Alberta Health Services

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RAI-HC* Tracking Tool for Use in Supportive Living

*** Resident Assessment Instrument - Home Care**

- Use this form at Designated Supportive Living sites. **Keep original on chart at site.**
- For each shift (**D**ay, **E**vening, **N**ight) complete each section using the instructions provided.
- Tracking Tool begins on Date _____ and ends on Date _____

Date *(yyyy-Mon-dd)*																				
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
I1 Bladder Control	**Write 'Y' = Yes or 'N' = No for each shift**																			
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
Continent (no wetting of urine)																				
Continent with catheter (if no catheter, draw line through)																				
Incontinent (Bladder incontinence includes any level of dribbling, or wetting of urine or leaking catheter).																				
I2 Bladder Devices	**Write 'Y' = Yes or 'N' = No for each shift**																			
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
Use of pads/briefs to protect from wetness (Do not include panty liners or use of pads on bed or chair for clients who are continent but use them "just in case").																				
Use of indwelling catheter (if no catheter, draw line through)																				
I3 Bowel Control	**Write 'Y' = Yes or 'N' = No for each shift**																			
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
Continent (full control of bowels)																				
Continent with ostomy (if no ostomy, draw line through)																				
Incontinent (no bowel control) (include an ostomy that leaks)																				
Had bowel movement (record each shift)																				
L1 Weight in kgs. (weigh client once in 7 day period - e.g. on bath day)																				
N5 Wound/Ulcer Care	**Write 'Y'= Yes or 'N'= No for each shift**																			
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
Wound present																				

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initals**	**Date**	**Time**

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H2 Physical Function (ADL)

Pick a number that best describes what the Client was able to do. Client may need more or less help during a shift, so record each time you helped them.
For example, Client was able to transfer independently first thing in morning (0), but by 2 PM Client needs 1 person to assist them back into bed (3).

What did the Client do?

Hands Off
0 - Independent - No help
1 - Set Up help only
2 - Supervision - encouraging or giving Client cues, reminders
8 - Activity did not happen

Hands On
3 - Limited Assistance - Client needs hands-on help but **no** weight-bearing assistance,
*e.g. guiding but **no** lifting of the arms/legs.*
4 - Extensive Assistance - Client does **more than** the caregiver **and** receives weight-bearing assistance.
5 - Maximal Assistance - Client does **less than** the caregiver **and** receives weight-bearing assistance.
6 - Total Dependence - Client does not do any part of the activity. Caregiver did all activity for the client.

Date *(yyyy-Mon-dd)*																					
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
H2j. **Bathing** Include getting in and out of bath/shower. How Client takes a full bath/shower/ sponge bath. How each part of body is bathed *e.g. arms, upper and lower legs, chest, abdomen, peri-area. Do not include washing of hair and back.*																					
H2a. **Mobility in Bed** Once in bed, help to turn to reposition	Complete only for Days 5, 6, 7																				
H2b. **Transfer** Moving to and between surfaces: bed, chair, wheelchair, or standing position **(Note: does not include to and from bath/toilet)**																					

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initials**	**Date**	**Time**

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H2 Physical Function (ADL)

Date *(yyyy-Mon-dd)*																				
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
H2c. **Locomotion - Inside** Type of assistance (if any) for the Client to move in their room/suite/building. Includes use of aids. Does not include stairs.																				
H2d. **Locomotion - Outside** Type of assistance (if any) for the Client to move outside/off site. Includes use of aids. Does not include stairs.																				
H2e. **Dressing - Upper Body** (above the waist) How Client dresses and undresses (street clothes, night clothes, underwear).																				
H2f. **Dressing - Lower Body** (from the waist down) How Client dresses and undresses (street clothes, night clothes, underwear, compression stockings, socks and shoes).																				
H2g. **Eating** How Client eats & drinks regardless of skill. Include tube feeding.																				
H2h. **Toilet Use** How Client uses/transfers to toilet/bedpan/commode/urinal, changes incontinence products, manages ostomy/catheter, adjusts clothes and cleans themselves.																				
H2i. **Personal Hygiene** AM and PM care tasks. Does NOT include baths or showers.																				

Complete only for Days 5, 6, 7

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initials**	**Date**	**Time**

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If any mood indicators occurred during each shift, write 'Y'= Yes or 'N'= No. If yes, please add details in the Comments section.

