RESIDENT ASSESSMENT TOOL

To be completed by a physician, certified nurse practitioner, registered nurse, or physician assistant within 30 days prior to admission, at least annually, & within 48 hours after a significant change of condition & each nonroutine hospitalization.

If this form is completed in its entirety by the Delegating Nurse/Case Manager (DN/CM), there is no need to complete an additional nursing assessment. If anyone other than the DN/CM completes this form, the DN/CM must document their assessment on a separate form.

An assisted living program may not provide services to an individual who at the time of initial admission requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or (6) Treatment for a disease or condition which requires more than contact isolation.
An exception is provided for residents who are under the care of a licensed general hospice program.

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy
Primary Spoken Language:	☐ Male ☐ Female	

Allergies (drug, food, & environmental):

Current Medical & Mental Health Diagnoses:

Past Medical & Mental Health History:

Airborne Communicable Disease.
Test to verify the resident is free from active TB *(completed no more than 1 year prior to admission)*:
PPD Date: mm-dd-yy Result: mm OR Chest X-Ray Date: mm-dd-yy Result:
Does the resident have any active reportable airborne communicable diseases? ☐ No ☐ Yes
(specify)

Vital Signs.
BP: / Pulse: Resp: T: °F Height: ft in Weight: lbs
Pain: ☐ No ☐ Yes (specify site, cause, & treatment)

Neuro. Alert & oriented to: ☐ Person ☐ Place ☐ Time
Answers questions: ☐ Readily ☐ Slowly ☐ Inappropriately ☐ No response
Memory: ☐ Adequate ☐ Forgetful – needs reminders ☐ Significant loss – must be directed
Is there evidence of dementia? ☐ No ☐ Yes (cause)
Cognitive status exam completed? ☐ No ☐ Yes (results)
Sensation: ☐ Intact ☐ Diminished/absent (describe below)
Sleep aids: ☐ No ☐ Yes (describe below) Seizures: ☐ No ☐ Yes (describe below)
Comments:

Eyes, Ears, & Throat. ☐ Own teeth ☐ Dentures Dental hygiene: ☐ Good ☐ Fair ☐ Poor
Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind - ☐ R ☐ L
Hearing: ☐ Adequate ☐ Poor ☐ Uses corrective aid ☐ Deaf - ☐ R ☐ L
Comments:

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy

Musculoskeletal. ROM: ☐ Full ☐ Limited
Mobility: ☐ Normal ☐ Impaired → Assistive devices: ☐ No ☐ Yes (describe below)
Motor development: ☐ Head control ☐ Sits ☐ Walks ☐ Hemiparesis ☐ Tremors
ADLs: (S=self; A=assist; T=total) Eating: Bathing: Dressing:
Is the resident at an increased risk of falling or injury? ☐ No ☐ Yes (explain below)
Comments:

Skin. Intact: ☐ Yes ☐ No (if no, a wound assessment must be completed)
☐ Normal ☐ Red ☐ Rash ☐ Irritation ☐ Abrasion ☐ Other
Any skin conditions requiring treatment or monitoring? ☐ No ☐ Yes (describe condition & treatment)

Respiratory. Respirations: ☐ Regular ☐ Unlabored ☐ Irregular ☐ Labored
Breath sounds: Right (☐ Clear ☐ Rales) Left (☐ Clear ☐ Rales)
Shortness of breath: ☐ No ☐ Yes (indicate triggers below)
Respiratory treatments: ☐ None ☐ Oxygen ☐ Aerosol/nebulizer ☐ CPAP/BIPAP
Comments:

Circulatory. History: ☐ N/A ☐ Arrhythmia ☐ Hypertension ☐ Hypotension
Pulse: ☐ Regular ☐ Irregular Edema: ☐ No ☐ Yes → Pitting: ☐ No ☐ Yes
Skin: ☐ Pink ☐ Cyanotic ☐ Pale ☐ Mottled ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic
Comments:

