HOSPICE NURSING VISIT/ ASSESSMENT UPDATE

DATE:_____ **TIME IN:**_____ **OUT:**_____

TYPE OF VISIT: ❍ **SN** ❍ **SN & Supervisory** ❍ **Supervisory only** ❍ **Other**_____

VITAL SIGNS

Temperature:_____

❍ Oral ❍ Axillary ❍ Tympanic ❍ Rectal ❍ Temporal/Forehead

Pulse:_____ ❑ Apical ❑ Radial ❑ Brachial

Respirations:_____

❍ Regular ❍ Irregular ❑ Cheyne Stokes ❑ Apnea ____ seconds

Blood Pressure: Right_____ ❍ Lying ❍ Sitting ❍ Standing

Left_____ ❍ Lying ❍ Sitting ❍ Standing

Level of Consciousness: ❍ Alert ❍ Lethargic ❍ Unresponsive

❍ Reacts to painful stimuli ❍ Other:_____

Weight: Actual weight today: _____kg/lbs. BMI_____

If unable to obtain weight, mid-arm circumference _____cm

PAIN

Is pain an active problem?

❍ Yes ❍ No

Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

❍ Yes ❍ No

Non-verbals demonstrated: ❑ Diaphoresis ❑ Grimacing

❑ Moaning/Crying ❑ Guarding ❑ Irritability ❑ Anger ❑ Tense

❑ Restlessness ❑ Change in vital signs ❑ Other:_____

Pain Location (site(s) specify):_____

_____

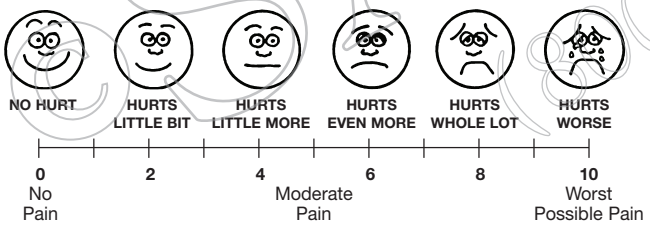
_____

_____

_____

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale



**From Wong D.L., Hockenberry-Eaton M., Wilson D., Winkelstein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.

Collected using: ❍ **FACES Scale** ❍ **0-10 Scale (subjective reporting)**

Present level of pain_____ Worst pain gets_____ Best pain gets_____

Acceptable level of pain_____

Type: ❑ Aching ❑ Nagging ❑ Dull ❑ Heavy ❑ Crushing

❑ Sharp ❑ Stabbing ❑ Throbbing ❑ Radiating ❑ Burning

❑ Tingling ❑ Cramping ❑ Other:_____

What makes pain worse? ❑ Movement ❑ Ambulation

❑ Other:_____

PAIN (Cont'd.)

What makes pain better? ❑ Heat ❑ Ice ❑ Massage ❑ Repositioning

❑ Rest ❑ Relaxation ❑ Medication ❑ Diversion

❑ Other:_____

How often is breakthrough medication needed?

❍ Never ❍ Less than daily ❍ 2-3 times/day

❍ Greater than 3 times/day

Current pain control medications adequate? ❍ Yes ❍ No

❑ Intervention/Instructions:_____

_____

_____

_____

_____

_____

SLEEP/REST

Patient usually sleeps: ❍ Less than 4 hours ❍ 5-12 hours

❍ 13-15 hours ❍ 16-18 hours ❍ 19-21 hours ❍ > 22 hours

Comments:_____

_____

_____

_____

_____

_____

Caregiver rest adequate: ❍ Yes ❍ No

MEDICATION

(New or changed since last visit) ❍ None ❍ Update Medication Profile

Drug_____

Dosage/frequency _____

Effective ❍ Yes ❍ No ❍ Other:_____

Drug_____

Dosage/frequency _____

Effective ❍ Yes ❍ No ❍ Other:_____

Drug_____

Dosage/frequency _____

Effective ❍ Yes ❍ No ❍ Other:_____

Instructed on:

❑ Safe use and disposal of medications

❑ S/S allergic reaction ❑ S/E contraindications

❑ Drug/food interactions ❑ Ample supply

❑ Drug/drug interactions ❍ Hospice

❑ Expiration dates ❍ Family/caregiver

❑ Prescription refill by _____ ❑ Proper disposal of sharps

❑ Missed dose/what to do ❑ Duration of therapy

❑ Pill count (if applicable) _____ ❑ Other:_____

❑ Administered by: ❑ Self ❑ RN ❑ Caregiver ❑ Family

❑ Other:_____

PATIENT NAME – Last, First, Middle Initial	ID#

SKIN

Color: ❑ Cyanotic ❑ Tanned ❑ Ashen ❑ Jaundiced ❑ Pale ❑ Flushed

Temperature: ❑ Cool ❑ Cold ❑ Warm ❑ Hot

❑ Other:_____

Turgor: ❍ Good ❍ Fair ❍ Poor

Condition: ❑ Itching ❑ Rash ❑ Ecchymosis ❑ Hematoma ❑ Petechiae ❑ Diaphoretic ❑ Tumor

❑ Other:_____

Eyes (Sclera): ❑ White ❑ Red ❑ Injected ❑ Jaundiced ❑ Pale

❑ Other:_____

Mucous Membranes: ❍ Moist ❍ Dry ❍ Pink ❍ Pallor

❑ Other:_____

Additional comments:_____

CARDIOPULMONARY

Breath Sounds:
(Clear, crackles/rales, wheezes/rhonchi, diminished, absent)

Anterior:
Right _____
Left _____

Posterior:
Right Upper _____
Right Lower _____
Left Upper _____
Left Lower _____

❑ Other:_____

Does this patient have a trach? ❍ Yes ❍ No

Who manages? ❑ Self ❑ RN ❑ Caregiver ❑ Family

Intermittent treatments (C&DB, medicated inhalation treatments, etc.)

