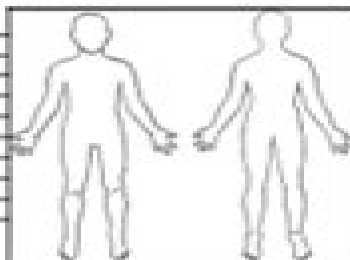


Skilled Nursing Note

☐ Initial Assessment ☐ Follow up visit ☐ Supervisory visit

Name of Patient: _____ Date: _____

Vital Signs Ht: _____ Wt: _____ Temp: _____ Pulse: A/R: _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Resp: _____ B/P: _____ <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Right <input type="checkbox"/> Left																																											
<i>Nursing assessment and observation of signs/symptoms (Mark all applicable with an "X" or circle (circle) separated by "Y")</i>																																											
CARDIOVASCULAR <input type="checkbox"/> WNL <input type="checkbox"/> Edema (Specify): _____ <input type="checkbox"/> R/L: <input type="checkbox"/> L/L: <input type="checkbox"/> R/L: <input type="checkbox"/> L/L: <input type="checkbox"/> S2/S4: <input type="checkbox"/> Flapping <input type="checkbox"/> Non-flapping <input type="checkbox"/> Other: _____	RESPIRATORY <input type="checkbox"/> WNL <input type="checkbox"/> Dyspnea/SOB <input type="checkbox"/> Cough/Sputum <input type="checkbox"/> Other: _____	PAEN <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"> <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>Tissue/ing</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Odor</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Nat tissue</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Wound bed</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stoma</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <input type="checkbox"/> Steri-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				Tissue/ing				Odor				Nat tissue				Wound bed				Stoma			
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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 LUE <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Other: _____	SAFETY CONCERNS: <input type="checkbox"/> Clear pathways/stair 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: _____																																									
SUPERVISORY VISITS: Follows Std Precautions <input type="checkbox"/> Yes <input type="checkbox"/> No Follows Plan of Care <input type="checkbox"/> Yes <input type="checkbox"/> No Performs Care 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																																											
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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/infection care <input type="checkbox"/> IV therapy <input type="checkbox"/> Infection control measures <input type="checkbox"/> Complications to report <input type="checkbox"/> Physician follow up <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: _____ Product applied: _____ Covered with: <input type="checkbox"/> Gauze <input type="checkbox"/> ABD pad <input type="checkbox"/> Telfa <input type="checkbox"/> Packed: _____ <input type="checkbox"/> Wet to dry-NS <input type="checkbox"/> Secured with tape/face 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: _____ mL Color: _____																																											
IV Therapy: Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes Flushed line: <input type="checkbox"/> NS _____ mL <input type="checkbox"/> Before <input type="checkbox"/> After med/blood draw <input type="checkbox"/> Final flush with Heparin _____ uL/mL _____ mL Peripheral IV inserted (site): _____ using (catheter): _____ Site prepped with <input type="checkbox"/> alcohol <input type="checkbox"/> betadine <input type="checkbox"/> chloraprep _____ line dressing changed on using sterile technique <input type="checkbox"/> 3 alcohol swabs <input type="checkbox"/> 3 providone 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) _____ Length _____ cm <input type="checkbox"/> Tip intact <input type="checkbox"/> Pressure dressing applied <input type="checkbox"/> 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"/> Pq/CG taught to administer: _____																																											

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Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

Restorative Care Nursing for Older Adults Barbara Resnick, 2004-07-28 The purpose of restorative care nursing is to take an active role in helping older adults maintain their highest level of function thus preventing excess disability This book was written to help formal and informal caregivers and administrators at all levels to understand the basic philosophy of restorative care and be able to develop and implement successful restorative care programs The book provides a complete 6 week education program in restorative care for caregivers many suggestions for suitable activities and practical strategies for motivating both older adults and caregivers to engage in restorative care In addition the book provides an overview of the requirements for restorative care across all settings the necessary documentation and ways in which to complete that documentation

The OTA's Guide to Documentation Marie Morreale, 2024-06-01 The bestselling newly updated occupational therapy assistant OTA textbook The OTA's Guide to Documentation Writing SOAP Notes Fifth Edition explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities worksheets and bonus videos The Fifth Edition contains step by step instruction on occupational therapy documentation and the legal ethical and professional documentation standards required for clinical practice and reimbursement of services Students and professors alike can expect the same easy to read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice Essentials of documentation reimbursement and best practice are reflected in the many examples presented throughout the text Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning learn documentation methods create occupation based goals and develop a repertoire of professional language Templates are provided to assist beginning OTA students in formatting occupation based SOAP notes and the task of documentation is broken down into smaller units to make learning easier Other formats and methods of recording client care are also explained such as the use of electronic health records and narrative notes This text also presents an overview of the initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions New in the Fifth Edition Incorporation of the Occupational

Therapy Practice Framework Domain and Process Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom this includes access to supplemental website worksheets learning activities and scenario based videos to practice the documentation process