Diet/Nutrition. ☐ Regular ☐ No added salt ☐ Diabetic/no concentrated sweets
☐ Mechanical soft ☐ Pureed ☐ Other (explain below) ☐ Supplements (explain below)
Is there any condition which may impair chewing, eating, or swallowing? ☐ No ☐ Yes (explain below)
Is there evidence of or a risk for malnutrition or dehydration? ☐ No ☐ Yes (explain below)
Is any nutritional/fluid monitoring necessary? ☐ No ☐ Yes (describe type/frequency below)
Are assistive devices needed? ☐ No ☐ Yes (explain below)
Mucous membranes: ☐ Moist ☐ Dry Skin turgor: ☐ Good ☐ Fair ☐ Poor
Comments:

Elimination.
Bowel sounds present: ☐ Yes ☐ No Constipation: ☐ No ☐ Yes Ostomies: ☐ No ☐ Yes
Bladder: ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Daily incontinence
Bowel: ☐ Normal ☐ Occasional incontinence (less than daily) ☐ Daily incontinence
(If any incontinence, describe management techniques)
Comments:

Additional Services Required. ☐ No ☐ Yes (indicate type, frequency, & reason)
☐ Physical therapy ☐ Home health ☐ Private duty ☐ Hospice ☐ Nursing home care ☐ Other
Comments:

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy

Substance Abuse. Does the resident have a history of or current problem with the abuse of medications, drugs, alcohol, or other substances? ☐ No ☐ Yes (explain)
Comments:

Psychosocial. KEY: *N = Never O = Occasional R = Regular C = Continuous*					
	N	O	R	C	Comments
Receptive/Expressive Aphasia	☐	☐	☐	☐	
Wanders	☐	☐	☐	☐	
Depressed	☐	☐	☐	☐	
Anxious	☐	☐	☐	☐	
Agitated	☐	☐	☐	☐	
Disturbed Sleep	☐	☐	☐	☐	
Resists Care	☐	☐	☐	☐	
Disruptive Behavior	☐	☐	☐	☐	
Impaired Judgment	☐	☐	☐	☐	
Unsafe Behaviors	☐	☐	☐	☐	
Hallucinations	☐	☐	☐	☐	
Delusions	☐	☐	☐	☐	
Aggression	☐	☐	☐	☐	
Dangerous to Self or Others	☐	☐	☐	☐	*(if response is anything other than never, explain)*

Awake Overnight Staff. Based on the results of this assessment & your clinical judgment, indicate if the resident requires monitoring by awake overnight staff: ☐ Yes ☐ No (explain your reason)

Health Care Decision-Making Capacity. Indicate the resident's highest level of ability to make health care decisions:

☐ Probably can make higher level decisions *(such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, & risks of proposed treatment)*

☐ Probably can make limited decisions that require simple understanding

☐ Probably can express agreement with decisions proposed by someone else

☐ Cannot effectively participate in any kind of health care decision-making

Ability to Self-Administer Medications. Indicate the resident's ability to take his/her own medications safely & appropriately:

☐ Independently without assistance

☐ Can do so with physical assistance, reminders, or supervision only

☐ Needs to have medications administered by someone else

General Comments.

Resident:	DOB: mm-dd-yy	Assessment Date: mm-dd-yy

Health Care Practitioner's Signature: _____ Date: mm-dd-yy

Print Name & Title:

Skip this box if you are not the Delegating Nurse/Case Manager (DN/CM).

When the DN/CM completes this entire Resident Assessment Tool, including this box, there is no need to document a separate nursing assessment.

Has a 3-way check (orders, medications, & MAR) been conducted for all of the resident's medications & treatments, including OTCs & PRNs? ☐ Yes ☐ No (explain below)

Were any discrepancies identified? ☐ No ☐ Yes (explain below)

Are medications stored appropriately? ☐ Yes ☐ No (explain below)

Has the caregiver been instructed on monitoring for drug therapy effectiveness, side effects, & drug reactions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below)

Have arrangements been made to obtain ordered labs? ☐ Yes ☐ No (explain below)

Is the resident taking any high risk drugs? ☐ No ☐ Yes (explain below)

For all high risk medications (such as hypoglycemics, anticoagulants, etc), has the caregiver received instructions on special precautions, including how & when to report problems that may occur? ☐ Yes ☐ N/A ☐ No (explain below)

Is the environment safe for the resident? ☐ Yes ☐ No (explain below)
(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture, & assistive devices.)

