Revised: 03112024

**Key Points for Negotiated Care Plan development -** Follow these brief instructions based on WAC 388-76-10355 through 388-76-10385 when developing your NCP:

* Must be developed using the Assessment and the Preliminary/Service Plan within 30 days of admission or, within 30 days of a significant change assessment marked complete/moved to current
* Describes/identifies: (a) The services to be provided; (b) Who will provide the services; and (c) When and How the services will be provided.
* Is designed to meet the Resident’s Needs, Preferences, and Choices.
* Is developed with input from the Resident and/or the Resident’s Representative / Surrogate Decision Maker, appropriate professionals, and the case manager, if applicable (indicate on the signature page all parties that participated in the NCP development)
* Is Agreed to, Signed and Dated by the Resident and/or the Resident’s Representative / Surrogate Decision Maker, and the provider.
* **Must be reviewed and Revised: (a) at least every 12 months; (b) upon any significant change in Resident’s physical or mental condition; and (c) upon resident request.**
* The signed copy of the NCP must be given to the Case Manager if the Resident is receiving any Medicaid services paid fully or partially by the department.

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**Abbreviations often used in NCPs:**

*If you use abbreviations in your NCP, be sure they are defined, and everyone know what they mean.*

|  |  |  |  |
| --- | --- | --- | --- |
| ADL= Activities of Daily Living | D/t = Due to | MD = Medical doctor | PRN = As needed |
| AFH = Adult Family HomeCG = Caregiver | Guardian = GUHx = History  | NCP =Negotiated Care PlanNSA = Necessary Supplementation | RND = Register Nurse DelegatorW/c= Wheelchair |
| Dr. = DoctorDPOA = Durable Power of Attorney | MAR = Medication Assistance Record | AccommodationPCP = Primary care physician |  |

**Negotiated Care Plan WACs**

|  |  |
| --- | --- |
| [388-76-10355](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) – Negotiated care plan | [388-76-10375](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10375) – Negotiated care plan – Signatures - Required |
| [388-76-10360](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10360) – Timing of development - Required | [388-76-10380](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10380) – Timing of reviews and revisions |
| [388-76-10365](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10365) – Implementation - Required | [388-76-10385](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10385) – Negotiated care plan – Copy to department case manager - Required |
| [388-76-10370](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10370) – Negotiated care plan – Persons involved in development |

**NOTE:** Details such as CODE status, Insurance company, preferred hospital, funeral home, etc. is not included in this form (as it will be located on the Resident’s face page in their file. If you would like to add a row in the middle of the table, [click here](#How_to_add_row) for instructions or on the link in the Index.

*Hover the mouse over the blue text throughout the document for WAC references and tips*

