

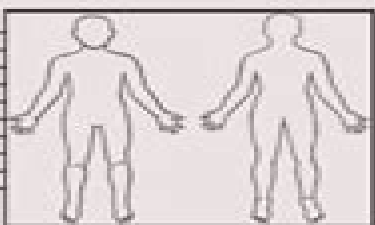
Skilled Nursing Note

☐ Initial Assessment ☐ Follow up visit ☐ Supervisory visit

Name of Patient: _____ Date: _____

Vital Signs
 Ht: _____ Wt: _____ Temp: _____ Pulse: A/R: _____ ☐ Regular ☐ Irregular
 Resp: _____ B/P: _____ ☐ Lying ☐ Sitting ☐ Standing ☐ Right ☐ Left

Noting assessment and observation of signs/symptoms (Mark all applicable with an "X" in circle column separated by "/")

CARDIOVASCULAR <input type="checkbox"/> WNL <input type="checkbox"/> Edema (Specify) _____ <input type="checkbox"/> RUE <input type="checkbox"/> LUE <input type="checkbox"/> RUE <input type="checkbox"/> LLE <input type="checkbox"/> G2/G4+ <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 00-100: _____ <input type="checkbox"/> 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"> <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>Penetration</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Color</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Scar tissue</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Wound bed</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stitches</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <input type="checkbox"/> Steel strips <input type="checkbox"/> Sutures <input type="checkbox"/> Staples <input type="checkbox"/> JP drain <input type="checkbox"/> IV line Type: _____		#1	#2	#3	Length				Width				Depth				Drainage				Penetration				Color				Scar tissue				Wound bed				Stitches				
	#1	#2	#3																																									
Length																																												
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Scar tissue																																												
Wound bed																																												
Stitches																																												
EMOTIONAL STATUS <input type="checkbox"/> WNL <input type="checkbox"/> Disoriented <input type="checkbox"/> Fearful <input type="checkbox"/> Depressed <input type="checkbox"/> Other: _____	GENITOURINARY <input type="checkbox"/> WNL <input type="checkbox"/> Incontinence <input type="checkbox"/> Catheter/Wire <input type="checkbox"/> Hematuria <input type="checkbox"/> Other: _____	DIGESTIVE <input type="checkbox"/> WNL <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Difficulty Swallowing <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/cable 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 LUE RUE LLE <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Other: _____	SUPERVISORY VISIT Follows Std Precautions <input type="checkbox"/> Yes <input type="checkbox"/> No Follows Plan of Care <input type="checkbox"/> Yes <input type="checkbox"/> No Performs Case Properly <input type="checkbox"/> Yes <input type="checkbox"/> No Patient satisfied <input type="checkbox"/> Yes <input type="checkbox"/> No HHA Present <input type="checkbox"/> Yes <input type="checkbox"/> No																																										

Functional Needs (Circle): ☐ Bathing ☐ Grooming ☐ Dressing ☐ Eating ☐ Transferring ☐ Patient/Client Independent in ADLs (IADLs)

Reason for Visit: ☐ Assessment ☐ Teaching/training ☐ Wound care ☐ IV Therapy ☐ Lab draw ☐ HHA/Companion services ☐ PT/OT/ST/MSW services
☐ Medication management ☐ Other: _____
 Recent history pertinent to reason for visit: _____
☐ Patient is homebound. Why? _____

Interventions/Instructions: Teaching/training re: ☐ Medication regimen, actions, side effects ☐ Disease process ☐ Bleeding precautions
☐ Wound/incision care ☐ IV therapy ☐ Infection control measures ☐ Complications to report ☐ Physician follow up ☐ Home safety ☐ Oxygen safety
☐ Diet ☐ Elevating legs to decrease edema ☐ Off loading techniques ☐ Sharps disposal ☐ Plan of care review ☐ Medication management
☐ Inability to void post Foley removal ☐ Discharge instructions

Wound Care Performed: ☐ Aseptic technique ☐ Sterile technique ☐ Cleaned with NS ☐ Cleaned with: _____
 Product applied: _____
 Covered with: ☐ Gauze ☐ ABD pad ☐ Telfa ☐ Packed: _____ ☐ Wet to dry-NS ☐ Secured with tape/ace wrap/stockinette
☐ Wound vac applied with ☐ Black ☐ White ☐ Silver foam ☐ Canister changed ☐ Constant suction ☐ Intermittent suction ☐ Pressure: _____ mmHg
☐ Approx. drainage in canister: _____ mLs Color: _____

