

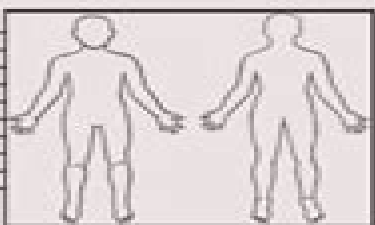
# Skilled Nursing Note

☐ 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 "/")*

<b>CARDIOVASCULAR</b> <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"/> Q/T/A+ <input type="checkbox"/> Pitting <input type="checkbox"/> Non-pitting <input type="checkbox"/> Other: _____	<b>RESPIRATORY</b> <input type="checkbox"/> WNL <input type="checkbox"/> Dyspnea/SOB <input type="checkbox"/> Cough/Sputum <input type="checkbox"/> Other: _____	<b>PAIN</b> <input type="checkbox"/> None <input type="checkbox"/> Location: _____  Severity 0-10: _____ <input type="checkbox"/> Other: _____	<b>SKIN</b> <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"/> BP 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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Penetration																																												
Color																																												
Scar tissue																																												
Wound bed																																												
Stitches																																												
<b>EMOTIONAL STATUS</b> <input type="checkbox"/> WNL <input type="checkbox"/> Disoriented <input type="checkbox"/> Fearful <input type="checkbox"/> Depressed <input type="checkbox"/> Other: _____	<b>GENITOURINARY</b> <input type="checkbox"/> WNL <input type="checkbox"/> Incontinence <input type="checkbox"/> Catheter/Wire <input type="checkbox"/> Hematuria <input type="checkbox"/> Other: _____	<b>DIGESTIVE</b> <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: _____	<b>SAFETY CONCERNS:</b> <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: _____ <b>SUPERVISORY VISIT:</b> 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																																									
<b>NEUROSENSORY</b> <input type="checkbox"/> WNL <input type="checkbox"/> Syncope/Vertigo <input type="checkbox"/> Visual Impairment <input type="checkbox"/> Other: _____	<b>MUSCULOSKELETAL</b> <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: _____																																											

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

Reason for Visit: ☐ Assessment ☐ 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  
☐ Appear, 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: \_\_\_\_\_ ☐ Pu/CG 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

**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: \_\_\_\_\_  
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 Connected to ☐ Leg bag ☐ Bedside drainage bag ☐ Foley removed without incident ☐ Instructions given regarding complications to report  
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☐ 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 Pu/CG 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: \_\_\_\_\_

# Nursing Documentation Template

**R Bogdan**



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