

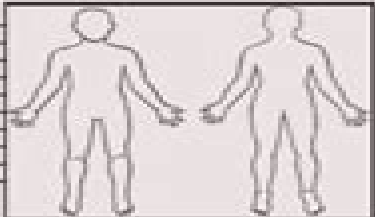
Skilled Nursing Note

☐ 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 of health, 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"/> Flaring <input type="checkbox"/> Non-flaring <input type="checkbox"/> Other: _____	RESPIRATORY <input type="checkbox"/> WNL <input type="checkbox"/> Dyspnea/COB <input type="checkbox"/> Cough/Sputum <input type="checkbox"/> Other: _____	PAIN <input type="checkbox"/> None <input type="checkbox"/> Location: _____ Severity 0-10: _____ <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>Penetrating</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Odor</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				Penetrating				Odor				Scar tissue				Wound bed				Stitches			
	#1	#2	#3																																								
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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: _____																																									
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: _____	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: _____																																									
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: _____ ☐ P/OC 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 P/OC 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

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Ying-Ying Zheng



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