Delaware Health and Social Services
Division of Health Care Quality

Uniform Assessment Instrument
for
Assisted Living Facilities

Revised January 23, 2008

INTRODUCTION

The purpose of the Uniform Assessment Instrument (UAI) is to collect information regarding an assisted living applicant/resident's physical condition, medical status and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement.

A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission and no later than day of admission. In all cases the assessment will be completed prior to admission. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.

Regulation 5.9 states that the Assisted Living facilities shall not admit, provide services to, or permit the provision of services to any individual with any of the following conditions: Check whether these conditions are present:

- ☐ Requires care by a nurse that is more than intermittent or for more than a limited period of time.
- ☐ Requires skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or reasonable potential of, an acute episode unless there is a RN to provide appropriate care.
- ☐ Requires monitoring of a chronic medical condition that is not essentially stabilized through available medications and treatments.
- ☐ Is bedridden for more than 14 days.
- ☐ Has developed stage three or four skin ulcers.
- ☐ Requires a ventilator.
- ☐ Requires treatment for a disease or condition that requires more than contact isolation.
- ☐ Has an unstable tracheostomy or has a stable tracheostomy of less than six months' duration.
- ☐ Has an unstable peg tube.
- ☐ Requires an IV or central line with an exception for a completely covered subcutaneously implanted venous port, provided the assisted living facility meets the following standards: 1) Facility records shall include the type, purpose and site of the port, the insertion date, and the last date medication was administered or the port flushed; 2) The facility shall document the presence of the port on the Uniform Assessment Instrument, the service plan, interagency referrals and any facility reports; and 3) The facility shall not permit the provision of care to the port or surrounding area, the administration of medication or the flushing of the port or the surgical removal of the port within the facility by facility staff, physicians or third party providers.
- ☐ Wanders such that the assisted living facility would be unable to provide adequate supervision and/or security arrangements.
- ☐ Exhibits behaviors that present a threat to the health or safety of themselves or others, such that the assisted living facility would be unable to eliminate the threat either through

immediate discharge or use of immediate appropriate treatment modalities with measurable documented progress within 45 days.

- ☐ Is socially inappropriate as determined by the assisted living facility such that the facility would be unable to manage the behavior after documented, reasonable efforts such as clinical assessments and counseling for a period of no more than 60 days.

If any of these conditions are present **and the resident/applicant is not receiving Hospice care**, assisted living is not appropriate for the resident/applicant**. If the resident is receiving Hospice care**, the above restrictions do not apply, provided that the Hospice program: 1) is licensed by the Department of Health and Social Services and 2) provides written assurance that, in conjunction with care provided by the assisted living facility, all of the resident's needs will be met without placing other residents at risk.

SECTION ONE – General Information

Resident Name (Last, First, MI)_____
SS #_____ DOB:_____ Sex: □ male □ female

Date of Admission:_____

Assessment (√ one):

□ Initial date_____
□ 30-day date_____
□ Significant Change date_____
□ Annual date_____

Source of Information (√ all that apply)

□ Self
□ Family
□ Healthcare Provider
□ Other

SECTION TWO – Functional Abilities, Supports, and Related Information

Activities of Daily Living (ADLs)

1. ____Eating Meals
   - A Independent
   - B Supervision, set up, cuing, coaching, reminders of meal times
   - C Fluid and food Intake recorded for each meal/supplements/snacks; and/or observation due to chewing, swallowing, eating difficulties
   - D Must be fed; needs tube feeding; 1:1 observation/assistance

2. ____Toileting
   - A Toilets self; completes own hygiene including incontinence care; colostomy/catheter self-care
   - B Assist with empty, flush, hygiene after use; toilets self during day; assisted at night
   - C Needs observation/standby/transfer assist during toileting; output monitored/recorded by staff
   - D Unable to toilet self or self manage incontinence; needs colostomy/catheter assist; requires formal bowel/bladder incontinence program

3. ____Mobility
   - A Independent (or with assistive device)
   - B Supervision, cuing and coaching
   - C Occasional physical assistance required
   - D Walks/wheels only with physical assistance

4. ____Bed Mobility
   - A Independent (or with assistive device)
   - B With supervision, cuing and coaching
   - C One person physical assistance
   - D Two person physical assistance, needs complete assistance

5. ____Use of Stairs
   - A Independent (or with assistive device)
   - B With supervision, or standby, or cuing and coaching
   - C One person physical assistance
   - D Two person physical assistance, or unable to use stairs

6. ____Transferring
   - A Transfers self
   - B Needs standby assistance during transfers
   - C One person physical assistance
   - D Two person physical assistance; needs complete assistance or mechanical assistance (e.g. Hoyer lift)

7. ____Grooming: oral hygiene, make-up, shaving, hair, nail care
   - A Independent
   - B Needs set up
   - C With supervision, cuing and coaching
   - D Needs complete assistance

