Florence Home Health Care

SKILLED NURSING NOTE

PURPOSE OF VISIT: _____ **PULSE:** _____ **R A R/I RESPIRATIONS** _____ **R/I**
TEMP:_____**F O/R/A BP: Sitting** ____/_____ **L/R Standing** ____/____ **L/R Lying** ____/____ **L/R** WEIGHT_____ lb Stated/Actual

MENTAL: ☐ Alert ☐ Oriented X ___ ☐ Restless ☐ Forgetful ☐ Confused ☐ Anxious ☐ Depressed
☐ Agitated ☐ Comatose ☐ Semi-Comatose Comment: _____

NEUROLOGICAL: ☐ No problem assessed at this time ☐ Aphasia ☐ Slurred Speech ☐ Seizures ☐ Headache ☐ Tremors ☐ Vertigo ☐ Change in LOC ☐ Grips Unequal ☐ Pupils Unequal ☐ Numbness ☐ Visual Deficit ☐ Hearing Deficit ☐ Speech Deficit
Comments: _____

CARDIOVASCULAR: ☐ No problem assessed at this time **Pedal Pulses**: ☐ Present ☐ Absent **Edema:** ☐ None ☐ Pitting ☐ Non-Pitting
Location/Amount: _____ ☐ Chest pain ☐ Palpitations ☐ Dizziness ☐ Orthopnea
Comment: _____

RESPIRATORY: ☐ No problem assessed at this time **Lung Sounds:** _____
☐ Cough: ☐ Prod ☐ Non-Prod ☐ O2____LPM/NC/Mask SOB: ☐ Rest ☐ Min Exertion Sputum: Color _____ Amt _____
Oxygen Saturation: _____% Comment: _____

GASTROINTESTINAL: ☐ No problem assessed at this time **Appetite:** ☐ Good ☐ Fair ☐ Poor **Bowel Sounds:** ☐ Present ☐ Absent ☐ Hypo ☐ Hyper ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Incontinent ☐ Last BM _____ ☐ Feeding Tube ___
Diet: _____ Comment: _____

GENITOURINARY: ☐ No problem assessed at this time ☐ Incontinent ☐ Frequency ☐ Urgency ☐ Pain on urination
☐ Nocturia ☐ Burning ☐ Retention ☐ FC ☐ Suprapubic Catheter/Size ___ F _____cc balloon ☐ Condom Catheter (S/M/L)
Urine: Color _____ ☐ Odor ☐ Cloudy Amount: _____ ml Comments: _____

ENDOCRINE: ☐ No problem assessed at this time Blood Glucose _____MG/dl random/fasting ☐ Per patient/PCG ☐ Diaphoretic ☐ Polyuria ☐ Blurred Vision ☐ Polydipsia ☐ Polyphagia ☐ S/S of Hypoglycemia ☐ S/S of Hyperglycemia ☐ Tachycardia
Comment: _____

SKIN: ☐ No problem assessed at this time **Turgor:** ☐ Good ☐ Fair ☐ Poor **Skin Temp:** ☐ Warm ☐ Hot ☐ Cold
☐ Rash ☐ Diaphoretic ☐ Bruises ☐ Dry ☐ Excoriation ☐ Pallor ☐ Jaundice ☐ Pruritis ☐ Blister(s) ☐ Surgical wound ☐ Skin tear ☐ Stasis ulcer ☐ Pressure ulcer ☐ Diabetic Ulcer Site: _____ ☐ Drainage/Description/Amount: _____ ☐ Odor ☐ Skin on Feet Intact ☐ Perineal Area Intact ☐ Wound Sheet Q week completed
Comment: _____

MUSCULOSKELETAL: ☐ No problem assessed at this time ☐ Stiff joints ☐ Painful joints ☐ Weakness _____ ☐ Contractures ☐ Unsteady Balance/Gait Comment: _____

PAIN: ☐ No ☐ Yes Location _____ Origin _____ Frequency _____
Intensity 1 2 3 4 5 6 7 8 9 10 (circle) ☐ Sharp ☐ Dull ☐ Burning ☐ Radiating Controlled?: ☐ Yes ☐ No Pain med last given: _____
Current Pain Management: _____ Comment: _____

MEDICATIONS: ☐ No meds currently ☐ No problem assessed at this time ☐ Pt/PCG compliant with med regime ☐ Pt/PCG lacks knowledge regarding med regime ☐ Medications are effective ☐ No drug interaction noted ☐ Started on new med _____ ☐ Med profile updated Comment: _____

Abnormal Findings/Skilled Care Provided: ☐ Standard Precautions observed ☐ Infection Control Measures observed including handwashing

☐ Two Identifiers used to verify Patient ☐ Safety Precautions Observed ☐ Medical Equipment in good working order
Requires SN since: ☐ No willing and able CG to administer Insulin ☐ No willing and able CG to provide wound care/administer IM/IV medication
Pt/PCG response: ☐ Pt/PCG verbalizes understanding of teaching _____ % ☐ Pt/PCG needs further instruction ☐ Pt/PCG demonstrated procedure properly w/o cues ☐ Pt/PCG demonstrated procedure w/ cues _____
Communication with (name and title) _____ Re: _____
☐ No new orders at this time ☐ Medication change ☐ Treatment change ☐ Physician appointment ☐ Lab specimen obtained
Plans for next Visit: _____
Homebound Status: ☐ Needs assistance with all activities ☐ Residual Weakness ☐ Requires assistance to ambulate ☐ Medical restrictions ☐ Confusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Dependent upon adaptive device (s) ☐ Severe SOB, SOB on exertion ☐ Other (specify) _____
AIDE SUPERVISION: Name of Aide_____ Aide present ☐ Yes ☐ No Follows task/care plan? ☐ Yes ☐ No
Patient satisfied with services? ☐ Yes ☐ No Cleans up work areas ☐ Yes ☐ No Uses good safety practice ☐ Yes ☐ No
Aide Task Sheet updated? ☐ Yes ☐ No Care Observed _____ Instructed in _____

Patient Name _____		Patient Number _____		
Nurse's Name _____	Nurse's Signature _____	Date of Visit _____	Time In _____	Time Out _____