| **NCP Template Field** | **Instruction – Sample Text** | **Strength & Abilities** | **Assistance Required** |
| --- | --- | --- | --- |
| Overview([Return to Index](#Top)) | The Negotiated Care Plan is required by [WAC 388-76-10355](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) and other applicable regulations. You are required to be familiar with and to follow all applicable laws and rules. **HOW TO:** LINKSAll blue underlined text will either move you to that section in the document, both the these instructions and the NCP form (for example: [ADL’s](#ADLs) located in the Index, or by a link to an external page, like a WAC reference (for example [388-76-10375](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10375)). To use a LINK, you must hold down your Ctrl key and then click on the LINK. **HOW TO:** SCREEN TIPSA “screen tip” provides additional information or references to that particular item/topic. These tips will help you be compliant with the applicable laws and regulations needed to complete an NCP. To read a screen tip, hover your mouse over any plain blue text (for example **[Date Completed](#Date_comp" \o "The NCP must be completed within 30 days of admit, or 30 days after the assessment has been completed/moved to current.Ignore the Ctrl+Click message below:)**) to display the information. | This section of the NCP is to document your resident’s preferences/choices, strengths/abilities, and if they prefer to do it independently.You can also document what the issue is and the resident’s skills and abilities. Who provides that help is documented under the assistance required column. Many of the tasks have unique strength & Abilities instruction/information specific to the task/issue – Check out the care tips. | This section of the NCP is to document who assist/do the task. Also document how the task is to be completed while honoring the resident’s skills, abilities, and preferences. Include when the task is done and how often the assistance is provided.Many of the tasks have unique strength & Abilities instruction/ information specific to the task/issue – Check out the care tips. |
| Provider’s Name([Return to Index](#Top)) | Enter your name and the name of your AFH |  |  |
| Date NCP Started([Return to Index](#Top)) | Enter the date you start to develop the NCP. This could be either the initial day or date of changes related to a significant change. The NCP **must** be completed within 30 days **of admit** [WAC 388-76-10360](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10360) or within 30 days when the assessment is completed/moved to current **for a significant change/annual assessment**. This date **starts** your 30 days count to the due date (Date Completed).  |  |  |
| Moved In Date([Return to Index](#Top))  | Enter the date your resident moved into your home. This date does not change. |  |  |
| Date Completed ([Return to Index](#Top)) | Enter the date you complete and [implement](https://apps.leg.wa.gov/WAC/default.aspx?cite=388-76-10365) the NCP. This date will change depending on when changes occur. This date should not exceed 30 days from the date the initial, significant change, or annual assessment (completed/moved to current). **NOTE:** Remember, if your resident is a Medicaid recipient, to send a copy to the CM after the plan is dated and has the required signatures. |  |  |
| Date Discharged([Return to Index](#Top)) | Enter the date the resident left your home. |  |  |
| Resident’s Name([Return to Index](#Top)) | Enter the resident’s name. Include other names (nicknames) they would prefer and preferred pronouns. |  |  |
| Date of Birth/Age([Return to Index](#Top)) | Enter the Resident’s date of birth and age. Some assessments provide you with the age, if it doesn’t, you will need to do the calculation.  |  |  |
| Primary Language([Return to Index](#Top)) | Enter the Resident’s primary language. Indicate if an interpreter is needed. |  |  |
| Allergies([Return to Index](#Top)) | Allergies are included here as a quick reference. Add the details in [medication allergy](#Medication_Allergies) or [food allergy](#eating) sections.  |  |  |
| Legal Documents([Return to Index](#Top)) | Indicate any legal documents that have an impact on the resident’s care, such as an advanced directive, POLST form, or guardianship. |  |  |
| Specialty Needs([Return to Index](#Top)) | Mark one or more boxes if the Resident has dementia, behavior health, and/or Developmental Disability needs. If any of these three specialties are checked, specialized training is required. Include any other specialty care (TBI, Bariatric, etc.) the resident needs under “Other:” |  |  |
| Emergency Evacuation([Return to Index](#Top)) | Indicate the level of assistance required for the resident to exit the home and how it will occur.  |  |  |
| Medical Status/Diagnosis Current Mental/Physical Health([Return to Index](#Top)) | Enter the Resident’s current diagnosis and medical status.  |  |  |
| Index([Return to Index](#Top)) | Click on the word in the list to take you to that section of these instructions. A similar index is provided on the NCP form. |  |  |
| Responsible Parties – Contacts([Return to Index](#Top)) | Enter the Name and Relationship of individuals that have an impact or involved in the plan of care. Is there a guardian, Durable Power Of Attorney for health care and/or financial, Doctor, Dentist, Family? If hospice is involved, be sure to add their contact information here as well. Is there a case manager?After the name and relationship, enter the contact information (Home/business phone, cell phone/FAX, address/email) and preferred contact method. **HOW TO:** ADD ADDITIONAL ROWS**Place your cursor in the square (cell) at the end of the last row in the table and hit the “Tab” key . Repeat to add as many row as needed.** |  |  |
| Communication([Return to Index](#Top)) | Identify any communication barriers the resident may have. How the resident makes themselves understood and how the resident understands others. Does the resident have any preferences?Indicate if you need to use behaviors and nonverbal gestures to communicate with the resident – see [WAC 388-76-10355](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) (8) Enter the resident’s **mode of expression.** Is it speech, ASL, communication board? – For example: (Resident Name) speaks clearly and can make resident’s needs known. Check either Yes or No to indicate if there are any problems with the person’s mode of expression. Add any problems in the describe section.Indicate if the resident has any problem with **hearing** – if so, describe how the resident is affected and any equipment they may use, for example, a hearing aid – for example: (Resident Name) can hear with left hearing aid in.Indicate if the resident has any problem with their **vision.** Is so, describe how the resident is impacted. Include any equipment they use – For Example: (Resident Name) can read regular print with her magnifying glasses on. Resident can see to walk in the AFH and to watch TV.Indicate if the resident has any problem with their **ability to use the phone**. Is so, describe how the resident is impacted. Include any equipment they use. See assistance required column for examples.**Preferred Language:** Enter the language the resident prefers to speak. Indicate if an interpreter is required. Add any additional comments. | Explain how the resident can manage these areas. Do they wear glasses or need assistance when using the phone? Is their primary language something other than English? Can you understand them? Can they understand you?Indicate how the resident makes themself understood aby those closest to them., using any means of communication. How the resident understands others, using any means of communication.. | Document how the caregivers will communicate with the resident.Explain how caregivers assist the resident with this task. You may choose to write something such as:**Example text:*** *After dressing help Mary put her hearing aide in before she leaves her room for breakfast.*
* *Speak to Resident using simple and direct questions and statements. Caregiver will use one-step directions when working with Mary. Caregiver will ask clarifying questions as needed to assess needs. Caregiver works to predict needs based on Resident daily schedule.*
* *Caregiver will adjust tonal quality and volume to ensure that Resident can hear what is said. Caregiver will repeat what is said as needed. Caregiver will assist with adjusting her hearing aids and assuring that they are working properly.*
* *Caregiver will assist Mary if she requests assistance with AFH phone. Caregiver will receive calls and will give the house phone to Mary and hang* up when she is finished.
 |
| Medication Management - Overview([Return to Index](#Top)) | * **Medication allergies:** Indicate if the resident has any medication allergies. If yes, check the box and indicate what they are and the reaction.

