Instructions - RN Assessment

The RN Assessment must be completed in full by the provider agency RN. The Plan of Care must be completed initially and annually thereafter or as indicated with any documented change in service recipient's needs.

1. Enter the service recipient's name, date of birth and the date the assessment is completed.
2. The Assessment must include a narrative which covers the service recipient's living conditions, medical history, medications, diagnoses, allergies and current condition.
3. Describe in detail, the service recipient's ability to perform personal care, mobility, nutritional, and environmental tasks. This assessment is used to develop the service recipient's Plan of Care; therefore, as much detail as possible must be included (additional pages may be attached as necessary). The documentation should paint a picture and validate the tasks and time frames on the Plan of Care.
4. The assessment must be completed in full. No areas should be left blank.
5. The provider agency RN must sign and date the assessment for the date it was completed. The original assessment must be kept in the service recipient's file.