**Skilled Nursing Note**

**[ ] Initial Assessment [ ] Follow up visit [ ] Supervisory visit**

Name of Patient: ___________________________________________ Date: ___________

**Vital Signs**

- Ht: ________ We: ________ Temp: ________ Pulse: A/R: ________ [ ] Regular [ ] Irregular
- Resp: ________ B/P: ________ [ ] Lying [ ] Sitting [ ] Standing [ ] Right [ ] Left

Nursing assessment and observation of signs/symptoms (Mark all applicable with an “X” or circle item(s) separated by “/”)

**CARDIOVASCULAR**

- [ ] WNL
- [ ] Edema (Specify)
- [ ] RUE [ ] LUE [ ] RLE [ ] LLE
- [ ] 1/2/3+ [ ] Pitting [ ] Non-pitting
- [ ] Other:

**RESPIRATORY**

- [ ] WNL
- [ ] Dyspnea/SOB
- [ ] Conge/Sputum
- [ ] Other:

**PAIN**

- [ ] None
- [ ] Location:

Severity (0-10):
- [ ] #1
- [ ] #2
- [ ] #3

**SKIN**

- [ ] WNL
- [ ] Cellulitis
- [ ] Pressure sore
- [ ] Rash
- [ ] Skin tear
- [ ] Wound
- [ ] Incision

- [ ] Length
- [ ] Width

**GENITOURINARY**

- [ ] WNL
- [ ] Incontinence
- [ ] Catheter/Size
- [ ] Heastrongy
- [ ] Other:

**DIGESTIVE**

- [ ] WNL
- [ ] Nausea/Vomiting
- [ ] Difficulty Swallowing
- [ ] Diarrhea/Constipation
- [ ] Colostomy
- [ ] Incontinence
- [ ] Last BM

**SAFETY CONCERNS**

- [ ] Clear pathways/safe ambulation
- [ ] Fall precautions
- [ ] Home safety
- [ ] Medication management
- [ ] IV safety
- [ ] Sharps disposal
- [ ] Oxygen safety
- [ ] Bleeding precautions
- [ ] Infection control

**EMOTIONAL STATUS**

- [ ] WNL
- [ ] Disoriented
- [ ] Forgetful
- [ ] Depressed
- [ ] Other:

**MUSCULOSKELETAL**

- [ ] WNL
- [ ] Syncope/Vertigo
- [ ] Visual Impairment
- [ ] Other:

**NEUROSENSORY**

- [ ] WNL
- [ ] Visual Impairment
- [ ] Other:

**FUNCTIONAL NEEDS/CIRCUMSTANCES**

- [ ] Bathing
- [ ] Dressing
- [ ] Grooming
- [ ] Toileting
- [ ] Patient/client independent in ADLs

**REASON FOR VISIT**

- [ ] Assessment
- [ ] Teaching/training
- [ ] Anemia
- [ ] IV Therapy
- [ ] Lab work
- [ ] 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
- [ ] 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**

- [ ] Sterile technique
- [ ] Cleansed with NS
- [ ] Cleansed with:

Product applied:

- [ ] 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 ________ u/cc
- [ ] ________ mls

Peripheral IV Inserted (site):

- [ ] Site prepped with:
- [ ] 3 alcohol swabs
- [ ] 3 proavdineline swabs
- [ ] Chloraprep swab
- [ ] Antimicrobial patch

Applied:

- [ ] IV dressing
- [ ] Tefla 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:
- [ ] Pt/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

**PATIENT/CAREGIVER RESPONSE**

- [ ] Patient tolerated interventions well
- [ ] Patient 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

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: ___________