*(Located under Health Indicators in the Assessment Details)** **Resident needs more than one kind of medication assistance:** Indicate if the resident needs more than one kind of medication assistance need. Identify which the resident needs and how they will be met in Medication Management.
* **Psychopharmacologic medication**: Check if the resident receives any psychopharmacologic medication. Describe the strategies and any modifications used in addition to the medication (environment/staff) in the behavior section.
* **See MAR:** Check the “See the MAR” box if you maintain all medication, dosages, frequency, routes, etc. on the mediation log/Medication Administration Record.
* **Meds ordered and delivered by:** Document who is responsible for ordering the resident’s medications and how they are delivered. Does family or provider pick them up? Does the pharmacy deliver?
* **Meds pharmacy packed:** Check the box if the pharmacy packets the resident’s mediation and in what format: for example: bubble pack, pill bottle, etc. Add a note to indicate the type of medication packaging.
 |  |  |
| Medication Management([Return to Index](#Top)) | Medication Management: WACs [388-76-10430](https://apps.leg.wa.gov/wac/default.aspx?cite=388-76-10430) through 10490[WAC 388-76-10460](https://app.leg.wa.gov/wac/default.aspx?cite=388-76-10460)**Medication—Negotiated care plan.**The adult family home must ensure that each resident's negotiated care plan addresses:(1) The amount of medication assistance needed by each resident, including but not limited to:(a) The reasons why a resident needs that amount of medication assistance; and(b) When there is a need for the resident to have more than one type of medication assistance.(2) How the resident will get their medications when the resident is away from the home or when a family member or resident representative is assisting with medications is not available.Check one or more types of medication assistance the resident needs and why that level of assistance is needed. Click on the WAC links for the definition for each type of medication management. This will help you determine which type of assistance your resident needs.* **SELF-ADMINISTRATION** – [WAC 388-76-10445](https://app.leg.wa.gov/wac/default.aspx?cite=388-76-10445)
* **SELF-ADMINISTRATION W/ ASSISTANCE** – [WAC 388-76-10450](https://app.leg.wa.gov/wac/default.aspx?cite=388-76-10450)
* **MEDICATION ADMINISTRATION** – [WAC 388-76-10455](https://app.leg.wa.gov/wac/default.aspx?cite=388-76-10455). Medication administration will require nurse delegation ([WAC 246-840-910](http://app.leg.wa.gov/WAC/default.aspx?cite=246-840-910) through 246-840-970) unless you are a medical professional working within the scope of your license or administration is done by a family member or legally appointed resident representative.

List any equipment the resident may use and the types of medication your resident will take. If nurse delegation is required, fill in who the delegator is and their contact information.Indicate what type of Medication Management is needed. | Is the resident able to self-administer any medication? They may use a medication, such as an inhaler, by themselves but other medications are administered by a caregiver. List the medications, if any, the resident uses on their own. | Are there any special directions on how the resident takes their own medication? You may state that a caregiver will ask the resident if they need assistance or check to see if a medication is running low. Does the resident’s ability fluctuate, and they need to be monitored for change?**NOTE:** “Static Text” is language that is included in the NCP form. For example, the text about the 5 rights of medication administration below is included in the form when you download/open it. You can edit/revise this text to fit your AFH.**Static Text:****Caregiver will follow the 5 Rights of Medication Administration every time unless resident self-administers their medication:**1. Right Resident
2. Right Medication
3. Right Dose
4. Right Route
5. Right Time **and** documentation

**Static text:**CG is to follow Dr. orders, follow RND instructions; document in MAR and report significant changes, concerns/adverse reactions to Dr. immediately. **Example text:**Document medication takenHand medication in cup or bowlInform client of each medication given.Place medication in client's handRemind client to take medicationsReport adverse reactions.Re-order medications. |
| Medication plan for when Resident is not in the home([Return to Index](#Top)) | [WAC 388-76-10460](https://app.leg.wa.gov/wac/default.aspx?cite=388-76-10460) (2)Indicate how the resident will get their medications when the resident is away from the home or when a family member or resident representative is assisting with medications is not available. |  | Explain what the plan is for the resident to get their medication when they are away from the home. For example, provider will tear off medication bubble from bubble pack for the dates resident will be with family. Family will assist/administer medication. Document how this medication was administered and by whom in the resident's MAR. |
| Medication Refusal Plan([Return to Index](#Top)) | Indicate what the plan is if the resident refuses one or more of their medications.[WAC 388-76-10435](https://app.leg.wa.gov/wac/default.aspx?cite=388-76-10435)**Medication refusal.**(1) Each resident has the right to refuse to take medications.(2) If the adult family home is assisting with or administering a resident's medications and the resident refuses to take or does not receive a prescribed medication:(a) The home must notify the resident's practitioner; unless(b) The provider, entity representative, resident manager or caregiver is a nurse or other health professional, acting within their scope of practice, is able to make a judgment about the impact of the resident's refusal.(3) If the home becomes aware that a resident who self-administers, or takes their own medications, refuses to take a prescribed medication:(a) The home must notify the practitioner; unless(b) The provider, entity representative, resident manager or caregiver is a nurse or other health professional, acting within their scope of practice, is able to make a judgment about the impact of the resident's refusal. |  | Learn and document the reason for the refusal and indicate solutions that work. Indicate the steps the caregiver should take if the mediation is not taken within the “window”. Who do they contact and how is it documented? |
| Health Indicators([Return to Index](#Top)) | Health Indicators help identify stability of client’s health related to factors such as weight loss or gain, self-rating of health, and frequency of hospitalization or emergency room care. Significant unintended declines in weight can indicate failure to thrive, a symptom of a potentially serious medical problem, or poor nutritional intake due to physical cognitive, and social/economic factors. Weight loss or gain secondary to appetite or swallowing may indicate a need to refer to nursing services. |  | **Static Text:****Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) |
| Pain([Return to Index](#Top)) | Be sure to address where the resident is experiencing pain, the level of pain, , how often the resident complains or show evidence of pain, how the pain will be managed, and the impact – if activities are limited for example. Other examples of documentation may include: Anxiety, Increased behaviors/acting out, and irritability |  | **Static Text:****Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) |
| Treatments/Programs/Therapies([Return to Index](#Top)) | Check the treatments/therapies/programs the resident uses/needs. Physical Enablers: does the resident use any assistive devices such as bedrails, trapeze, transfer pole, walker, wheelchair, Hoyer lift, CPAP, Nebulizer, Pacemaker, bowel program, speech therapy, etc. Ensure you have met all the WAC requirements in 388-76-10650. | Explain if the resident receives any therapies or treatments. For example, a resident may use oxygen or receive PT/OT or wound care.Explain any needs listed in the assessment here.If there is a new treatment or therapy prescribed after the assessment, write it in and be sure to note the start date or end date if there is one.What is the resident’s assessed need to use the piece of equipment?What are the resident’s needs around pain control? | Explain how the therapy or treatment happens. If it is a caregiver helping, provide directions on how to complete the task here. If the resident receives home health or some kind of treatment from an outside source, explain how that happens here so your caregivers know what to expect.Has a risk assessment been done to ensure this is safe for this resident?  |
| Treatment/Program/Therapy Refusal Plan([Return to Index](#Top)) | Residents have the right to refuse any treatment, program, and/or therapy. Consider different ways to approach the task, including coming back to it about a short amount of time. Explore why the resident may be refusing and adjust if possible to address the issue.  | Document the resident’s skills, abilities, and preferences.  | Indicate how you will respond to a resident’s refusal of care or treatment, including when the resident’s physician or practitioner should be notified of the refusal. [WAC 388-76-10355(7)(d)](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) |
| Range of Motion (ROM)([Return to Index](#Top)) | **Range of Motion:** The extent or limit to which a part of the body can be moved around a joint (or a fixed point); the totality of movement a joint can do. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body. | Does the resident need Skin Care? If so, how often and what is the status of their skin? If there is a problem, describe it and how it is being addressed. Are there any pressure injuries? Are they being addressed? Do they need any dressing changes, if so, how often and do you have nurse delegation involved? | Indicate who and how ROM occurs. |
| **Psych/Social/Cognitive Status** | Some of the items listed will be included in the resident’s assessment, but others will develop over time. Be sure to have current information listed for behaviors. If a behavior is no longer happening, be sure to say so. [WAC 388-76-10355 (7)(a)](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) requires that a plan be developed and followed in the case of a foreseeable crisis due to a resident’s assessed need. Do you need awake staff or nighttime interventions?Indicate if there is a Mental Health Provider and a crisis plan in place. If there is a crisis plan, sure it is attached to your NCP. List any relevant past behaviors.  | What resident does - Describe behaviors – be specific | **For Each Behavior/Symptom/ Pattern:** * Describe specific non-medication (behavioral/environmental) interventions to address the symptoms:
* Staff strategies/environmental modifications to address behavior:
* Indicate what strategies tried that did not work.
* If **Psychopharmacological Medication** isprescribed to address behavior, list medication, and describe symptom that each medication is addressing (*for example Lorazepam – for Anxiety*)