Comments:

DN/CM's Signature: _____ Date: mm-dd-yy

Print Name:

Six months after this assessment is completed, it must be reviewed.
If significant changes have occurred, a new assessment must be completed.
If there have been no significant changes, simply complete the information below.

Six-Month Review Conducted By:

Signature: _____ *Date:* _____

Print Name & Title: _____

Resident Name:	DOB: mm-dd-yy	Date Completed: mm-dd-yy

PRESCRIBER'S SIGNED ORDERS

(You may attach *signed* prescriber's orders as an alternative to completing this page.)

ALLERGIES (list all):

MEDICATIONS & TREATMENTS:

List all medications & treatments, including PRN, OTC, herbal, & dietary supplements.

Medication/Treatment Name	*Dose*	*Route*	*Frequency*	*Reason for Giving*	*Related Monitoring & Testing (if any)*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					

Resident Name:			DOB: mm-dd-yy	Date Completed: mm-dd-yy	
19.					
20.					
21.					
22.					
23.					
24.					
25.					

LABORATORY SERVICES:

Lab Test	*Reason*	*Frequency*
1.		
2.		
3.		
4.		
5.		
6.		

Total number of medications & treatments listed on these signed orders?

Prescriber's Signature: _____ Date: _____

Office Address: Phone: - -

Maryland Medical Orders for Life-Sustaining Treatment (MOLST)

Patient's Last Name, First, Middle Initial	Date of Birth	☐ Male ☐ Female

This form includes medical orders for Emergency Medical Services (EMS) and other medical personnel regarding cardiopulmonary resuscitation and other life-sustaining treatment options for a specific patient. It is valid in all health care facilities and programs throughout Maryland. This order form shall be kept with other active medical orders in the patient's medical record. The physician or nurse practitioner must accurately and legibly complete the form and then sign and date it. The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. A copy or the original of every completed MOLST form must be given to the patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

CERTIFICATION FOR THE BASIS OF THESE ORDERS: Mark any and all that apply.

I hereby certify that these orders are entered as a result of a discussion with and the informed consent of:

_____ the patient; or
_____ the patient's health care agent as named in the patient's advance directive; or
_____ the patient's guardian of the person as per the authority granted by a court order; or
_____ the patient's surrogate as per the authority granted by the Heath Care Decisions Act; or
_____ if the patient is a minor, the patient's legal guardian or another legally authorized adult.

Or, I hereby certify that these orders are based on:

_____ instructions in the patient's advance directive; or
_____ other legal authority in accordance with all provisions of the Health Care Decisions Act. All supporting documentation must be contained in the patient's medical records.

_____ Mark this line if the patient or authorized decision maker declines to discuss or is unable to make a decision about these treatments. **The patient's or authorized decision maker's participation in the preparation of the MOLST form is always voluntary.** If the patient or authorized decision maker has not limited care, except as otherwise provided by law, CPR will be attempted and other treatments will be given.

1

CPR (RESUSCITATION) STATUS: EMS providers must follow the *Maryland Medical Protocols for EMS Providers*.

_____ **Attempt CPR:** If cardiac and/or pulmonary arrest occurs, attempt cardiopulmonary resuscitation (CPR). This will include any and all medical efforts that are indicated during arrest, including artificial ventilation and efforts to restore and/or stabilize cardiopulmonary function.

[If the patient or authorized decision maker does not or cannot make any selection regarding CPR status, mark this option. Exceptions: If a valid advance directive declines CPR, CPR is medically ineffective, or there is some other legal basis for not attempting CPR, mark one of the "No CPR" options below.]

