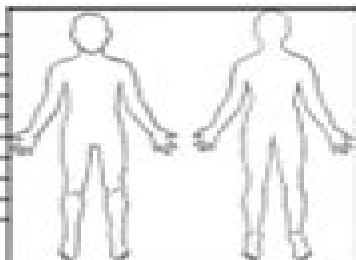


Skilled Nursing Note

☐ 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																																											
<i>Nursing assessment and observation of signs/symptoms (Mark all applicable with an "X" or circle number separated by "Y")</i>																																											
CARDIOVASCULAR ☐ WNL ☐ Edema (Specify): _____ ☐ R/L: ☐ L/L: ☐ R/L: ☐ L/L: ☐ M/D/A: ☐ Flitting ☐ Non-flitting ☐ Other: _____	RESPIRATORY ☐ WNL ☐ Dyspnea/SOB ☐ Cough/Sputum ☐ Other: _____	PAEN ☐ None ☐ Location: _____ Severity (0-10): _____ Other: _____	SKIN ☐ WNL ☐ Cellulitis ☐ Pressure sore ☐ Rash ☐ Skin tear ☐ Wound ☐ 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>Tissue/ing</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Odor</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Nat tissue</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Wound bed</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Stoma</td> <td></td> <td></td> <td></td> </tr> </tbody> </table> ☐ Steri-strips ☐ Sutures ☐ Staples ☐ JP drain ☐ IV line Type: _____		#1	#2	#3	Length				Width				Depth				Drainage				Tissue/ing				Odor				Nat tissue				Wound bed				Stoma			
	#1	#2	#3																																								
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NEUROSENSORY ☐ WNL ☐ Syncope/Vertigo ☐ Visual Impairment ☐ Other: _____	MUSCULOSKELETAL ☐ WNL ☐ ROM ☐ RUE LUE RUE LUE ☐ Unsteady gait ☐ Generalized weakness ☐ Other: _____	SAFETY CONCERNS: ☐ Clear pathways/adequate ambulation ☐ Fall precautions ☐ Home safety ☐ Medication management ☐ IV safety ☐ Sharps disposal ☐ Oxygen safety ☐ Bleeding precautions ☐ Infection control ☐ Other: _____																																									
SUPERVISORY VISITS: Follows Std Precautions ☐ Yes ☐ No Follows Plan of Care ☐ Yes ☐ No Performs Care Properly ☐ Yes ☐ No Patient satisfied ☐ Yes ☐ No HHA Present ☐ Yes ☐ No																																											
Personal Needs (Circle): ☐ Bathing ☐ Dressing ☐ Eating ☐ Grooming ☐ Hygiene ☐ Transferring ☐ Patient/Client Independent in ADLs/IADLs																																											
Reason for Visit: ☐ Assessment ☐ Teaching/training ☐ Wound care ☐ IV Therapy ☐ Lab draw ☐ 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/dressings 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 ☐ Cleansed with NS ☐ Cleansed with: _____ Product applied: _____ Covered with: ☐ Gauze ☐ ABD pad ☐ Telfa ☐ Packed: _____ ☐ Wet to dry-NS ☐ Secured with tape/face wrap/stockinette ☐ Wound vac applied with ☐ Black ☐ White ☐ Silver foam ☐ Canister changed ☐ Constant suction ☐ Intermittent suction ☐ Pressure: _____ mmHg ☐ Approx. drainage in canister: _____ mL Color: _____																																											
IV Therapy: Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes Flushed line: ☐ NS _____ mL ☐ Before ☐ After med/blood draw ☐ Final flush with Heparin _____ mL Peripheral IV inserted (site): _____ using (catheter): _____ Site prepped with ☐ alcohol ☐ betadine ☐ chloraprep _____ line dressing changed on using sterile technique ☐ 3 alcohol swabs ☐ 3 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: _____ ☐ Pq/CG taught to administer: _____																																											