What is it that a caregiver can do to address the behaviors or resident is displaying? Document any ono-medication interventions that they should attempt prior to giving a resident a medication (if prescribed “as needed or PRN”)**Example text:**You may say something such as “Mary is often tearful at night. Speak to her gently and reassure her she is safe. Give her time to express herself and listen to her concerns. If she continues to be tearful, she may have XYZ to help her sleep. If the behavior continues, contact her doctor and daughter. See Current MAR [WAC 388-76-10463 - Medication - Psychopharmacologic](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10463)“Static Text”:**Monitoring/Reporting significant changes and/or concerns:** Caregiver is to report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) |
| Sleep Disturbance([Return to Index](#Top)) | Sleep disturbance is difficulty falling asleep, fewer, or more hours of sleep than is usual for the individual, waking up too early and unable to fall back to sleep. Disrupts household at night when others are sleeping and requires intervention(s). |  | **Example text:**If Resident begins having difficulty sleeping, Caregiver should consult MD. Caregiver helps as needed during the night.  |
| Memory Impairment – Short Term([Return to Index](#Top)) | The following may be evidence of short-term memory loss:* Forgets food cooking on the stove
* Doesn’t remember son visiting in the last week
* Can’t remember what they had for breakfast

The following are NOT good indicators of short-term memory loss:* Report that memory isn’t what it used to be
* -Has to write notes in order to remember appointments
* Can’t remember the doctor’s phone number
 |  |  |
| Memory Impairment – Long Term([Return to Index](#Top)) | The following may be evidence of long-term memory loss:* Doesn’t remember birthplace
* Doesn’t remember the names of their children
 |  |  |
| Impaired decision making([Return to Index](#Top)) | Decision Making* ***Moderately impaired*** – meaning decisions are poor and the resident is unaware of consequences. The resident requires reminders, cues, and supervision in planning, organizing, and correcting daily routines, OR
* ***Severely impaired*** – meaning the resident never makes decisions or rarely makes decisions about activities of daily living.
 |  | **Example text:**AFH will provide an organized daily routine, as well as supervision and cueing as needed to help Resident navigate safely through their day. AFH provides verbal and physical assistance in one step directions and tasks. AFH will consult POA for larger decisions. |
| Disruptive behavior([Return to Index](#Top)) | Behavioral symptoms that cause distress to the resident or are distressing or disruptive to others with whom the resident comes in contact. Focus on the resident’s action not the reason for the behavior. Include behaviors potentially harmful to the individual or disruptive to others.***Combative during personal care*** – During personal care, hits, shoves, scratches, bites, pinches, or engages in other behaviors which could result in injury to individuals.  |  |  |
| Assaultive([Return to Index](#Top)) | Assaultive (not during personal care) –The individual is physically abusive/ combative toward others. Examples include hitting, kicking, pushing, scratching, biting or any other behavior which could result in injury to others at times other than during the provision of personal care. Breaks, throws their own things or other's property. |  |  |
| Resistive to care([Return to Index](#Top)) | Resistive to care with words/gestures (does not include informed choice) – Resists taking medications, injections, ADL assistance, help with eating or treatments. The signs of resistance are limited to words or gestures not physical actions. This does not include instances where the individual has made an informed choice not to follow a course of care (e.g., individual has exercised the right to refuse treatment and reacts negatively as others try to reinstate treatment). |  |  |
| Depression([Return to Index](#Top)) | An emotional state in which there are extreme feelings of sadness, lack of worth or emptiness. |  | **Example text:**AFH will monitor Resident For symptoms/signs of depression (for example: anger, withdrawal, change in appetite/sleep, sadness) and consult MD as needed. AFH to reassure the Resident when in sad moments, by giving the resident a hug, telling the resident you care about them, if this does not work notify MD. |
| Anxiety([Return to Index](#Top)) | A state of uneasiness and apprehension as about future uncertainties. An emotion characterized by an unpleasant state of inner turmoil. |  |  |
| Irritability([Return to Index](#Top)) | A tendency to get excited, angry, or upset easily. |  | **Example text:**AFH has created a stress-free environment with adequate lighting, and a quiet, room for Resident to retreat to if they are feeling irritable. |
| Disorientation([Return to Index](#Top)) | Disorientation to person, place - such as City, State, and County, or Time, such as day, month, and year. |  |  |
| Wandering in home([Return to Index](#Top)) | Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to their physical or safety needs. The resident may have a purpose such as searching to find something, but they persist without knowing the exact direction or location of the object, person, or place. The behavior may or may not be driven by confused thoughts or delusional ideas - for example: when a resident believes they must find their mother who is deceased. |  |  |
| Exit seeking([Return to Index](#Top)) | To get outside or off the property |  |  |
| Hallucinations([Return to Index](#Top)) | Sensory experiences that can’t be verified by anyone other than the person experiencing them. Hallucinations may occur in all senses.* **Hearing** (auditory hallucinations) voices that are familiar or unfamiliar that are perceived as distinct from the person’s own thoughts. Derogatory or threatening voices are especially common, two or more voices conversing with one another or voices maintaining a running commentary on the person’s thoughts or behavior. Auditory hallucinations are the most common.
* **Seeing** (visual hallucinations). Seeing objects or people that no one else can see.
* **Feeling** (tactile hallucinations). Feeling strange sensations, odd feelings in the body or feeling that something is crawling on him/her.
* **Tasting** (gustatory hallucinations). Client feels that there is a strange taste in their mouth e.g., metal, electricity, poisons, etc.
* **Smelling** (olfactory hallucinations). Client thinks there is a strange odor that cannot be accounted for, e.g., something burning, sewage, odd smells from their own body, dead spirits, etc.).
* **Command hallucinations**. These are hallucinations that direct the client to do something or act in a particular manner. It is a voice telling the individual to hurt or kill himself or herself or someone else or perform some other dramatic act. Command hallucinations are separated out from the others because of their severity and the potential lethality of the content of the hallucination.
 |  |  |
| Delusions([Return to Index](#Top)) | **Delusions** – a fixed, false belief of any of the following types:* **Delusions of grandeur**- a false belief that one’s own importance is greatly exaggerated.
* **Paranoid/persecutory delusions**- a false belief of being attacked, harassed, cheated, persecuted, poisoned, or conspired against.