8. ____Dressing
   - A Independent
   - B With supervision, or set-up, or cuing and coaching.
   - C With physical assistance
   - D Needs complete assistance

9. ____Bathing
   - A Bathes self
   - B Bathes with reminders/prompts
   - C Needs to be set up with water and supplies; needs occasional assistance with back, feet, peri-care
   - D Needs complete assistance or constant supervision

10. ____Medication Management
   - A Independent
   - B Reminders
   - C Set-up or assistance
   - D Administration of medication

11. ____Emergency Response
   - A Independent (or with assistive device)
   - B With supervision, cuing and coaching
   - C One person physical assistance
   - D Two person physical assistance, needs complete assistance

Assistive Devices and Medical Equipment (Please check all that apply)

	Currently Uses	Requires Assessment to Determine Need
MOBILITY		
Cane	☐	☐
Crutches	☐	☐
Hoyer Lift	☐	☐
Walker	☐	☐
Wheelchair (electric)	☐	☐
Wheelchair (manual)	☐	☐
Other_____		
RESPIRATION		
Nebulizer	☐	☐
Oxygen	☐	☐
Other_____		
EATING		
Hand Splint/Braces	☐	☐
Feeding Pump	☐	☐
Special Utensil/Plate	☐	☐
Other_____		
SKIN CARE		
Special Mattress	☐	☐
Pressure Relief Device	☐	☐
Positioning Device	☐	☐
Other_____		

	Currently Uses	Requires Assessment to Determine Need
TOILETING	☐	☐
Bed pan/Urinal	☐	☐
Commode	☐	☐
Grab Bars	☐	☐
Raised Toilet Seat	☐	☐
Other_____		
COMMUNICATION		
Electronic Communication Device	☐	☐
Eye Glasses/Corrective Lenses	☐	☐
Hearing Aid	☐	☐
Interpreter (Language)	☐	☐
Interpreter (Sign)	☐	☐
Lifeline	☐	☐
TTY (Teletypewriter)	☐	☐
Other_____		
BATHING		
Bath Bench	☐	☐
Grab Bar/Tub Rail	☐	☐
Other_____		

SECTION THREE – Health Information

Primary Physician's Name:_____
Telephone:_____ Fax:_____

Most Recent Hospitalization - date and reason: _____

Vital Signs: BP_____ T_____ P_____ R_____

Physical and Mental Health (check all that apply)
Onset (if known)

Neurological Disorders/Developmental Disabilities

☐_____ Brain Injury
☐_____ Seizure disorder/Epilepsy
☐_____ Spinal Cord Injury, _____Level
☐_____ Stroke
☐_____ Paralysis
☐_____ Dementia/Alzheimer's
☐_____ ALS
☐_____ Multiple Sclerosis
☐_____ Mental Retardation
☐_____ Autism
☐_____ Cerebral Palsy
☐_____ Parkinson's
☐_____ Other_____

Eye Disorders

☐_____ Cataracts
☐_____ Glaucoma
☐_____ Macular Degeneration
☐_____ Blindness
☐_____ Other_____

Metabolic Disorders

☐_____ Diabetes: _____Type I _____Type II
☐_____ Renal: _____Dialysis _____Chronic Renal Failure
☐_____ Thyroid: _____Hyper _____Hypo
☐_____ Other_____

Musculoskeletal

☐_____ Amputation
☐_____ Arthritis: _____Osteo _____Rheumatoid
☐_____ Osteoporosis
☐_____ Fractures
☐_____ Weakness
☐_____ Other_____

Cardio/Vascular/Pulmonary Disorders

☐_____ Congestive Heart Failure
☐_____ Hypertension
☐_____ Myocardial Infarct
☐_____ _____CABG _____Valve Surgery
☐_____ _____Afib _____V-tach _____AICD _____PACER _____Angina
☐_____ Peripheral Vascular Disease
☐_____ COPD: ____Asthma _____Asbestosis ____Emphysema
____Chronic Bronchitis
☐_____ Pneumonia

ALLERGIES

☐ Food:
_____
_____
_____
☐ Latex
_____
☐ IV Contrast
_____
_____
_____
☐ Other
_____
_____
_____

□_____ Sleep Apnea
□_____ Shortness of Breath
□_____ Other_____

Gastrointestinal Disorders

□_____ Stomach: _____GERD _____Ulcers
□_____ Liver: _____Hepatitis _____Cirrhosis
□_____ Intestinal: _____Colitis _____Diverticulosis _____Hemorrhoids ____ Constipation _____Loose Stools
□_____ Bowel Incontinence
□_____ Other_____

Hematologic/Oncological Disorders

□_____ Anemia
□_____ Cancer_____
□_____ Immune System Disorder _____
□_____ Other_____

Psychiatric

□_____ Anxiety Disorders
□_____ Bipolar
□_____ Major Depression
□_____ Schizophrenia
□_____ Other_____

Infectious Disease Disorders

□_____ Hepatitis ____A ____B ____C
□_____ HIV/AIDS
□_____ TB
□_____ MRSA
□_____ VRE
□_____ Other_____

GenitoUrinary Disorders

□_____ Incontinence
□_____ Urinary Tract Infection
□_____ Nocturia

Past Surgeries (date, if known)

_____
_____
_____

All Other Problems

_____
_____

HOSPICE

Is the resident currently receiving or arranging for hospice care?

