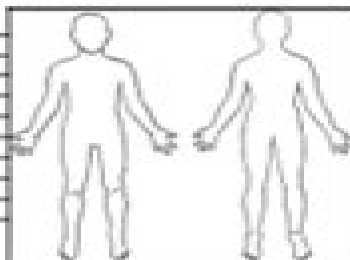


# Skilled Nursing Note

☐ Initial Assessment ☐ Follow up visit ☐ Supervisory visit

Name of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

<b>Vital Signs</b> Ht: _____ Wt: _____ Temp: _____ Pulse: A/R: _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular Resp: _____ B/P: _____ <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Right <input type="checkbox"/> Left																																											
<i>Nursing assessment and observation of signs/symptoms (Mark all applicable with an "X" or circle number separated by "Y")</i>																																											
<b>CARDIOVASCULAR</b> <input type="checkbox"/> WNL <input type="checkbox"/> Edema (Specify): _____ <input type="checkbox"/> R/L: <input type="checkbox"/> L/L: <input type="checkbox"/> R/L: <input type="checkbox"/> L/L: <input type="checkbox"/> M/D/A: <input type="checkbox"/> Flitting <input type="checkbox"/> Non-flitting <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>PAEN</b> <input type="checkbox"/> None <input type="checkbox"/> Location: _____ Severity (0-10): _____ 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>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> <input type="checkbox"/> Steri-strips <input type="checkbox"/> Sutures <input type="checkbox"/> Staples <input type="checkbox"/> JP drain <input type="checkbox"/> IV line Type: _____		#1	#2	#3	Length				Width				Depth				Drainage				Tissue/ing				Odor				Nat tissue				Wound bed				Stoma			
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<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/Stra <input type="checkbox"/> Hematuria <input type="checkbox"/> Other: _____	<b>DEGESTIVE</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>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 LUE <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Other: _____	<b>SAFETY CONCERNS:</b> <input type="checkbox"/> Clear pathways/hall 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 VISITS:</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 Care 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>Personal Needs (Circle):</b> <input type="checkbox"/> Bathing <input type="checkbox"/> Dressing <input type="checkbox"/> Eating <input type="checkbox"/> Grooming <input type="checkbox"/> Hygiene <input type="checkbox"/> Transferring <input type="checkbox"/> Patient/line independent in ADLs/IADLs																																											
<b>Reason for Visit:</b> <input type="checkbox"/> Assessment <input type="checkbox"/> Teaching/training <input type="checkbox"/> Wound care <input type="checkbox"/> IV Therapy <input type="checkbox"/> Lab draw <input type="checkbox"/> HHA/Companion services <input type="checkbox"/> PT/OT/ST/MSW services <input type="checkbox"/> Medication management <input type="checkbox"/> Other: _____ Recent history pertinent to reason for visit: _____ <input type="checkbox"/> Patient is homebound Why? _____																																											
<b>Interventions/Instructions:</b> Teaching/training re: <input type="checkbox"/> Medication regimen, actions, side effects <input type="checkbox"/> Disease process <input type="checkbox"/> Bleeding precautions <input type="checkbox"/> Wound/infection care <input type="checkbox"/> IV therapy <input type="checkbox"/> Infection control measures <input type="checkbox"/> Complications to report <input type="checkbox"/> Physician follow up <input type="checkbox"/> Home safety <input type="checkbox"/> Oxygen safety <input type="checkbox"/> Diet <input type="checkbox"/> Elevating legs to decrease edema <input type="checkbox"/> Off loading techniques <input type="checkbox"/> Sharps disposal <input type="checkbox"/> Plan of care review <input type="checkbox"/> Medication management <input type="checkbox"/> Inability to void post foley removal <input type="checkbox"/> Discharge instructions																																											
<b>Wound Care Performed:</b> <input type="checkbox"/> Aseptic technique <input type="checkbox"/> Sterile technique <input type="checkbox"/> Cleansed with NS <input type="checkbox"/> Cleansed with: _____ Product applied: _____ Covered with: <input type="checkbox"/> Gauze <input type="checkbox"/> ABD pad <input type="checkbox"/> Telfa <input type="checkbox"/> Packed: _____ <input type="checkbox"/> Wet to dry-NS <input type="checkbox"/> Secured with tape/face wrap/stockinette <input type="checkbox"/> Wound vac applied with <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Silver foam <input type="checkbox"/> Canister changed <input type="checkbox"/> Constant suction <input type="checkbox"/> Intermittent suction <input type="checkbox"/> Pressure: _____ mmHg <input type="checkbox"/> Approx. drainage in canister: _____ mLs Color: _____																																											
<b>IV Therapy:</b> Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes Flushed line: <input type="checkbox"/> NS _____ mLs <input type="checkbox"/> Before <input type="checkbox"/> After med/blood draw <input type="checkbox"/> Final flush with Heparin _____ mLs Peripheral IV inserted (site): _____ using (catheter): _____ Site prepped with <input type="checkbox"/> alcohol <input type="checkbox"/> betadine <input type="checkbox"/> chloraprep _____ line dressing changed on using sterile technique <input type="checkbox"/> 3 alcohol swabs <input type="checkbox"/> 3 providone swabs <input type="checkbox"/> chloraprep swab <input type="checkbox"/> antimicrobial patch Applied <input type="checkbox"/> Occlusive dressing <input type="checkbox"/> Gauze dressing <input type="checkbox"/> Extension set <input type="checkbox"/> Injection site <input type="checkbox"/> Site free of complications <input type="checkbox"/> Flushes easily <input type="checkbox"/> Good blood return <input type="checkbox"/> Line removed (type) _____ Length _____ cm <input type="checkbox"/> Tip intact <input type="checkbox"/> Pressure dressing applied <input type="checkbox"/> Lab draw of: _____ from (site): _____ Taken to (Lab name): _____ <input type="checkbox"/> Administered: _____ <input type="checkbox"/> IM <input type="checkbox"/> SQ Site: _____ <input type="checkbox"/> Pq/CG taught to administer: _____																																											