* **Somatic delusions**- the central theme of this typeof delusion involves body functions or sensations. (E.g., the individual has a false belief related to the body such as believing that they have cancer despite exhaustive negative testing, or that they emit a foul odor from their skin or mouth, etc.).
* **Jealous type delusions**- the central theme of this type of delusion is the individual’s persistent belief that their spouse, partner or lover is unfaithful. This belief has no basis for truth and is arrived at without due cause.
* **Religious delusions**-persistent belief that he or she is God, Jesus Christ, other deities, or a representative of a deity.
 |  |  |
| Verbally agitated/aggressive([Return to Index](#Top)) | Such as: Accuses others of stealing, inappropriate verbal noises, resistive to care with words/gestures (does not include informed choice), Uses offensive language, verbally abusive, or yelling/screaming. |  |  |
| Physically agitated/aggressive([Return to Index](#Top)) | Assaultive (not during personal care), Combative during personal care, Hiding Items, Hoarding, Intimidating/threatening, rummages, takes belongings of others, deleverage sexual violence, wanders/exit seeking, wanders/not exit seeking. |  |  |
| Inappropriate or unsafe behavior([Return to Index](#Top)) | Inappropriate nakedness, eats non-edible substances/objects (Pica)(persistent for at least a month), deliberate fire setting behaviors, inappropriate toileting/menses activity (specify), intentional self-injury, left home and gotten lost, law-breaking activities. |  |  |
| Suicidal Ideation([Return to Index](#Top)) | Suicidal ideation is when you think about killing yourself. The thoughts might or might not include a plan to die by suicide. |  |  |
| Requires psychopharmacological medications([Return to Index](#Top)) | [WAC 388-76-10463](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10463) - **Medication—Psychopharmacologic.**For residents who are given psychopharmacologic medications, the adult family home **must ensure**:(1) The resident assessment indicates that a psychopharmacologic medication is necessary to treat the resident's medical symptoms;(2) The drug is prescribed by a physician or health care professional with prescriptive authority;**(3) The resident's negotiated care plan includes strategies and modifications of the environment and staff behavior to address the symptoms for which the medication is prescribed;**(4) Changes in medication only occur when the prescriber decides it is medically necessary; and(5) The resident or resident representative is aware the resident is taking the psychopharmacologic medication and its purpose. |  | Include the strategies and modification of the environment and staff behavior to address the symptoms for each psychopharmacologic medication prescribed. Include what the medication was prescribed to do. |
| DSHS Specialized Behavior Programs([Return to Index](#Top)) | Document if the resident is receiving Meaningful Day, expanded Community services, specialized Behavior Services and/or a Mental health Provider/Program. | Document the Resident’s preferences.  | Document how the caregiver will assist the resident. |
| Narrative (optional) – What does a typical day look like?([Return to Index](#Top)) | This is an optional field. Documenting what a typical day looks like will help you see when changes are happening over time that may need to be addressed. |  |  |
| Ability of Resident to be Left Alone([Return to Index](#Top)) | Document the ability for resident to be left unattended for a specific length of time. [WAC 388-76-10355](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10355) (9) | Document the Resident’s preferences. | Document how the caregiver will assist the resident. |
| Universal Precautions([Return to Index](#Top)) | Use universal precautions every time regardless of condition or diagnosis. | Indicate here what the resident is able and willing to do, for example, can the resident wear a mask, properly wash their hands, etc.  | “Static Text” (in all documents – part of the template)Caregiver will always use latex/plastic gloves when in contact with any secretions to prevent spread of infection. Thorough hand washing with soap will be done before and after gloving. Gloves will be put on and discarded at the end of each task. If the AFH provider orders these gloves they can be paid for through the medical coupon.Consider:**INFECTION PREVENTION PROCEDURE*** Masking/social distancing/hand hygiene
* Resident comm. Education
* Outbreak-PPE
* Quarantine/Isolation
* Infection Control
 |
| ADL’s |  |  | **Static Text:** **Monitoring/Reporting significant changes and/or concerns:** Caregiver is to monitor the resident during the ADL, report concerns and significant changes immediately to relevant individuals (health Care provider POA, CM, etc.) |
| Resident functional limitations that impact ADL functioning([Return to Index](#Top)) |  |  |  |
| Ambulation/Mobility ([Return to Index](#Top)) | Indicate care level for mobility in room and immediate living environment – independent, supervision/cueing, assistance needed, or totally dependentIndicate care level for mobility outside of immediate living environment (including outdoors) – independent, supervision/cueing, assistance needed, or totally dependentIf your resident is a risk for falls, document their fall prevention plan – steps/actions to prevent fallingResident chooses bedroom door lock – Refer to WACs* [388-76-10685](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10685)(6): Give each resident the opportunity to have a lock on their bedroom door if they choose to unless having a locked door would be unsafe for the resident and this is documented according to WAC 388-76-10401
* [388-76-10401](http://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10401) (1)(a): The home must ensure that the following conditions are present for each resident (a) Privacy in each resident's bedroom, including lockable doors when chosen, with only the resident or residents who live in the room and appropriate staff having the key.
 | Explain how the resident gets around. Do they walk independently or with assistance? Do they use a walker or a cane or are they wheelchair bound? What does their assessment say and what is happening currently? Be sure to document any changes and any discrepancies between the NCP and the assessment. If there is a fall prevention plan, include it here.  | What do caregivers do to help the resident get around? Do they provide a one person assist when walking or remind them to use their walker? |