□ Yes □ No

If Yes, name of provider

_____

VISION (□ - check one)

□ Sees adequately with or without corrective lenses
□ Impaired vision, describe_____
□ Blind in _____left, ____right, _____both

HEARING (□ - check one)

□ No impairment
□ Hard of Hearing
□ Requires hearing aids
□ Deaf – Means of Communication_____

TEMPORARY SENSORY IMPAIRMENT

Taste_____ Touch/Pain_____ Smell_____ Hearing _____ Sight_____

NUTRITION/HYDRATION

Height_____ Weight_____

Nutritional Risk Information

Yes	No	
□	□	Does resident have dental or mouth problems that make it hard to chew or swallow?
□	□	Does resident have dentures (□ top □ bottom)?
□	□	Does resident have an illness or condition that changes the kind of food and/or amount of food eaten?
□	□	Has resident had a 10% or more unplanned weight change in the last month? _____gain _____loss

Hydration Risk Information

Yes	No	
□	□	Does resident require monitoring for hydration?

Diet Information

Please specify any special diet(s) from the choices below:

□ ADA calorie-calculated
□ Regular diet with added supplements
□ Mechanically altered
□ Restricted sodium
□ Consistent Carbohydrate
□ Low cholesterol
□ Liquid
□ Low fat
□ Other_____

Is resident following the diet? ____yes ____no

SLEEP PATTERNS:

The resident usually goes to bed at _____
The resident usually wakes up at_____

Does the resident take frequent naps?	□ Yes	□ No
Does the resident have difficulty sleeping at night?	□ Yes	□ No
Is the resident agitated at night?	□ Yes	□ No

If yes, please elaborate as to the frequency and type of disturbance:

_____
_____

FALL RISK ASSESSMENT

Identify any conditions and/or factors currently present that may increase the resident's risk of falling and/or suffering injury from a fall (check all that apply):

- ☐ Paralysis
- ☐ Orthostatic Hypotension
- ☐ Osteoporosis
- ☐ Gait Problem
- ☐ Impaired balance
- ☐ Confusion
- ☐ Parkinsonism
- ☐ Amputation
- ☐ Pain
- ☐ TIA
- ☐ Dizziness/Vertigo
- ☐ Unstable transition from seated to standing position
- ☐ Balance problems when standing
- ☐ Limits activities due to fear of falling
- ☐ Fell in last 30 days
- ☐ Fell in last 31-180 days
- ☐ Other (describe)_____

SMOKING HABITS

Does resident smoke? ☐ yes ☐ no
If yes, does resident smoke - ☐ indoors ☐ outdoors
Is resident receiving oxygen therapy? ☐ yes ☐ no
Describe any safety concerns pertaining to the resident's smoking habits:

ALCOHOL HABITS

Does resident drink alcoholic beverages? ☐ yes ☐ no
How many drinks per week? _____
Has the resident ever had any health and/or personal problems due to his/her intake of alcohol? ☐ yes ☐ no

SKIN CARE/TREATMENTS

Skin ulcers ☐ yes ☐ no
Type ☐ pressure ☐ Stasis
Stage (1,2) _____

- ☐ Reddened areas/frequent assessments
- ☐ Decubitus care required (stages 1, 2)

Current Skin Condition: (check all that apply)

- ☐ Normal skin care required, including diabetic skin assessment
- ☐ Dry skin requires frequent lotioning
- ☐ Wound care required for Stage 3, 4 (Hospice only)
- ☐ Bruises, abrasions
- ☐ Cancerous lesions
- ☐ Rash (eczema, herpes zoster, etc.)
- ☐ Skin tears
- ☐ Other (describe)_____

Skin Treatment: (describe)

_____
_____

PAIN MANAGEMENT

Does resident have pain? ☐ Intermittent ☐ Constant ☐ Not Applicable

Location of Pain:_____ Pain Intensity on a scale of 0 to 5: Now:___ On Average (usual):___