IV Therapy: Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes
 Flushed line: ☐ NS _____ mLs ☐ Before ☐ After med/blood draw ☐ Final flush with Heparin _____ mLs
 Peripheral IV inserted (site): _____ using (catheter): _____ Site prepped with ☐ alcohol ☐ betadine ☐ chloraprep
 _____ line dressing changed on using sterile technique ☐ 5 alcohol swabs ☐ 5 povidone swabs ☐ chloraprep swab ☐ antimicrobial patch
 Applied ☐ Occlusive dressing ☐ Gauze dressing ☐ Extension set ☐ Injection site ☐ Site free of complications ☐ Flushes easily ☐ Good blood return
☐ Line removed (type) _____ Length _____ cm ☐ Tip intact ☐ Pressure dressing applied
☐ Lab draw of: _____ from (site): _____ Taken to (Lab name): _____
☐ Administered: _____ ☐ IM ☐ SQ Site: _____ ☐ POC taught to administer: _____

Bowel Bladder: ☐ Foley catheter inserted _____ Fr _____ cc balloon using sterile technique with _____ return
 Connected to ☐ Leg bag ☐ Bedside drainage bag ☐ Foley removed without incident ☐ Instructions given regarding complications to report
☐ Bowel program performed ☐ Suppository used _____ ☐ Digital stimulation Results: _____
☐ Written instructions given re: _____
 Other: _____
☐ 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 POC are independent

Patient/Designee: I certify that the Marris Home Care Employee 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/side: _____ Date: _____ Rvnd 11/12

Skilled Nursing Facility Progress Note Template

Mia Erickson, Rebecca McKnight



Skilled Nursing Facility Progress Note Template:

Documentation Basics Mia L. Erickson, Becky McKnight, 2005 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively Necessary for both students and clinicians Documentation Basics A Guide for the Physical Therapist Assistant will teach and explain physical therapy documentation from A to Z Documentation Basics A Guide for the Physical Therapist Assistant covers all of the fundamentals for prospective physical therapist assistants preparing to work in the clinic or clinicians looking to refine and update their skills Mia Erickson and Becky McKnight have also integrated throughout the text the APTA's Guide to PT Practice to provide up to date information on the topics integral for proper documentation What's Inside Overview of documentation Types of documentation Guidelines for documenting Overview of the PTA's role in patient/client management from the patient's point of entry to discharge How to write progress notes How to use the PT's initial examinations/evaluations and plan of care when writing progress notes Legal matters related to documentation Reimbursement basics and documentation requirements The text also contains a section titled SOAP Notes Across the Curriculum or SNAC This section provides sample scenarios and practice opportunities for PTA students that can be used in a variety of courses throughout a PTA program These include Goniometry Range of motion exercises Wound care Stroke Spinal cord injury Amputation Enter the physical therapy profession confidently with Documentation Basics A Guide for the Physical Therapist Assistant by your side *Morbidity and Mortality Weekly Report*, 1984-11 *Documentation for Physical Therapist Practice* Jacqueline A. Osborne, 2015-08-03 Documentation for Physical Therapist Practice A Clinical Decision Making Approach provides the framework for successful documentation It is synchronous with Medicare standards as well as the American Physical Therapy Association's recommendations for defensible documentation It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper based and electronic systems This key resource skillfully explains how to document the interpretation of examination findings so that the medical record accurately reflects the evidence In addition the results of consultation with legal experts who specialize in physical therapy claims denials will be shared to provide current meaningful documentation instruction Documentation for Rehabilitation - E-Book Lori Quinn, James Gordon, 2024-04-12 Better patient management starts with better documentation Documentation for Rehabilitation 4th Edition demonstrates how to accurately document treatment progress and patient outcomes using a framework for clinical reasoning based on the International Classification for Functioning Disability and Health ICF model adopted by the American Physical Therapy Association APTA The documentation guidelines in this practical resource are easily adaptable to different practice settings and patient populations in physical therapy and physical therapy assisting Realistic examples and practice exercises reinforce the understanding and application of concepts improving skills in both documentation and clinical reasoning Workbook textbook format with examples and exercises in each chapter helps reinforce understanding of concepts

Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care nursing homes pediatrics school and community settings Case examples for a multitude of documentation types include initial evaluations progress notes daily notes letters to insurance companies Medicare documentation and documentation in specialized settings NEW Movement Analysis Linking Activities and Impairments content addresses issues related to diagnosis NEW An eBook version included with print purchase provides access to all the text figures and references with the ability to search customize content make notes and highlights and have content read aloud Updated case examples provide clinical context for patient documentation Revised content including updated terminology from the latest updates to the Guide to Physical Therapist Practice provides the most current information needed to be an effective practitioner Updated references ensure content is current and applicable for today's practice