| Bed Mobility/Transfer([Return to Index](#Top)) | Transfer includes moving between bed, chair, wheelchair, standing position – excludes to/from bath/toiletIndicate care level for bed mobility/transfer – independent, supervision/cueing, assistance needed, or totally dependent.Also indicate if skin care is required due to inability to position self – include any equipment or supplies used.Does the resident need a safety assessment? If so, document how you are going to keep the resident safe.[WAC 388-76-10650.](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10650) - **Medical devices.**(1) The adult family home must not use a medical device with a known safety risk as a restraint or for staff convenience.(2) Before a medical device with a known safety risk is used by a resident, the home must:(a) Ensure an assessment has been completed that identifies the resident's need and ability to safely use the medical device;(b) Provide the resident and his or her family or legal representative with information about the device's benefits and safety risks to enable them to make an informed decision about whether to use the device;(c) Ensure the resident's negotiated care plan includes how the resident will use the medical device; and(d) Ensure the medical device is properly installed. | How does the resident reposition themselves in bed? Do they require assistance or turning on a schedule? Do they have special equipment or procedures such as bridging to prevent bed sores?If the resident uses a bedrail, trapeze, or transfer pole, has there been an assessment completed to explain the dangers to the resident and or their family? **This assessment must be in the resident’s file.**  | Specifically, what will the caregiver need to do to help this resident while they are in bed? If any specialized equipment is used to help the resident transfer, how is it used? Is the resident a fall risk and if so, what is being done to prevent falls? |
| Eating([Return to Index](#Top)) | How individual eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)Indicate care level for eating – independent, supervision/cueing, assistance needed, or totally dependent.Indicate if there is a special dies/supplements, eating habits, and/or food allergies. Does the resident use any special equipment/supplies or procedures? | What kind of food does the resident like to eat? Do they have a special diet prescribed by their doctor?Do they need assistance eating or monitoring for choking? Do they require a soft diet or have any allergies? | What does the caregiver do to help the resident eat? Do they prepare meals or ask the resident what his/her preferences are? Do they provide assistance and if so, how?If a resident receives a supplement shake, make sure they have been approved by the resident’s doctor first.  |
| Toileting/Continence Issues([Return to Index](#Top)) | How individual uses the toilet room (or commode, bed pan, urinal); transfers on/off toilet, cleanses, changes incontinence pads, manages ostomy or catheter, adjusts clothes.Indicate care level for toileting/continence issues – independent, supervision/cueing, assistance needed, or totally dependent.Indicate frequency/how often toileting occurs.Are there continence issues? Indicate what they are and if there are any equipment/supplies/procedures used.Are there any limitations? | Explain what needs to be done to toilet the resident. Can they assist in the process? How does the resident prefer to toilet (bedside commode, bathroom)? Does the resident require special equipment such as a Hoyer?If incontinent, how often? Does the resident wear incontinence care products, or do they prefer to wear clothes and change if wet?Does the resident have a potential for skin breakdown due to incontinence? Can the resident complete their own incontinent care? If resident can assist with peri care, what can they do? | What does the caregiver need to do to help? How many caregivers should assist? Does the caregiver need to remain with the resident in the bathroom for safety? If required, how should the caregiver use special equipment such as a Hoyer?How often should the resident be toileted?For incontinent residents, how should caregivers protect the resident’s skin? Is there a barrier cream? A particular way to cleanse the area? How often should the client be cleaned and changed?If a resident has a special request such as – do not disturb during the night – make a note here for caregiving staff. |
| Dressing([Return to Index](#Top)) | How individual puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesisIndicate care level for Dressing – independent, supervision/cueing, assistance needed, or totally dependent.Indicate if there are any equipment/supplies/procedures used.Are there any limitations? | What assistance does the resident require for dressing? Can they complete the task by themselves? Do they require stand by, minimal, total assist? Does the resident have special equipment (shoehorn, grabber device)? Do they require set up of these items for use? | If the resident requires assist, how many staff are needed? If the resident requires set up, should the staff stay in the room or just check on the resident periodically? What does the caregiver do to help the resident dress?Make a note of any special preferences resident has, such as “no sweatpants, “likes to wear a sweater at all times”. |
| Personal Hygiene([Return to Index](#Top)) | Indicate care level for Dressing – independent, supervision/cueing, assistance needed, or totally dependent.Does the resident have their own teeth, partials, or dentures What kind of oral care is needed? Flossing, brushing, soaking?Does the resident need assistance with their hair?Does the resident need assistance with Menses Care?When/how often?Indicate if there are any equipment/supplies/procedures used.Are there any limitations? | What hygiene tasks, such as brushing teeth, cleaning dentures, brushing hair, washing face, grooming self, shaving can the resident do independently or need some help with? Can resident do tasks independently if needed items are set up? | What will staff need to do to assist resident with brushing hair, brushing teeth, cleaning dentures, shaving, putting on makeup? Do staff set up items and cue resident or do staff complete the task for the resident? Does the resident have a beard or moustache they want to keep? How will staff assist in grooming facial hair if resident does not want it shaved off?Does resident have any special personal care items or brand/product preferences the resident likes to use (favorite shaving cream, certain type of brush, favorite toothpaste)? Who will provide this if it is not an item normally offered by your AFH? |
| Bathing([Return to Index](#Top)) | How individual takes full-body shower, sponge bath, and transfer in/out of tub/showerIndicate care level for Bathing – independent, supervision/cueing, assistance needed, or totally dependent.When/how often?Indicate if there are any equipment/supplies/procedures used.Are there any limitations? | Will resident prefer a bath or a shower? How often does resident prefer to bathe? Can resident do own bedside bath between routine showers? | How will staff assist with bathing? Stand by assist, total assist, wash resident's back but allow resident to do everything else? Does the staff person need to be in the bathroom while resident is in shower/bath?How many times a week will the staff assist the resident with bathing?Include any special equipment staff will use such as shower chair, transfer board, equipment to help resident reach feet or back, etc. |