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## **Table of Contents Skilled Nursing Documentation Sheet**

1. Understanding the eBook Skilled Nursing Documentation Sheet
  - The Rise of Digital Reading Skilled Nursing Documentation Sheet
  - Advantages of eBooks Over Traditional Books
2. Identifying Skilled Nursing Documentation Sheet
  - 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 Documentation Sheet
  - User-Friendly Interface
4. Exploring eBook Recommendations from Skilled Nursing Documentation Sheet

- Personalized Recommendations
- Skilled Nursing Documentation Sheet User Reviews and Ratings
- Skilled Nursing Documentation Sheet and Bestseller Lists
- 5. Accessing Skilled Nursing Documentation Sheet Free and Paid eBooks
  - Skilled Nursing Documentation Sheet Public Domain eBooks
  - Skilled Nursing Documentation Sheet eBook Subscription Services
  - Skilled Nursing Documentation Sheet Budget-Friendly Options
- 6. Navigating Skilled Nursing Documentation Sheet eBook Formats
  - ePub, PDF, MOBI, and More
  - Skilled Nursing Documentation Sheet Compatibility with Devices
  - Skilled Nursing Documentation Sheet Enhanced eBook Features
- 7. Enhancing Your Reading Experience
  - Adjustable Fonts and Text Sizes of Skilled Nursing Documentation Sheet
  - Highlighting and Note-Taking Skilled Nursing Documentation Sheet
  - Interactive Elements Skilled Nursing Documentation Sheet
- 8. Staying Engaged with Skilled Nursing Documentation Sheet
  - Joining Online Reading Communities
  - Participating in Virtual Book Clubs
  - Following Authors and Publishers Skilled Nursing Documentation Sheet
- 9. Balancing eBooks and Physical Books Skilled Nursing Documentation Sheet
  - Benefits of a Digital Library
  - Creating a Diverse Reading Collection Skilled Nursing Documentation Sheet
- 10. Overcoming Reading Challenges
  - Dealing with Digital Eye Strain
  - Minimizing Distractions
  - Managing Screen Time
- 11. Cultivating a Reading Routine Skilled Nursing Documentation Sheet
  - Setting Reading Goals Skilled Nursing Documentation Sheet
  - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Skilled Nursing Documentation Sheet

- Fact-Checking eBook Content of Skilled Nursing Documentation Sheet
- 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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