What, if any, medications are taken for pain relief?_____

What, if any, other treatment is resident receiving for pain?_____

Is pain satisfactorily controlled with treatment?_____

PAIN INTENSITY SCALE

0	1	2	3	4	5
No pain	Mild	Moderate	Severe	Very Severe	Worst Possible

Which word(s) describe your pain? ____Sore ____Heavy ____Sharp ____Dull ____Shooting ____Pressing____Burning ____Cramping ____Aching ____Stinging ____Tingling ____Another word_____

MEDICATIONS

☐ CHECK HERE IF NO PRESCRIBED MEDICATIONS

Prescribed Name/Dosage | Frequency | Route

_____ | _____ | _____

Route Codes
Oral
NG/Gastric Tube
Rectal
Topical (site)
Inhaled: Metered Disc inhaler/Aerosol (MDI)
IM (site)
Subcutaneous (sc)(site)
Vaginal

Non-Prescription/Herbal Name/Dosage | Frequency | Route

_____ | _____ | _____

Frequency Codes
Once a day
BID (2 x a day)
TID (3 x a day)
QID (4 x a day)
HS (at bedtime)
5 or more/24 hours
PRN (as needed)
2-3 x a week
4-5 x a week

Medication Allergies /Adverse Reactions

_____

Vaccines and Dates

☐ Pneumovax_____
☐ Tetanus_____
☐ PPD_____
☐ Influenza_____

TREATMENTS/THERAPIES: Identify physician ordered/referred, or authorized services resident currently receives

	Self-Arranged or Self-Administered	Arranged by Facility	Administered by Facility
Behavior Management Program	☐	☐	☐
Bladder Control Program	☐	☐	☐
Bowel Control Program	☐	☐	☐
Catheter Care	☐	☐	☐
Chemo/Radiation Therapy	☐	☐	☐
Diabetic Management	☐	☐	☐
Dialysis Treatment	☐	☐	☐
Feeding Tube (established)	☐	☐	☐
Ostomy Care	☐	☐	☐
Rehab (pt,ot,st)	☐	☐	☐
Psychotherapy or Counseling Services	☐	☐	☐
Respiratory Therapy Program	☐	☐	☐
Wound or Skin Care	☐	☐	☐
Other_____	☐	☐	☐

TESTING/MONITORING:

Describe any assistance required to facilitate treatments/therapies, including and specifying any assistance provided by family member/support person:

_____
_____
_____
_____
_____
_____

Does a recommendation need to be made that the resident see a physician for a medical problem not being addressed?

☐ Yes ☐ No

If Yes, describe medical problem:

_____
_____
_____
_____
_____
_____

SECTION FOUR – Psychological/Social/Cognitive Information

Background Information

Orientation: Indicate Yes or No ☐_____Person ☐_____Place ☐_____Time

Short-term Memory OK – seems to recall after five (5) minutes: ☐ Memory OK ☐ Memory Problem

Long-Term Memory OK – seems/appears to recall long past: ☐ Memory OK ☐ Memory Problem

Appears Anxious: ☐ Yes ☐ No

Expresses sadness, anger, empty feelings over lost roles or status: ☐ Yes ☐ No

Absence of personal contact with family/friends: ☐ Yes ☐ No

Compared to other people resident gets down in the dumps more often: ☐ Yes ☐ No

Problems making self understood: ☐ Yes ☐ No

Problems understanding others: ☐ Yes ☐ No

History of danger to self and/or others: ☐ Yes ☐ No

History of wandering: ☐ Yes: ☐ Inside ☐ Outside ☐ No

History of: ____Disruptive ____Socially inappropriate ____Assaultive ____Destructive _____Demanding behaviors. Please describe:

_____

Resists care: Refuses to bathe, eat, medicate, care for self, allow others to assist, etc.

____Yes ____No

If yes, please describe:

_____

THIS INSTRUMENT IS A BASELINE DETERMINATION. IT IS THE RESPONSIBILITY OF THE FACILITY TO ANALYZE THE DATA COLLECTED HEREIN AND REFER FOR, AND/OR CONDUCT, FURTHER EVALUATION AS NEEDED.

The applicant/resident represents that all oral and/or written information made or furnished by, or on behalf of, the applicant for completion of the Uniform Assessment Instrument are true and accurate to the best of his/her knowledge and belief. The applicant understands and acknowledges that providing this information does not represent a commitment for, or guarantee of, service or admission to an Assisted Living Facility and is provided solely for the purpose of evaluation.

Signature	**Print Name**	**Date**
_____	_____	_____
Applicant/Resident		
_____	_____	_____
Legal Representative, if applicable		

UAI completed by:

_____	_____	_____
Registered Nurse License #: _____ State of Licensure: _____		

□ **30 Day Assessment (date)_____** □ **No Change**	□ **Change**
_____	_____
Signature (RN)	Date

f:ltcrp\DLTCRP regs & draft regs/AL Regs & UAI\UAI revision 01-23-08 final