No CPR, Option A, Comprehensive Efforts to Prevent Arrest: Prior to arrest, administer all medications needed to stabilize the patient. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

_____ **Option A-1, Intubate:** Comprehensive efforts may include intubation and artificial ventilation.

_____ **Option A-2, Do Not Intubate (DNI):** Comprehensive efforts may include limited ventilatory support by CPAP or BiPAP, but do not intubate.

_____ **No CPR, Option B, Palliative and Supportive Care:** Prior to arrest, provide passive oxygen for comfort and control any external bleeding. Prior to arrest, provide medications for pain relief as needed, but no other medications. Do not intubate or use CPAP or BiPAP. If cardiac and/or pulmonary arrest occurs, do not attempt resuscitation (No CPR). Allow death to occur naturally.

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

Patient's Last Name, First, Middle Initial	Date of Birth	Page 2 of 2 ☐ Male ☐ Female

Orders in Sections 2-9 below do not apply to EMS providers and are for situations other than cardiopulmonary arrest. Only complete applicable items in Sections 2 through 8, and only select one choice per applicable Section.

2 ARTIFICIAL VENTILATION

2a. _____ May use intubation and artificial ventilation indefinitely, if medically indicated.

2b. _____ May use intubation and artificial ventilation as a limited therapeutic trial.
Time limit_____

2c. _____ May use only CPAP or BiPAP for artificial ventilation, as medically indicated.
Time limit_____

2d. _____ Do not use any artificial ventilation (no intubation, CPAP or BiPAP).

3 BLOOD TRANSFUSION

3a. _____ May give any blood product (whole blood, packed red blood cells, plasma or platelets) that is medically indicated.

3b. _____ Do not give any blood products.

4 HOSPITAL TRANSFER

4a. _____ Transfer to hospital for any situation requiring hospital-level care.

4b. _____ Transfer to hospital for severe pain or severe symptoms that cannot be controlled otherwise.

4c. _____ Do not transfer to hospital, but treat with options available outside the hospital.

5 MEDICAL WORKUP

5a. _____ May perform any medical tests indicated to diagnose and/or treat a medical condition.

5b. _____ Only perform limited medical tests necessary for symptomatic treatment or comfort.

5c. _____ Do not perform any medical tests for diagnosis or treatment.

6 ANTIBIOTICS

6a. _____ May use antibiotics (oral, intravenous or intramuscular) as medically indicated.

6b. _____ May use oral antibiotics when medically indicated, but do not give intravenous or intramuscular antibiotics.

6c. _____ May use oral antibiotics only when indicated for symptom relief or comfort.

6d. _____ Do not treat with antibiotics.

7 ARTIFICIALLY ADMINISTERED FLUIDS AND NUTRITION

7a. _____ May give artificially administered fluids and nutrition, even indefinitely, if medically indicated.

7b. _____ May give artificially administered fluids and nutrition, if medically indicated, as a trial.
Time limit_____

7c. _____ May give fluids for artificial hydration as a therapeutic trial, but do not give artificially administered nutrition.
Time limit_____

7d. _____ Do not provide artificially administered fluids or nutrition.

8 DIALYSIS

8a. _____ May give chronic dialysis for end-stage kidney disease if medically indicated.

8b. _____ May give dialysis for a limited period.
Time limit_____

8c. _____ Do not provide acute or chronic dialysis.

9 OTHER ORDERS _____

_____

_____

_____

_____

PHYSICIAN'S OR NURSE PRACTITIONER'S SIGNATURE (Signature and date are required to validate order)

Practitioner's Signature	Print Practitioner's Name	
Maryland License #	Phone Number	Date

INSTRUCTIONS

Completing the Form: The physician or nurse practitioner shall select only 1 choice in Section 1 and only 1 choice in any of the other Sections that apply to this patient. If any of Sections 2-9 do not apply, leave them blank. Use Section 9 to document any other orders related to life-sustaining treatments. The order form is not valid until a physician or nurse practitioner signs and dates it. Each page that contains orders must be signed and dated. A copy or the original of every completed MOLST form must be given to a competent patient or authorized decision maker within 48 hours of completion of the form or sooner if the patient is discharged or transferred.

