NEEDS ASSESSMENT AND RECORD OF CARE
HOME CARE

Y an assessed need to be met

* Flow sheet recording
Initial if needs met, no written note required
✓ if needs met and written note required
✖ if needs not met therefore a written note is required

Date (Y/M/D)																		
Time (24hr)	**Arrived**																	
	Departed																	
	Total Time																	
PERSONAL HYGIENE	**Bath – dependent**																	
	– assist																	
	Grooming																	
	Skin Care																	
	Oral Care																	
	Foot Care																	
	Dress – dependent																	
	– assist																	
ELIM	**Bowel**																	
	Bladder																	
	Ostomy																	
	Catheter																	
NUTRITION	**Feeding – dependent**																	
	– assist																	
MOB	**Mobilize – dependent**																	
	– assist																	
	Devices																	
OBS AND MEAS	**Vital signs**																	
	Weight																	
	Blood Glucose																	
	Pain Assessment *(0-10)*																	
	Blood testing																	
MED	**IV**																	
	Medications																	
TX AND PRO	**Dressing Change**																	
	Exercises/ROM																	
	PICC/CVAD care																	
TE	**Teaching**																	
S	**Safety**																	
PS	**Emotional**																	
	BEHAVIOR MANAGMENT 1																	
	2																	
	3																	
HOME-MAKING																		
	ID																	

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