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Stein, Chiplin



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The OTA's Guide to Documentation Marie Morreale, 2024-06-01 The bestselling newly updated occupational therapy assistant OTA textbook *The OTA's Guide to Documentation Writing SOAP Notes Fifth Edition* explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities worksheets and bonus videos The Fifth Edition contains step by step instruction on occupational therapy documentation and the legal ethical and professional documentation standards required for clinical practice and reimbursement of services Students and professors alike can expect the same easy to read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice Essentials of documentation reimbursement and best practice are reflected in the many examples presented throughout the text Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning learn documentation methods create occupation based goals and develop a repertoire of professional language Templates are provided to assist beginning OTA students in formatting occupation based SOAP notes and the task of documentation is broken down into smaller units to make learning easier Other formats and methods of recording client care are also explained such as the use of electronic health records and narrative notes This text also presents an overview of the initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions New in the Fifth Edition Incorporation of the Occupational Therapy Practice Framework Domain and Process Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom this includes access to supplemental website worksheets learning activities and scenario based videos to practice the documentation process

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

Pedretti's Occupational Therapy - E-Book Heidi McHugh Pendleton, Winifred Schultz-Krohn, 2024-03-25 2025
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practical clinical decision making approach and applies this framework to all aspects of documentation This text emphasizes how the common and standard language of the Guide to Physical Therapist Practice and the International Classification of Functioning Disability and Health ICF model can be integrated with a physical therapist s clinical reasoning process and a physical therapist assistant s skill set to produce successful documentation Includes content on documentation formations Initial Evaluations Re examination Notes Daily Notes Conclusion of the Episode of Care Summaries Home Exercise Program Reviews all the important issues related to style types of documentation and utilization of documentation Covers documentation relevant in different settings inpatient home health skilled nursing facility outpatient Helps students learn how to report findings and demonstrate an appropriate interpretation of results Includes up to date information in line with APTA Guidelines for Defensible Documentation World Health Organization International Classification of Functioning Disability and Health Mode and Medicare Reviews electronic documentation ICD 9 ICD 10 and CPT codes Includes important chapters on Interprofessional Communication Legal Aspects Principles of Measurement Physical Therapy Documentation Mia Erickson,Ralph Utzman,Rebecca McKnight,2024-06-01 Newly updated and revised Physical Therapy Documentation From Examination to Outcome Third Edition provides physical therapy students educators and clinicians with essential information on documentation for contemporary physical therapy practice Complete and accurate documentation is one of the most essential skills for physical therapists In this text authors Mia L Erickson Rebecca McKnight and Ralph Utzman teach the knowledge and skills necessary for correct documentation of physical therapy services provide guidance for readers in their ethical responsibility to quality record keeping and deliver the mechanics of note writing in a friendly approachable tone Featuring the most up to date information on proper documentation and using the International Classification of Functioning Disabilities and Health ICF model as a foundation for terminology the Third Edition includes expanded examples across a variety of practice settings as well as new chapters on Health informatics Electronic medical records Rules governing paper and electronic records Billing coding and outcomes measures Included with the text are online supplemental materials for faculty use in the classroom An invaluable reference in keeping with basic documentation structure Physical Therapy Documentation From Examination to Outcome Third Edition is a necessity for both new and seasoned physical therapy practitioners Developing Clinical Indicators for Needed Skilled Nursing Facility Care Robert Schmitz,2001 **"Code of Massachusetts regulations, 2005"** ,2005 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 **"Code of Massachusetts regulations, 2010"** ,2010 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 **"Code of Massachusetts regulations, 2009"** ,2009 Archival snapshot of entire looseleaf Code of Massachusetts Regulations held by the Social Law Library of Massachusetts as of January 2020 **"Code of Massachusetts regulations, 2011"** ,2011 Archival snapshot of entire looseleaf Code of

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Social Law Library of Massachusetts as of January 2020 Compilation of Federal Requirements for Skilled Nursing Home Facilities United States,United States. Medical Services Administration,1971

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