

Date: \_\_\_\_\_

**SKILLED DAILY NURSES NOTE**

**DIRECTIONS:** ✓ all applicable items each shift. Enter code where directed. Record additional notes on reverse side, including date, time, signature and title of nurse for corresponding shift. For 12 hour shifts, do not record in "E" boxes. Draw a line through those boxes.

Date Skilled Stay Began: \_\_\_\_\_ Primary Diagnosis for Skilled Stay (I0020B): \_\_\_\_\_

Vital Signs											
D: T _____ P _____ R _____ B/P _____			E: T _____ P _____ R _____ B/P _____			N: T _____ P _____ R _____ B/P _____					
<b>Hearing/Speech/Vision</b>			<b>Behavior</b>			<b>Functional Abilities (Cont'd.)</b>			<b>GI (Cont'd.)</b>		
No Problems Observed			No Problems Observed			1 step (curb)			Holding food in mouth/ residual food in mouth after meals		
Unable to Hear			Hallucinations			4 steps					
Hearing Aid: Rt ear			Delusions			12 steps			Coughing/choking during meals or swallowing meds		
Lt ear			Inappropriate Physical Behaviors (hitting, kicking, scratching, pushing)			Picking up object			Pain or difficulty swallowing		
Unable to Speak						Wheel 50 feet w/2 turns					
Unclear Speech						Wheel 150 feet					
Unable to Make Self Understood			Inappropriate Verbal Behaviors (screaming, cursing, threatening)			<b>Bowel &amp; Bladder</b>			<b>Pain</b>		
Unable to Comprehend						No Problems Observed			No Complaints of Pain		
Unable to See			Inappropriate Sexual Behaviors			Catheter, Type:			Origin:		
Corrective Lenses						○ Indwelling ○ External			Location:		
<b>Cognitive Patterns</b>			Inappropriate Social Behaviors (throwing food)			Intermittent Catheterization			Intensity (0-10):		
Alert/Oriented x 3						Scheduled Toileting Program			Scheduled Pain Med Regimen		
Disoriented:			Wandering			Bladder Training Program			PRN Pain Meds Received		
Person			Rejects Care			Prompted Voiding			PRN Pain Meds Offered and Declined		
Place			Intrudes on Privacy of Others			Burning			Non-medication Pain Interventions Provided		
Time			Disrupts Care/Living Environment			Distention/Retention			Pain Effects Sleep		
Long-term Memory: Able to Recall Long Past			Puts Others at Risk for Injury			Frequency/Urgency			Pain Interferes with Therapies		
Short-term Memory: Able to Recall After 5 Minutes			Change in Behavior			Hematuria			Pain Interferes with Daily Activities		
Acute Onset Mental Status Change (Delirium)			<b>Functional Abilities</b>			Discharge			<b>Cardiovascular</b>		
Able to Make Decisions			<b>CODE 1: SELF-PERFORMANCE</b>			Bladder Incontinence			No Problems Observed		
Inattention			01. Dependent 07. Resident refused			Urine			Regular Rhythm		
Disorganized Thinking			02. Substantial/ 09. Not applicable			Color:			Radial/Apical Irregular		
Vigilant			03. Partial/moderate 10. Not attempted due to			Consistency:			Capillary Refill Sluggish		
Lethargic			04. Supervision or 88. Not attempted due to			Odor:			Neck Vein Distention		
Stuporous			05. Setup or 06. Independent			Dialysis			Chest Pain		
Comatose						Briefs/Pads Utilized			Edema		
Persistent Vegetative State						Bowel Incontinence			Dependent		
<b>Mood</b>						Ostomy, Type:			Pedal: <input type="checkbox"/> Lt <input type="checkbox"/> Rt		
No Mood Issues Observed			Eating			Diarrhea			Pitting: +1 <input type="checkbox"/> Lt <input type="checkbox"/> Rt		
Little Interest/Pleasure in Doing Things			Oral hygiene			Constipation/Impaction			+2 <input type="checkbox"/> Lt <input type="checkbox"/> Rt		
Depressed/Hopeless			Toileting hygiene			Bowel Sounds:			+3 <input type="checkbox"/> Lt <input type="checkbox"/> Rt		
Abnormal Sleep Patterns			Shower/Bathe self			Present			+4 <input type="checkbox"/> Lt <input type="checkbox"/> Rt		
Tired/Little Energy			Upper body dressing			Absent			Abn. Peripheral Pulses <input type="checkbox"/> Lt <input type="checkbox"/> Rt		
Poor Appetite			Lower body dressing			Hyperactive			Change in Vital Signs		
Overeating			Put on/take off footwear			Hypoactive			Abnormal Heart Sounds/ Murmur Present		
Feeling Bad About Self			Personal hygiene			Bowel Training Program			Dizziness When Standing		
Trouble Concentrating			Roll left and right			No Problems Observed			Increased Fatigue		
Restless/Fidgety/Anxious			Sit to lying			Nausea			Increased Weight		
Self-deprivation/Suicidal Thoughts			Lying to sitting on side of bed			Vomiting			<b>Respiratory</b>		
Short-tempered/Easily Annoyed			Sit to stand			Epigastric Distress			No Problems Observed		
			Chair/bed to chair transfer			Difficulty Swallowing			Labored Breathing		
			Toilet transfer			Difficulty Chewing			Shallow Respirations		
			Tub/Shower transfer			Mouth Pain			Rales/Rhonchi		
			Car transfer			Poor Fitting Denture/Partial			Wheezing		
			Walk 10 feet			Abnormal Mouth/Gum Tissue					
			Walk 50 feet w/2 turns			Edentulous					
			Walk 150 feet			Abdominal Distension					
			Walk 10 feet on uneven surfaces			Loss of liquids/solids from mouth-eating or drinking					

Signature/  
Title:

D:

E:

N:

NAME-Last

First

Middle

Attending Physician

Record No.

Room/Bed

[illegible]