Date *(yyyy-Mon-dd)*																					
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
E1 Mood	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
E1a. **Talked about being sad or depressed, made negative comments about themselves** *e.g. I'd rather be dead, what's the use, nothing matters.*																					
E1b. **Easily annoyed or angry** *e.g. anger at care received, all the time.*																					
E1c. **Talks about fears** *e.g. fear of being abandoned, left alone, being with others, afraid of nighttime.*																					
E1d. **Repeatedly makes comments about health** *e.g. always looking for medical attention.*																					
E1e. **Repeatedly seeks attention/reassurance about non-medical things** *e.g. worries about missing their care or a meal or a visit.*																					
E1f. **Sad, and/or worried look on face** *e.g. furrowed brows. NOT physical pain.*																					
E1g. **Repeatedly crying, being teary or weepy**																					
E1h. **Less interest or participation in usual activities** *e.g. loss of interest in family, friends or usual activities. NOT due to physical reasons.*																					
E1i. **Reduced social interaction** *e.g. less talkative, more isolated. NOT due to physical reasons.*																					

Complete only for Days 5, 6, 7

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initials**	**Date**	**Time**

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If any behaviour occured during each shift, write 'Y'= Yes or 'N'= No. Add details in the Comments section as needed.

Date *(yyyy-Mon-dd)*																				
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
E3 Behaviour	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
E3a. **Wandering (may happen in wheelchair)** *e.g. with no purpose, no concern for their safety or physical needs. Does not include pacing.*																					
If yes, were staff able to distract/stop the behavior easily?																					
E3b. **Was Client verbally abusive?** *e.g. others were threatened, cursed at, screamed at.*																					
If yes, were staff able to distract/stop the behavior easily?																					
E3c. **Was Client physically abusive?** *e.g. hit, shoved, scratched or struck others, or was sexually abusive.*																					
If yes, were staff able to distract/stop the behavior easily?																					
E3d. **Was Client socially inappropriate or disruptive?** *e.g. making disruptive sounds, disrobing, smearing or throwing food or feces, hoarding, rummaging or pacing.*																					
If yes, were staff able to distract/stop the behavior easily?																					
E3e. **Did Client resist care (can be verbal or physical)?** *e.g. refuses or resists taking medication or getting help with care.*																					
If yes, were staff able to distract/stop the behavior easily?																					

Complete only for Days 5, 6, 7

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initials**	**Date**	**Time**

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H4a. Locomotion (How Client gets around) - Indoors	**Enter the number of the aid that is used MOST OFTEN during each shift.**																				
Date *(yyyy-Mon-dd)*																					
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
0. No aid	Complete only for Days 5, 6, 7																				
1. Cane																					
2. Walker/Crutches																					
3. Scooter (e.g. Amigo)																					
4. Wheelchair																					
8. Did not mobilize during shift																					

H4b. Locomotion (How Client gets around) - Outdoors	**Enter the number of the aid that is used MOST OFTEN during each shift.**																				
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
0. No aid	Complete only for Days 5, 6, 7																				
1. Cane																					
2. Walker/Crutches																					
3. Scooter (e.g. Amigo)																					
4. Wheelchair																					
8. Did not mobilize during shift																					

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initials**	**Date**	**Time**

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Date *(yyyy-Mon-dd)*																				
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
K2 and K3 Problem Conditions, K4 Pain	**Write 'Y' = Yes or 'N' = No for each shift**																			
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
K2a. **Diarrhea** (frequent watery stools)																				
K2b. **Difficulty urinating** or urinating 3 + times/night																				
K2c. **Fever**																				
K2d. **Loss of appetite**																				
K2e. **Vomiting**																				
K3a. **Chest pain**																				
K3c. **Dizziness or light headedness**																				
K3d. **Edema**																				
K3e. **Shortness of breath**																				
K3f. **Delusions** (false beliefs not shared by others) *e.g. someone is stealing their things, someone is trying to kill them.*																				
K3g. **Hallucinations** (seeing, hearing, smelling, feeling, or tasting something that is not there)																				
K4a. **Complains of pain** (includes crying, wincing, frowning, moaning, or less movement). Please add number of times client complains of pain.																				
K4c. **Unable to do usual activities** because of pain																				
K4d. **Complains of pain in more than one area**																				

Complete only for Days 5, 6, 7

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Date *(yyyy-Mon-dd)*																					
	Day 1			**Day 2**			**Day 3**			**Day 4**			**Day 5**			**Day 6**			**Day 7**		
L2 Nutritional/Hydration Status	**Write 'Y'= Yes or 'N'= No for each shift**																				
	D	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**	**D**	**E**	**N**
Change in usual eating and/or fluid intake	Complete only for Days 5, 6, 7																				
N1 and N3 Skin Problems	**Write 'Y'= Yes or 'N'= No for each shift**																				
Is there a skin problem? *e.g. rash, itchiness, bruises, skin tears/cuts, areas of redness*																					
HCA time spent caring for client per shift (in minutes) *e.g. MAP, Wound Care, Bathing, Other ADL Tasks*																					
LPN time spent caring for client per shift (in minutes) *e.g. MAP, Wound Care, Other Assessments/Treatments*																					
HCA Initials *(end of shift)* →																					
LPN Initials *(end of shift)* →																					

Comments: Add details as needed. Initial and enter the date and time beside your comment.	**Initals**	**Date**	**Time**

Staff Name *(print)*	**Initials**	**Staff Name** *(print)*	**Initials**