Tabbner's Nursing Care Gabrielle Koutoukidis, Kate Stainton, 2020-07-17 Written by Gabby Koutoukidis and Kate Stainton Tabbner's Nursing Care Theory and Practice 8th edition provides students with the knowledge and skills they will require to ensure safe quality care across a range of healthcare settings Updated to reflect the current context and scope of practice for Enrolled Nurses in Australia and New Zealand the text focuses on the delivery of person centred care critical thinking quality clinical decision making and application of skills Now in an easy to handle 2 Volume set the textbook is supported by a skills workbook and online resources to provide students with the information and tools to become competent confident Enrolled Nurses Key features All chapters aligned to current standards including the NMBA Decision Making Framework 2020 the Enrolled Nurse Standards for Practice 2016 and the National Safety Quality Health Services Standards 2018 Clinical skills videos provide visual support for learners Supported by Essential Enrolled Nursing Skills Workbook 2nd edition An eBook included in all print purchases New to this edition Chapter 5 Nursing informatics and technology in healthcare focuses on competency in nursing informatics for beginning level practice aligned to the National Nursing and Midwifery Digital Capability Framework 2020 An increased focus on cultural competence and safety Supported by Elsevier Adaptive Quizzing Tabbner's Nursing Care 8th edition

Effective Management of Long Term Care Facilities Douglas Singh, 2010-02-18 Effective Management of Long Term Care Facilities explores the complex operations of the long term care facility and offers critical skills to current and future nursing home administrators for delivering quality cost effective services The Second Edition has been thoroughly revised and reorganized to offer a more cohesive presentation of the material New chapters that have been added cover the long term care industry long term care policy and supportive case studies that incorporate management and patient care issues

Documentation Basics for the Physical Therapist Assistant Mia Erickson, Rebecca McKnight, 2024-06-01 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Third Edition of Documentation Basics for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Third Edition to

reflect changes in the ever evolving profession Newly addressed are the changes in documentation requirements for major payers changes in the disablement models used and the increasingly common use of electronic documentation in the physical therapy profession Features inside the Third Edition Readers are encouraged to think about disablement and disablement concepts when writing notes How to document impairments in body structure and function but more importantly activity limitations and participation restriction Descriptions of the differences in documentation methods using a computer vs paper chart Evidence tied to benefits and challenges of computerized documentation Documenting the rationale for treatment and the unique skills of the physical therapist assistant in patient management New inside the Third Edition Incorporation of the International Classification of Functioning Disability and Health disablement model Chapter on electronic documentation Screenshot examples of the popular WebPT electronic medical record platform Updated chapters on reimbursement and legal issues Additional examples for student practice included in each chapter Included with the text are online supplemental materials for faculty use in the classroom Documentation Basics for the Physical Therapist Assistant Third Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation

Physical Therapy Documentation Mia Erickson, Mia L. Erickson, Rebecca McKnight, Ralph Utzman, 2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout Managing Anticoagulation Patients in the Hospital Michael Gulseth, 2007 Whether you are starting your institution s inpatient anticoagulation service or providing care in an inpatient anticoagulation service this is your step by step guide to systematic anticoagulation management in the inpatient setting Designed in a practical user friendly manner this resource is ideal for any pharmacist who wants to build expertise in caring for inpatients on anticoagulants or is tasked with teaching other pharmacists the clinical knowledge they need to manage patients on anticoagulants Managing Anticoagulation Patients in the Hospital is welcomed by all pharmacists who practice in or are developing implementing and maintaining an inpatient anticoagulation service Inside you ll find A comprehensive step by step guide to setting up an inpatient anticoagulation service A review of anticoagulant medications Clinical and management case studies that illustrate key concepts Clinical pearls for anticoagulation management and therapy Resources such as policies and procedures clinical dosing tools and business plans that have been used by other hospitals across America An accompanying CD ROM that includes practice tools references policies and PowerPoint presentations that can be easily adapted by the user for their own setting

Hearings, Reports and Prints of the House Committee on Veterans' Affairs United States. Congress. House. Committee on Veterans' Affairs, 1968 Trends in Long-term Care United States. Congress. Senate. Special Committee on Aging. Subcommittee on Long-Term Care, 1970

Nursing Home Ombudsman Services for the Elderly Community Research Applications, Inc, 1977 *Documentation for Physical Therapist Assistants* Wendy D Bircher, 2017-10-01 Build your documentation skills and your confidence Step by step

this text workbook introduces you to the importance of documentation shows you how to develop and write a proper and defensible note and prepares you to meet the technological challenges you ll encounter in practice You ll learn how to provide the proper documentation to assure all forms of reimbursement including third party for your services You ll also explore issues of patient confidentiality HIPAA requirements and the ever increasing demands of legal and ethical practice in a litigious society

