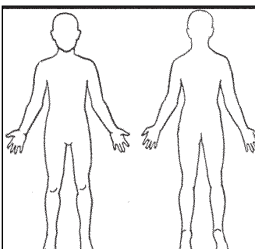




SKILLED NURSING NOTE

Initial Assessment Follow Up visit Supervisory Visit

Name of Patient: _____ Date: _____

Vital Signs																																							
Ht: _____ Wt: _____ Temp: _____ Pulse: A/R: _____ <input type="radio"/> Regular <input type="radio"/> Irregular																																							
Resp: _____ B/P: _____ <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Right <input type="checkbox"/> Left																																							
Nursing assessment and observation of signs/symptoms (Mark all applicable with an "X" or circle item(s) separated by "/")																																							
CARDIOVASCULAR <input type="checkbox"/> WNL <input type="checkbox"/> Edema (Specify) _____ <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE 1/2/3/4+ <input type="checkbox"/> Pitting <input type="checkbox"/> Non-pitting <input type="checkbox"/> Other: _____	RESPIRATORY <input type="checkbox"/> WNL <input type="checkbox"/> Dyspnea/SOB <input type="checkbox"/> Cough/Sputum <input type="checkbox"/> Other: _____	PAIN <input type="checkbox"/> None <input type="checkbox"/> Location: _____ Severity (0-10): _____ Other: _____	SKIN <input type="checkbox"/> WNL <input type="checkbox"/> Cellulitis <input type="checkbox"/> Pressure Sore <input type="checkbox"/> Rash <input type="checkbox"/> Skin tear <input type="checkbox"/> Wound <input type="checkbox"/> Incision <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th></th> <th>#1</th> <th>#2</th> <th>#3</th> </tr> </thead> <tbody> <tr><td>Length</td><td></td><td></td><td></td></tr> <tr><td>Width</td><td></td><td></td><td></td></tr> <tr><td>Depth</td><td></td><td></td><td></td></tr> <tr><td>Drainage</td><td></td><td></td><td></td></tr> <tr><td>Tunneling</td><td></td><td></td><td></td></tr> <tr><td>Odor</td><td></td><td></td><td></td></tr> <tr><td>Sur tissue</td><td></td><td></td><td></td></tr> <tr><td>Wound</td><td></td><td></td><td></td></tr> </tbody> </table>  Stoma: _____ <input type="checkbox"/> Steri-strips <input type="checkbox"/> Sutures <input type="checkbox"/> Staples <input type="checkbox"/> JP drain <input type="checkbox"/> IV line		#1	#2	#3	Length				Width				Depth				Drainage				Tunneling				Odor				Sur tissue				Wound			
	#1	#2	#3																																				
Length																																							
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Tunneling																																							
Odor																																							
Sur tissue																																							
Wound																																							
EMOTIONAL STATUS <input type="checkbox"/> WNL <input type="checkbox"/> Disoriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Depressed <input type="checkbox"/> Other: _____	GENITOURINARY <input type="checkbox"/> WNL <input type="checkbox"/> Incontinence <input type="checkbox"/> Catheter/Size _____ <input type="checkbox"/> Ileostomy <input type="checkbox"/> Other: _____	DIGESTIVE <input type="checkbox"/> WNL <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Diarrhea/Constipation <input type="checkbox"/> Colostomy <input type="checkbox"/> Incontinence <input type="checkbox"/> Last BM _____	SAFETY CONCERNS: <input type="checkbox"/> Clear pathways/safe ambulation <input type="checkbox"/> Fall precautions <input type="checkbox"/> Home safety <input type="checkbox"/> Medication management <input type="checkbox"/> IV safety <input type="checkbox"/> Sharps disposal <input type="checkbox"/> Oxygen safety <input type="checkbox"/> Bleeding precautions <input type="checkbox"/> Infection control <input type="checkbox"/> Other: _____																																				
NEUROSENSORY <input type="checkbox"/> WNL <input type="checkbox"/> Syncope/Vertigo <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Other: _____	MUSCULOSKELETAL <input type="checkbox"/> WNL <input type="checkbox"/> ROM: _____ <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RLE <input type="checkbox"/> LLE <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Other: _____	SUPERVISORY VISIT: Follows Std Precautions <input type="radio"/> Yes <input type="radio"/> No Follows Plan of Care <input type="radio"/> Yes <input type="radio"/> No Performs Care Properly <input type="radio"/> Yes <input type="radio"/> No Patient satisfied <input type="radio"/> Yes <input type="radio"/> No HHA Present <input type="radio"/> Yes <input type="radio"/> No																																					
Functional (Check): <input type="checkbox"/> Bathing <input type="checkbox"/> Grooming <input type="checkbox"/> Dressing <input type="checkbox"/> Eating <input type="checkbox"/> Transferring <input type="checkbox"/> Patient/client independent in ADL's/IADL's																																							
Reason for Visit: <input type="checkbox"/> Assessment <input type="checkbox"/> Teaching/training <input type="checkbox"/> Wound care <input type="checkbox"/> IV Therapy <input type="checkbox"/> Lab draw <input type="checkbox"/> HHA/Companion services <input type="checkbox"/> PT/OT/ST/MSW services <input type="checkbox"/> Medication management <input type="checkbox"/> Other: _____																																							
