _____

**Client History/Condition:** _____

**Care Plan Span from** _____ **To** _____

**CODE STATUS:** **FULL RESUSCITATION** **DNR/DNI** **HOSPICE CARE**

| | Type of Services | Frequency | Instructions/Comments |
|---|---|---|---|
| **A.** | **PERSONAL CARE SERVICES** | | |
| | **Bathing** | | |
| | **Grooming** | | |
| | ☐ Oral Hygiene Dentures | | |
| | ☐ Skin Care Cast Care | | |
| | Fingernail Care | | |
| | Foot Care | | |
| | Shave | | |
| | Hair care/Shampoo | | |
| | **Dressing** | | |
| | **Vital Signs**: T P R BP | | |
| | Others (specify) | | |
| **B.** | **ACTIVITIES** | | |
| | BED Rest BRP | | |
| | Up in Chair | | |
| | Ambulation: Assist Indep. Stand-by | | |
| | Walker Wheelchair Cane Crutches Other | | |
| | **Transfer:** Assist Indep. Stand-by | | |
| | **Mobility** | | |

| | | | |
|---|---|---|---|
| | **Positioning** | | |
| | Assist with Special Equipment | | |
| | Other (specify) | | |
| **C.** | **DIET AND NUTRITION** | | |
| | Meal Preparation | | |
| | Diet (specify) | | |
| | Assist with meal Set-up | | |
| | **Eating**: Total Assist Indep. | | |
| | Encourage Fluids cc/day | | |
| | Restrict Fluids | | |
| | Weight | | |
| **D.** | **ELIMINATION** | | |
| | **Toileting** Assist Indep Stand-by | | |
| | | | |
| | Ostomy care- type: | | |
| | Catheter care- type: | | |
| | | | |
| | **Incontinence/Diapers** | | |
| | Peri-Care/Skin Needs | | |
| **E.** | **HOME MANAGEMENT** | | |
| | **Infection Control** | | |
| | Clean Rooms: Bathroom Bedroom Kitchen Other | | |
| | Clean Equipment- List | | |
| | Type of Cleaning | | |
| | Client's Laundry | | |
| | Shopping/Errands | | |
| **F.** | **COMMUNICATION** | | |
| | Complete Documentation | | |
| | Report Changes in Client Condition to RN (QP) | | |
| | Follow Care Plan and report any changes as needed | | |
| | Other (specify): | | |
| **G.** | **BEHAVIOR** | | |
| | | | |
| | | | |
| | | | |
| | | | |

**ExpectedOutcome/Goals:**_____

_____

_____

**Plan of Care Developed in Consultation with:**

Client_____Family/SignificantOthers_____
Physician _____Other_____

**PCA oriented to client and care plan by QP**_____ **Date**_____

**Plan of care developed by:**_____**Date**_____

**Client/RP: _____Sign_____Date_____**

**Plan of Care Review/Update (minimally every 60 days):**

Signature_____Date_____

Signature_____Date_____