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

Documentation Manual for Occupational Therapy Crystal Gateley, 2024-06-01 The best selling newly updated occupational therapy textbook Documentation Manual for Occupational Therapy Fifth Edition is made for students and early career practitioners learning the critical skill of documentation The workbook format offers students ample opportunities to practice writing occupation based problem statements and goals intervention plans SOAP notes and other forms of documentation The Fifth Edition has also been updated to reflect changes in the American Occupational Therapy Association's Occupational Therapy Practice Framework Domain and Process Fourth Edition What's included in Documentation Manual for Occupational Therapy Numerous worksheets for students to practice individual skills with suggested answers provided in the Appendix Updated information on coding billing and reimbursement to reflect recent Medicare changes particularly in post acute care settings Examples from a variety of contemporary occupational therapy practice settings Included with the text are online supplemental materials for faculty use in the classroom Instructors in educational settings can visit the site for an Instructor's Manual with resources to develop an entire course on professional documentation or to use the textbook across several courses One of the most critical skills that occupational therapy practitioners must learn is effective documentation to guide client care communicate with colleagues and maximize reimbursement The newly updated and expanded Documentation Manual for Occupational Therapy Fifth Edition will help students master their documentation skills before they ever step foot into practice

Inspector General Audit of Health Care Financing Administration Financial Statements United States. Congress. House. Committee on Ways and Means. Subcommittee on Health, 1998

Nursing Documentation Ellen Thomas Eggland, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good documentation

Nursing Care Plans & Documentation Lynda Juall Carpenito-Moyet, 2009 The Fifth Edition of Nursing Care Plans and Documentation provides nurses with a comprehensive guide to creating care plans and effectively documenting care This user friendly resource presents the most likely diagnoses and collaborative problems with step by step guidance on nursing action and rationales for interventions New chapters cover moral distress in nursing improving hospitalized patient outcomes and nursing diagnosis risk for compromised human dignity The book includes over 70 care plans that translate theory into

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Handbook of Home Health Care Administration Marilyn D. Harris,2005 Nursing **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 **Fundamentals of Nursing Care** Marti A Burton,Linda J May

Ludwig,2014-10-10 Take a fresh new approach to nursing fundamentals that teaches students how to think learn and do while they make the connections each step of the way **Orientation to Home Care Nursing** Carolyn J. Humphrey,Paula Milone-Nuzzo,1996 Intended for both financial and nonfinancial managers this text covers six primary areas the author deems necessary for managers to incorporate into their decision making processes financial reporting prospective and retrospective payment systems cost accounting management accounting financial management and strategic management

The author a business and finance consultant stresses the importance of teamwork in working toward an outcome management system that honors clients and coworkers promotes innovation and balances clinical and financial organizational requirements Annotation c by Book News Inc Portland Or [Nursing Homes](#) United States. General

Accounting Office,2002 **Medicare, Home Health Agency Manual** United States. Health Care Financing

Administration,1990 **Home Care Nursing Handbook** Carolyn J. Humphrey,1998 Here s the brand new third edition of the very popular Home Care Nursing Handbook considered by readers as a beacon of excellence in home care nursing Now better than ever this book that so many nurses have turned to for immediate excellent advice has been significantly expanded

It is reorganized for quicker access to expert guidance devotes separate chapters to interventions for each impairment Use this guide every day to assess situations quickly develop efficient plans of care provide accurate intervention strategies document patient care quickly precisely promote quality patient outcomes in the shortest number of contacts so much more This book is a vital addition to critical pathways point of care computer systems OASIS data collection *Nursing Informatics 2016* W. Sermeus,P.M. Procter,P. Weber,2016-07-21 As the importance of electronic and digital devices in the provision of healthcare increases so does the need for interdisciplinary collaboration to make the most of the new technical possibilities which have become available This book presents the proceedings of the 13th International Conference on Nursing Informatics held in Geneva Switzerland in June 2016 This biennial international conference provides one of the most important opportunities for healthcare professionals from around the world to gather and exchange expertise in the research and practice of both basic and applied nursing informatics The theme of this 13th conference is eHealth for All Every Level Collaboration From Project to Realization The book includes all full papers as well as workshops panels and poster summaries from the conference Subjects covered include a wide range of topics from robotic assistance in managing medication to intelligent wardrobes and from low cost wearables for fatigue and back stress management to big data analytics for optimizing work processes and the book will be of interest to all those working in the design and provision of healthcare today Documenting Care Frances Talaska Fischbach,1991 University of Wisconsin Milwaukee School of Nursing s comprehensive charting and documentation manual for students and practitioners **Medicare at Risk** United States. Congress. Senate. Committee on Governmental Affairs. Permanent Subcommittee on Investigations,1997 **HHS Inspector General's Audit of the HCFA's FY 1997 Financial Statements** United States. Congress. House. Committee on Commerce. Subcommittee on Health and the Environment,1998 **Home Care Nursing Practice** Robyn Rice,2006-01-01 This text covers conceptual information leadership skills and current issues and trends It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care Cover

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