| **Foot Care**([Return to Index](#Top))**Diabetic Foot Care**([Return to Index](#Top)) | Indicate care level for Foot Care – independent, supervision/cueing, assistance needed, or totally dependent.Foot care for non-diabetic residents that may need nails files, foot soaks, pads, protective booties, etc.Diabetic foot care: Includes unskilled tasks such as keeping feet clean and dry, using tepid water to wash feet, drying feet well, especially between the toes, daily inspection of feet, toes and between toes for skin and nail changes (blisters, sores, swelling, redness or sore toenails), rubbing lotion on the feet (not between the toes), making sure client wears protective foot coverings (shoes or slippers), reporting to health care professionals any observed changes in skin or nails. Be sure to add the professional that will be involved. | What are the resident’s needs for body care? For example, if they are assessed as having dry skin and they need to have lotion applied after each bath or incontinence episode, document it here. They may need to have a medication applied. If so, is there nurse delegation in place?Also, the resident may have dry skin and requires lotion, but they are able to apply it themselves. Be sure to say how this activity takes place.If the resident is diabetic, what is the plan around foot care? | Diabetic Foot Care Instructions **(Example**) – Daily foot care can help keep a client with diabetes feet safe. Keep the client’s feet clean and dry and look at the feet every day for skin and nail changes. Look for blisters, sores, swelling, dry or cracked skin, redness, or sore toenails. If you notice any of these changes tell the appropriate health care professional right away. Use warm water to wash your client’s feet every day. Check the temperature to be sure it is not too hot. Dry your client/s feet well, especially between all the toes. It is okay to apply lotion to the feet, but not between the toes. Always encourage your client wear-well-fitting shores or slippers to protect the feet from injury.  |
| Skin Care([Return to Index](#Top)) | The skin is the largest organ of the body and the body’s first line of defense. The health of the skin reflects the general health of the individual. Skin can be damaged by mechanical forces (pressure, trauma, or surgery), chemical irritants, poor blood supply to an area (disease processes), allergic reactions, heat, or other causes.  |  | Determine the condition of the individual’s skin and to identify any types of skin breakdown including pressure injuries. Baths are the best time to observe the skin. Check for areas of redness, blisters, small cuts, or dry patches. Be sure to note and report anything new or unusual. |
| Managing Finances([Return to Index](#Top)) | Indicate care level for Managing Finances – independent, assistance, or dependent.Indicate who manages the finances and keeps the financial records. What is the resident’s preference?If there is a Payee, it may be helpful to include it here as well as in the contacts. | Does the resident keep their own money and handle their own accounts/checkbook? Is the resident working on a money management program with a goal of independence? | What will the staff do to assist the resident in managing the finances? If the home manages the resident’s funds, how will this be managed and monitored? How will the resident access funds if they need petty cash or need a bill paid?If the facility doesn’t manage the resident funds, how will the facility make sure resident can access funds in a timely fashion if they were to go on an outing or purchase items? How will the facility assist the resident in keeping the funds/checkbook/bank statements/etc. safe? |
| Shopping([Return to Index](#Top)) | Indicate care level for Shopping – independent, assistance, or dependent.Does the resident have any special transportation needs? How often would the resident like to go shopping and what are their preferences. | How does the resident do their personal shopping? They may like to go with a family member or purchase special items. | The AFH will provide most of the shopping for food, toiletries, etc. but some residents or their families may do some shopping. Explain how this happens for the resident.  |
| Transportation([Return to Index](#Top)) | Special transportation needs may include using a lift van, assistive devices to help get in or out of the car, seatbelt extension, etc.Indicate care level for Transportation – independent, assistance, or dependent.Does the resident need an escort? If so, how will it be provided? | What are the resident’s transportation needs? Do they have a standing appointment or require special transportation? | The AFH is not required to provide transportation for residents. You do, however, need to coordinate transportation for the resident. Explain how transportation happens for the resident. For example, their family member may transport to medical appointments, or they may use medical transportation services.  |
| Activities/Social([Return to Index](#Top)) | Social/Cultural considerations, traditions, or preferencesIndicate care level for Activities/Social – independent, assistance Needed, or dependent.Check all the boxes that the resident is interested in or participating in; describe.In the “Activity Preferences at a Glance” section, indicate all the activities the resident enjoys doing or is interested in doing. Add any other items that are not listed in “Other”. There is room for an “Activity narrative” below the “Activity at a Glance” section. | What activities does the resident like? Do they go to church on Sunday or meet with family at a particular time? Do they enjoy sitting outside or playing cards?  | What do caregivers do to assist the resident in their activities? Do they set up transportation or facilitate an activity? The directions may read something like 'Make sure Mrs. Johnson is up, showered and dressed for church on Sunday’s by 9:45.' |
| Smoking([Return to Index](#Top)) | Check and address the appropriate boxes. | Does the resident smoke? If so, are they safe to smoke independently? Address any safety concerns | Do caregivers need to provide any assistance or supervision with smoking?How are the cigarettes/lighter stored for safety? |
| Case Management([Return to Index](#Top)) | Indicate if the resident receives case management. | Does the resident have a case manager? If so, are they with DDA, RSN, HCS?Add name and contact information. | AFH is required to provide the CM with a signed copy of the NCP within 30 days of the CM moving the assessment to current regardless of the reason for the update. The NCP can be sent through secure email or FAX. The CM will review the received NCP and compare it to the CARE assessment to ensure all current care needs have been addressed. If not, the CM will discuss with the AFH Provider, changes that need to be made to the plan. |
| Other issues/concerns/problems([Return to Index](#Top)) | This is a free flow narrative box to add anything else to the NCP that you feel should be included to help provide care for your resident.  |  |  |
| Negotiated Care Plan review([Return to Index](#Top)) | Did you remember to include other topics that may be required, but are not included in the template such planning for a service dog |  |  |
| NCP Review and Approval([Return to Index](#Top)) | Ensure you have included all relevant parties in the development of the NCP. You must involve the resident, their family if the resident requests, the resident’s representative if there is one, professionals involved in the care of the resident, other individuals the resident requested, and the case manager if the resident is receiving care and services paid by the department. [WAC 388-76-10370](https://app.leg.wa.gov/WAC/default.aspx?cite=388-76-10370)Be sure to document any recommendations by the resident and the plan to address them.Obtain all required signatures (AFH Provider, Resident) – There have been several lines added to document changes/updates to the plan.If the resident is receiving case management, send a copy of the signed/dated NCP to the Case Manager. |  |  |

