

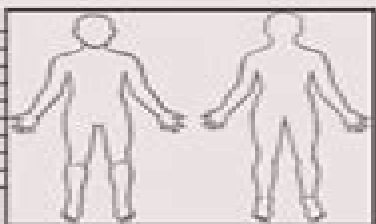
Skilled Nursing Note

☐ 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 "/")

CARDIOVASCULAR	RESPIRATORY	PAIN	SKIN																																								
☐ WNL ☐ Edema (Specify) _____ ☐ RUE ☐ LUE ☐ RUE ☐ LLE ☐ G2/G4+ ☐ Pitting ☐ Non-pitting ☐ Other: _____	☐ WNL ☐ Dyspnea/SOB ☐ Cough/Sputum _____ ☐ Other: _____	☐ None ☐ Location: _____ Severity 0-10: _____ ☐ Other: _____	☐ 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>Penetration</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Odor</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> ☐ Steel strips ☐ Sutures ☐ Staples ☐ JP drain ☐ IV line Type: _____		#1	#2	#3	Length				Width				Depth				Drainage				Penetration				Odor				Scar tissue				Wound bed				Stitches			
	#1	#2	#3																																								
Length																																											
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Penetration																																											
Odor																																											
Scar tissue																																											
Wound bed																																											
Stitches																																											
EMOTIONAL STATUS ☐ WNL ☐ Disoriented ☐ Fearful ☐ Depressed ☐ Other: _____	GENITOURINARY ☐ WNL ☐ Incontinence ☐ Catheter/Wire ☐ Hematuria ☐ Other: _____	DIGESTIVE ☐ WNL ☐ Nausea/Vomiting ☐ Difficulty Swallowing ☐ Diarrhea/Constipation ☐ Colostomy ☐ Incontinence ☐ Last BM: _____																																									
NEUROSENSORY ☐ WNL ☐ Syncope/Vertigo ☐ Visual Impairment ☐ Other: _____	MUSCULOSKELETAL ☐ WNL ☐ ROM ☐ RUE LUE RUE LLE ☐ Unsteady gait ☐ Generalized weakness ☐ Other: _____	SAFETY CONCERNS: ☐ Clear pathways/cable ambulation ☐ Fall precautions ☐ Home safety ☐ Medication management ☐ IV safety ☐ Sharps disposal ☐ Oxygen safety ☐ Bleeding precautions ☐ Infection control ☐ Other: _____																																									
SUPERVISORY VISIT: Follows Std Precautions ☐ Yes ☐ No Follows Plan of Care ☐ Yes ☐ No Performs Case Properly ☐ Yes ☐ No Patient satisfied ☐ Yes ☐ No HHA Present ☐ Yes ☐ No Functional Needs (Circle): ☐ Bathing ☐ Grooming ☐ Dressing ☐ Eating ☐ Transferring ☐ Patient/Client Independent in ADLs (Circle)																																											

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/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
☐ 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 _____ 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: _____ ☐ POC 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 /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 POC 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: _____ Rvnd 11/12

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Christine Henshaw, Renee Rassilyer

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Table of Contents Skilled Nursing Progress Note

1. Understanding the eBook Skilled Nursing Progress Note
 - The Rise of Digital Reading Skilled Nursing Progress Note
 - Advantages of eBooks Over Traditional Books
2. Identifying Skilled Nursing Progress Note
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Skilled Nursing Progress Note
 - User-Friendly Interface
4. Exploring eBook Recommendations from Skilled Nursing Progress Note
 - Personalized Recommendations
 - Skilled Nursing Progress Note User Reviews and Ratings
 - Skilled Nursing Progress Note and Bestseller Lists
5. Accessing Skilled Nursing Progress Note Free and Paid eBooks

- Skilled Nursing Progress Note Public Domain eBooks
- Skilled Nursing Progress Note eBook Subscription Services
- Skilled Nursing Progress Note Budget-Friendly Options
- 6. Navigating Skilled Nursing Progress Note eBook Formats
 - ePub, PDF, MOBI, and More
 - Skilled Nursing Progress Note Compatibility with Devices
 - Skilled Nursing Progress Note Enhanced eBook Features
- 7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Skilled Nursing Progress Note
 - Highlighting and Note-Taking Skilled Nursing Progress Note
 - Interactive Elements Skilled Nursing Progress Note
- 8. Staying Engaged with Skilled Nursing Progress Note
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Skilled Nursing Progress Note
- 9. Balancing eBooks and Physical Books Skilled Nursing Progress Note
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Skilled Nursing Progress Note
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Skilled Nursing Progress Note
 - Setting Reading Goals Skilled Nursing Progress Note
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Skilled Nursing Progress Note
 - Fact-Checking eBook Content of Skilled Nursing Progress Note
 - Distinguishing Credible Sources
- 13. Promoting Lifelong Learning
 - Utilizing eBooks for Skill Development

- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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