Recent history pertinent to reason for visit: _____ <input type="checkbox"/> Patient is homebound Why? _____																																							
Interventions/Instructions: Teaching/training re: <input type="checkbox"/> Medication regimen, actions, side effects <input type="checkbox"/> Disease process <input type="checkbox"/> Bleeding precautions <input type="checkbox"/> Wound/incision care <input type="checkbox"/> IV therapy <input type="checkbox"/> Infection control measures <input type="checkbox"/> Complications to report <input type="checkbox"/> Home safety <input type="checkbox"/> Oxygen safety <input type="checkbox"/> Diet <input type="checkbox"/> Elevating legs to decrease edema <input type="checkbox"/> Off loading techniques <input type="checkbox"/> Sharps disposal <input type="checkbox"/> Plan of care review <input type="checkbox"/> Medication management <input type="checkbox"/> Inability to void post foley removal <input type="checkbox"/> Discharge instructions																																							
Wound Care Performed: <input type="checkbox"/> Aseptic technique <input type="checkbox"/> Sterile technique <input type="checkbox"/> Cleansed with NS <input type="checkbox"/> Cleansed with: _____ <input type="checkbox"/> Product applied: _____ Covered with: <input type="checkbox"/> Gauze <input type="checkbox"/> ABD pad <input type="checkbox"/> Telfa Packed: <input type="checkbox"/> Wet to dry-NS <input type="checkbox"/> Secured with tape/ace wrap/stockinette <input type="checkbox"/> Wound vac applied with <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Silver foam <input type="checkbox"/> Canister changed <input type="checkbox"/> Constant suction <input type="checkbox"/> Intermittent suction <input type="checkbox"/> Pressure: mmHg <input type="checkbox"/> Approx. drainage in canister: mls Color: _____																																							
IV Therapy: Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes Teaching/training re: <input type="checkbox"/> NS mls <input type="checkbox"/> Before <input type="checkbox"/> After meds/blood draw <input type="checkbox"/> Final flush with Heparin _____ u/cc _____ mls Peripheral IV inserted <input type="checkbox"/> (site) <input type="checkbox"/> using (catheter) Site prepped with <input type="checkbox"/> alcohol <input type="checkbox"/> betadine <input type="checkbox"/> line dressing changed on using sterile technique <input type="checkbox"/> 3 alcohol swabs <input type="checkbox"/> 3 provodine swabs <input type="checkbox"/> chloraprep swab <input type="checkbox"/> antimicrobial patch Applied <input type="checkbox"/> Occlusive dressing <input type="checkbox"/> Gauze dressing <input type="checkbox"/> Extension set <input type="checkbox"/> Injection site <input type="checkbox"/> Site free of complications <input type="checkbox"/> Flushes easily <input type="checkbox"/> Good blood return <input type="checkbox"/> Line removed (type) <input type="checkbox"/> Length _____ cm <input type="checkbox"/> Tip intact <input type="checkbox"/> Pressure dressing applied																																							
Lab draw of: _____ from (site): _____ Taken to (Lab name): _____ <input type="checkbox"/> Administered: _____ <input type="checkbox"/> IM <input type="checkbox"/> SQ Site: _____ <input type="checkbox"/> Pt/CG taught to administer: _____																																							
IV Therapy: <input type="checkbox"/> Foley catheter inserted _____ Fr _____ cc balloon using sterile technique with _____ return Connected to <input type="checkbox"/> Leg bag <input type="checkbox"/> Bedside drainage bag <input type="checkbox"/> Foley removed without incident <input type="checkbox"/> Instructions given regarding complications to report <input type="checkbox"/> Bowel program performed <input type="checkbox"/> Suppository used <input type="checkbox"/> Digital stimulation Results: _____ <input type="checkbox"/> Written instructions given re: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> See communication sheet for addendum notes																																							

Patient/Caregiver Response: Patient tolerated interventions well

Patient /CG verbalized/demonstrated understanding of instructions provided Patient/Caregiver independent with: Wound care IV therapy
 Medication management Wound/ incision healing without complications Tolerating medications without side effects or adverse reactions

Patient will follow with physician as instructed

Discharge/no other nursing visits needed/ordered Other: _____ Next visit:

Patient/Caregiver unable to be independent in care due to: Physical limitations Learning limitations Refuses to learn N/A Pt/CG are independent

NOTES:

Patient/Designee: I certify that the NURSE listed on this note worked the times indicated and the work was performed in a satisfactory manner.

I agree to the times regarding this slip. Time in: _____ am pm Time out: _____ am pm

Patient Signature: _____ Date: _____

Caregiver signature/title: _____ Date: _____