**HOW TO ADD A ROW IN A TABLE (FORM)** - Either in the middle or at the end of the table/form:

|  |  |
| --- | --- |
| 1. Left click in the row where you want to add the additional row (either above it or below). You should see your cursor blinking.
2. Right click on your mouse to display/show a menu on your screen.
3. Left click on the word, “Insert”
4. Left click on either the “Insert Row Above” or “Insert Row Below” depending on where you want to add the row.
 |  |

**DEFINITIONS**

**Conservator**

A person a court appoints to make decisions about your money and property.

**Durable Power of Attorney (DPOA)**

A power of attorney is “durable” if it says that your agent can use it even if you become sick or injured and cannot make decisions for yourself.

**Guardian (GU)**

A person a court appoints to help you make decisions about your health, safety, and self-care.

**Guardian ad litem (GAL)**

A Guardian ad Litem (GAL) is an individual appointed by the court to represent the best interests of a child or incapacitated person involved in a case in superior court

**Power of Attorney (POA)**

A power of attorney form lets you choose a trusted friend or relative to help you with your finances and/or health care decisions.

**Necessary Supplemental Accommodation (NSA)**

Necessary supplemental accommodation (NSA) services are services provided to you if you have a mental, neurological, physical, or sensory impairment or other problems that prevent you from getting program benefits in the same way that an unimpaired person would get them. [WAC 388-472-0010](https://app.leg.wa.gov/wac/default.aspx?cite=388-472-0010)