

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																																							
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 <input type="checkbox"/> 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: GENITOURINARY <input type="checkbox"/> WNL <input type="checkbox"/> Incontinence <input type="checkbox"/> Catheter/Size <input type="checkbox"/> Ileostomy <input type="checkbox"/> Other: MUSCULOSKELETAL <input type="checkbox"/> WNL <input type="checkbox"/> ROM: <input type="checkbox"/> RUE LUE RLE LLE <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Other:	PAIN <input type="checkbox"/> None <input type="checkbox"/> Location: Severity (0-10): 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	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;"> <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 bed</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 Type:		#1	#2	#3	Length				Width				Depth				Drainage				Tunneling				Odor				Sur tissue				Wound bed			
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Odor																																							
Sur tissue																																							
Wound bed																																							
EMOTIONAL STATUS <input type="checkbox"/> WNL <input type="checkbox"/> Disoriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Depressed <input type="checkbox"/> Other:																																							
NEUROSENSORY <input type="checkbox"/> WNL <input type="checkbox"/> Syncope/Vertigo <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Other:	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:																																						
FUNCTIONAL NEEDS (Circle): Bathing Grooming Dressing Eating Transferring <input type="checkbox"/> Patient/client independent in ADLs / IADLs																																							
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"/> 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/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 Flushed line: <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 (site): _____ using (catheter): _____ Site prepped with <input type="checkbox"/> alcohol <input type="checkbox"/> betadine <input type="checkbox"/> chloraprep <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 <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"/> Pt/CG taught to administer: _____																																							
Bowel Bladder: <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: _____ Other: _____ <input type="checkbox"/> See communication sheet for addendum notes																																							
Patient/Caregiver Response: <input type="checkbox"/> Patient tolerated interventions well <input type="checkbox"/> Patient/CG verbalized/demonstrated understanding of instructions provided Patient/Caregiver independent with: <input type="checkbox"/> Wound care <input type="checkbox"/> IV therapy <input type="checkbox"/> Medication management <input type="checkbox"/> Wound/ incision healing without complications <input type="checkbox"/> Tolerating medications without side effects or adverse reactions <input type="checkbox"/> Patient will follow with physician as instructed <input type="checkbox"/> Discharge/no other nursing visits needed/ordered Other: _____ Next visit: _____ Patient/Caregiver unable to be independent in care due to: <input type="checkbox"/> Physical limitations <input type="checkbox"/> Learning limitations <input type="checkbox"/> Refuses to learn <input type="checkbox"/> N/A Pt/CG are independent																																							
Patient/Designee: I certify that the Matrix 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/title: _____ Date: _____																																							