Selecting CPR (Resuscitation) Status: EMS Option A-1 – Intubate, Option A-2 – Do Not Intubate, and Option B include a set of medical interventions. You cannot alter the set of interventions associated with any of these options and cannot override or alter the interventions with orders in Section 9.

No-CPR Option A: Comprehensive Efforts to Prevent Cardiac and/or Respiratory Arrest / DNR if Arrest – No CPR. This choice may be made either with or without intubation as a treatment option. Prior to arrest, all interventions allowed under *The Maryland Medical Protocols for EMS Providers.* Depending on the choice, intubation may or may not be utilized to try to prevent arrest. Otherwise, CPAP or BiPAP will be the only devices used for ventilatory assistance. In all cases, comfort measures will also be provided. No CPR if arrest occurs.

No-CPR Option B: Supportive Care Prior to Cardiac and/or Respiratory Arrest. DNR if Arrest Occurs – No CPR. Prior to arrest, interventions may include opening the airway by non-invasive means, providing passive oxygen, controlling external bleeding, positioning and other comfort measures, splinting, pain medications by orders obtained from a physician (e.g., by phone or electronically), and transport as appropriate. No CPR if arrest occurs.

The DNR A-1, DNR A-2 (DNI) and DNR B options will be authorized by this original order form, a copy or a fax of this form, or a bracelet or necklace with the DNR emblem. EMS providers or medical personnel who see these orders are to provide care in accordance with these orders and the applicable *Maryland Medical Protocols for EMS Providers*. Unless a subsequent order relating to resuscitation has been issued or unless the health care provider reasonably believes a DNR order has been revoked, every health care provider, facility, and program shall provide, withhold, or withdraw treatment according to these orders in case of a patient's impending cardiac or respiratory arrest.

Location of Form: The original or a copy of this form shall accompany patients when transferred or discharged from a facility or program. Health care facilities and programs shall maintain this order form (or a copy of it) with other active medical orders or in a section designated for MOLST and related documents in the patient's active medical record. At the patient's home, this form should be kept in a safe and readily available place and retrieved for responding EMS and health care providers before their arrival. The original, a copy, and a faxed MOLST form are all valid orders. There is no expiration date for the MOLST or EMS DNR orders in Maryland.

Reviewing the Form: These medical orders are based on this individual's current medical condition and wishes. Patients, their authorized decision makers and attending physicians or nurse practitioners shall review and update, if appropriate, the MOLST orders **annually and whenever the patient is transferred between health care facilities or programs, is discharged, has a substantial change in health status, loses capacity to make health care decisions, or changes his or her wishes.**

Updating the Form: The MOLST form shall be voided and a new MOLST form prepared when there is a change to any of the orders. If modified, the physician or nurse practitioner shall void the old form and complete, sign, and date a new MOLST form.

Voiding the Form: To void this medical order form, the physician or nurse practitioner shall draw a diagonal line through the sheet, write "VOID" in large letters across the page, and sign and date below the line. A nurse may take a verbal order from a physician or nurse practitioner to void the MOLST order form. Keep the voided order form in the patient's active or archived medical record.

Revoking the Form's DNR Order: In an emergency situation involving EMS providers, the DNR order in Section 1 may be revoked at any time by a competent patient's request for resuscitation made directly to responding EMS providers.

Bracelets and Necklaces: If desired, complete the paper form at the bottom of this page, cut out the bracelet portion below, and place it in a protective cover to wear around the wrist or neck or pinned to clothing. If a metal bracelet or necklace is desired, contact Medic Alert at 1-800-432-5378. Medic Alert requires a copy of this order along with an application to process the request.

How to Obtain This Form: Call 410-706-4367 or go to marylandmolst.org

Use of an EMS DNR bracelet is OPTIONAL and at the discretion of the patient or authorized decision maker. Print legibly, have physician or NP sign, cut off strip, fold, and insert in bracelet or necklace.	☐ DNR A-1 Intubate ☐ DNR A-2 Do Not Intubate ☐ DNR B Pt. Name _____ DOB _____ Phys./NP Name _____ Date _____ Phys./NP Signature _____ Phone _____