TOP CHOICE HOME HEALTCARE, INC.

CLINICAL SKILLED NURSING NOTE

ASSESSMENTS:

MENTAL: ☐Restless ☐Disoriented ☐Forgetful ☐Confused ☐Anxious ☐Depressed ☐Agitated ☐Other: oriented

INTEGUMENTARY: ☐Wound ☐Decube Stage☐1☐2☐3☐4 ☐Infected ☐ Foul odor drainage ☐Rashes ☐Sizes_____ ☐Tubes _____ ☐Shunt _____ ☐Other:

EENT: ☐Legally blind/poor vision ☐Epistaxis ☐Dysphagia ☐Deaf_____ ☐Prone to aspiration

RESPIRATORY:SOB☐Rest ☐Exertion☐ Cough☐Productive ☐Non-productive Sputum Color:_____Amount:_____ Lung Sound:_____O2____LPM/_____ Other:_____

MUSCULOSKELETAL: ☐Stiff joints ☐Weakness ☐Limited ROM ☐Contractures ☐ Foot drop ☐Unsteady balance ☐Other_____

PAIN: ☐No ☐Yes Location: _____ _____

Inten. ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 ☐Sharp ☐Dull ☐Radiating ☐Burning Controlled ☐No ☐Yes by: meds and rest

GASTROINTESTINAL: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Impaction ☐Abd. Dist. ☐Incontinent ☐ Last BM _____ Appetite: ☐Good ☐Fair ☐Poor Diet: _____ ☐Tube Feeding_____

NEUROLOGICAL: ☐Aphasic ☐Slurred speech ☐Seizures ☐Headache ☐Tremors ☐Vertigo ☐Grips unequal ☐Pupils unequal ☐PERRLA ☐Weakness R☐ L☐

CARDIOVASCULAR: ☐Chest pain ☐Palpitations ☐Dizziness Pedal pulses: ☐Present ☐Absent Edema: ☐Pitting ☐Non-pitting ☐ Pacer. ☐1+ ☐2+ ☐3+ ☐4+ ☐ Dependent Location: ☐Ankles R/L ☐Dorsum R/L

GENITOURINARY: ☐Incontinent ☐Frequency ☐Urgency ☐Pain ☐Nocturia ☐Burning ☐Retention ☐Catheter ☐Condom ☐IFC ☐Suprapub ☐ Odor ☐Cloudy ☐Hematuria ☐Chills

ENDOCRINE: ☐Weak ☐Diaphoretic ☐Polyuria ☐Blurred vision ☐Poor foot care ☐Tremors ☐Other: _____

SN NAME: _____

SN SIGNATURE: X _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Vital Signs: T____F HR ____/min RR ____/min BS ____ F ☐ R ☐ **BP** _____ Lying ☐ Sitting ☐ Standing ☐ Wt ____**HOMEBOUND STATUS**: ☐Poor/Limited Endurance ☐ Poor/Limited Strength ☐ SOBOE ☐Poor Unsteady Gait ☐Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt bearing ☐Ambulates ____ ft then requires rest/stop ☐Requires assist with transfer ☐Requires assistive device to ambulate ☐ Confusion ☐Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☐Requires assist to ambulate ☐Poor coordination or balance ☐Partial wt bearing ☐ Others: requires considerable & taxing effort to leave home even with caregiver assistance.

MEDICAL NECESSITY: ☐ Skilled nursing care reasonable & necessary for management/evaluation of patient's plan of care ☐ Abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity abnormal/fluctuating lab values, & respiratory changes on auscultation ☐ Reasonable/necessary teaching & training activities requires skilled nursing personnel to teach patient/patient's family/caregivers how to manage treatment regimen ☐ Patient requires insertion/sterile irrigation & replacement of a catheter/care of a supra-pubic catheter ☐ Skilled services of a nurse are required to administer medication safely/effectively & the medication is reasonable/necessary for the treatment of the illness/injury/condition ☐Skills of a licensed nurse are needed to provide wound care safely/effectively ☐Patient requires ostomy care during post-operative period with presence of associated complications ☐Patient requires rehabilitation nursing procedures, including the related teaching & adaptive aspects of nursing part of active treatment (e.g., the institution & supervision of bowel/bladder training programs).

CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES:

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INTERVENTIONS: (Specific to problems identified and who was given the instructions.)

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SAFETY MEASURES/INFECTION CONTROL MEASURES:

☐Standard Precautions ☐Hand washing ☐Medication Safety ☐Fall Precautions ☐Proper Medical Waste/Sharps Disposal ☐Bleeding Precautions ☐Oxygen Precautions ☐Other:_____

PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):

☐Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☐No side effects/adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☐Requires more instruction ☐BP/BS/Pain decreased/increased ☐Other:_____

PLAN: (for next visit) :_____

_____

COMMUNICATION:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other _____

Re: _____

MEDICATIONS: NEW(N)/CHANGED(C)/DISCONTINUED(D)/DATE

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PATIENT NAME: _____ **MR#** _____

DATE: _____ **TIME IN:** _____ **TIME OUT:** _____