Ebersole and Hess' Gerontological Nursing & Healthy Aging Theris A. Touhy, DNP, CNS, DPNAP, Kathleen F Jett, PhD, GNP-BC, 2013-03-11 Ebersole Hess Gerontological Nursing and Healthy Aging is the only gerontological nursing text that follows a wellness based holistic approach to older adult care Designed to facilitate healthy aging regardless of the situation or disease process this text goes beyond simply tracking recommended treatments to address complications alleviate discomfort and help older adults lead healthy lives Featuring evidence based practice boxes safety alerts expanded tables and careful attention to age gender and cultural differences Ebersole Hess Gerontological Nursing and Healthy Aging is the most complete text on the market Focus on health and wellness helps you gain an understanding of the patient s experience AACN and the Hartford Institute for Geriatric Nursing core competencies integrated throughout Consistent chapter organization and pedagogy including Learning Objectives Glossary and Research and Study Questions Activities Evidence Based Practice boxes summarize research findings that confirm effective practices or identify practices with unknown ineffective or harmful effects Careful attention to age cultural and gender differences helps you understand these important considerations in caring for older adults Expanded tables boxes and forms including the latest scales and guidelines for proper health assessment make information easy to find and use Activities and discussion questions at the end of every chapter equip you with the information you need to assess the patient UPDATED Healthy People 2020 boxes integrate information about healthy aging NEW Safety Alerts highlight safe practices and quality of care QSEN competencies NEW Chapter on Neurologic Compromise expands content on stroke and Parkinson s disease

The OTA's Guide to Writing SOAP Notes Sherry Borcharding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA s Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical

abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA's role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA's Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA's Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today's healthcare environment

Mosby's Textbook for Long-Term Care Nursing Assistants - E-Book Clare Kostelnick, 2023-06-15 Selected for Doody's Core Titles 2024 with Essential Purchase designation in Long Term Care Gain the knowledge and skills you need to provide safe compassionate long term care Mosby's Textbook for Long Term Care Nursing Assistants 9th Edition prepares you to succeed as a professional caregiver for residents in long term care settings More than 100 step by step procedures include clear instructions for performing skills such as bedmaking measuring vital signs and collecting specimens Not only does the book cover the functions and limitations of the nursing assistant's role but its delegation guidelines outline the information you need to collect from the nurse and care plan before performing and then documenting a procedure Written by Clare Kostelnick an experienced nurse and instructor this text also helps you prepare for success on the Nursing Assistant certification exam Concise long term care content is presented at a 6th grade reading level to make understanding easier for readers of all levels and abilities More than 100 procedures are divided into pre procedure procedure and post procedure sections for easier learning and a NATCEP icon indicates skills that are covered in certification exams Color illustrations and photographs depict key ideas concepts and procedure steps Featured boxes highlight principles of care with Teamwork and Time Management Quality of Life Residents with Dementia Time to Reflect Promoting Safety and Comfort Focus on Rehabilitation Focus on Communication and Delegation Guidelines Procedure icons in the headings identify content for which a related procedure is included Play icons in the Procedure boxes alert you to related video clips on the Evolve website Key Terms and Key Abbreviations at the beginning of each chapter introduce important words and commonly used abbreviations and a separate glossary for each is included at the end of the book Chapter Review Questions help you evaluate your comprehension Review Question Answers are included at end of the text to allow for self evaluation NEW Updated photographs and illustrations show the latest equipment and supplies used in caring

for long term care residents NEW Basic Emergency Care chapter has new vital information on controlling bleeding and the Stop the Bleed program as well as a description of equipment used in medical emergencies NEW Preventing Infection chapter includes updates on PPE and changes to procedures related to COVID 19 NEW Mental Health Problems chapter adds information on dealing with individuals experiencing emotional pain and suicide prevention as well as expanded information on types of depression NEW Nutrition chapter adds new information on residents experiencing dysphagia including current guidelines from the International Dysphagia Diet Standardisation Initiative IDDSI

Program Development Handbook for State and Area Agencies on Nursing Home Ombudsman Services for the Elderly Community Research Applications, Inc,1978 Prepared for the Administration on Aging

Program Development Handbook for State and Local Agencies on Nursing Home Ombudsman Services for the Elderly Community Research Applications, Inc,1978

Congressional Record United States. Congress,1971 The Congressional Record is the official record of the proceedings and debates of the United States Congress It is published daily when Congress is in session The Congressional Record began publication in 1873 Debates for sessions prior to 1873 are recorded in The Debates and Proceedings in the Congress of the United States 1789 1824 the Register of Debates in Congress 1824 1837 and the Congressional Globe 1833 1873

Long-term Facility Improvement Study ,1975

Decoding **Skilled Nursing Facility Progress Note Template**: Revealing the Captivating Potential of Verbal Expression

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