❍ No

❍ Yes, explain:_____

❑ **Cough:** ❍ No

❍ Yes: ❍ Productive ❍ Non-productive

Describe:_____

❍ Able ❍ Unable to cough up secretions

Suction: ❍ Yes ❍ No

❑ **Dyspnea:**

No SOB ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10 Worst Possible SOB

Best SOB gets:_____ Worst SOB gets:_____

Comments:_____

Positioning necessary for improved breathing:

❍ No

❍ Yes, describe:_____

CARDIOPULMONARY (Cont'd.)

When is the patient dyspneic or noticeably **Short of Breath?**

❍ Never, patient is not short of breath

❍ When walking more than 20 feet, climbing stairs

❍ With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)

❍ With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation

❍ At rest (during day or night)

❍ **Assessed** ❍ **Reported**

Additional comments:_____

Respiratory Status: ❑ Accessory muscles used ❑ Death rattle

❑ Cheyne Stokes ❑ Orthopnea ❑ Stridor/retractions

❑ Dyspnea: ❍ At rest ❍ With exertion/activity

❑ Periods of apnea _____ seconds ❑ O_2 saturation _____%

❑ O_2 _____LPM ❍ PRN ❍ Continuous

Cardiac Status:

Heart Sounds: ❍ Normal ❍ Regular ❍ Irregular ❍ Murmur

❑ Fatigued ❑ Edema ❑ Pedal: ❍ R ❍ L ❑ Dependent ❑ Sacral

❑ Pitting Left ❍ +1 ❍ +2 ❍ +3 ❍ +4

❑ Pitting Right ❍ +1 ❍ +2 ❍ +3 ❍ +4

❑ Non-pitting site:_____

❑ Cramps/claudication

Capillary refill: ❍ Greater than 3 seconds ❍ Less than 3 seconds

❑ Intervention/Instructions:_____

MENTAL/NEUROLOGICAL

Mental Status: ❑ **No Problem**

Alert/Oriented to: ❑ Person ❑ Place ❑ Time

Not Tired ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10 Worst Possible Tiredness

Patient is (check all that apply):

❑ Comatose ❑ Forgetful ❑ Depressed ❑ Disoriented

❑ Lethargic ❑ Agitated ❑ Other:_____

Comments:_____

Neuro Status: ❑ **No Problem**

❑ Sedated ❑ Non-verbal

❑ Speech: ❍ Clear ❍ Garbled

❑ Aphasia: ❍ Receptive ❍ Expressive

❑ Nuchal rigidity

Grips: ❍ Equal ❍ Unequal ❑ Strong: ❑ R ❑ L ❑ Weak: ❑ R ❑ L

Pupils: ❑ PERRLA ❑ Sluggish ❑ Dilated ❑ Constricted/nonreactive

Other neurological problems such as tremors, seizures, paralysis (explain)_____

PATIENT NAME – Last, First, Middle Initial	ID#

NUTRITION

Diet: _____

_____

Appetite: ❍ Good ❍ Fair ❍ Poor ❍ NPO

Best Appetite ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10 Worst Possible Appetite

❑ Anorexia ❑ Nausea ❑ Vomiting ❑ Hematemesis ❑ Dysphagia
❑ Heartburn ❑ Reflux

Not Nauseated ❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5 ❍ 6 ❍ 7 ❍ 8 ❍ 9 ❍ 10 Worst Possible Nausea

❑ Patient ❑ Caregiver ❑ Family concerns about nutrition (explain)

_____
_____
_____
_____
_____
_____
_____

❑ Assistance required with meals ❑ Small frequent meals
❑ Chewing difficulties ❑ Swallowing difficulties
❑ Swallowing precautions/aids (e.g. thickened liquids)_____

_____
_____

❑ Pureed foods
❑ Enteral support ❑ Supplements_____
❑ Intervention/Instructions:_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Fluid Restriction: ❍ No ❍ Yes
If yes, amount in 24 hours: _____

ENDOCRINE

❑ **No Endocrine Issues**
❑ Diabetes Mellitus: ❍ Type 1 ❍ Type 2
❑ Blood sugar range_____
❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia
❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor
❑ Drug/Insulin changes (specify): _____

_____
❑ Intervention/Instructions:_____

_____
_____
_____
_____
_____
_____
_____

ELIMINATION

Urinary

Patient is experiencing (check all that apply):
❑ Urgency ❑ Frequency ❑ Burning ❑ Pain ❑ Hesitancy
❑ Nocturia ❑ Oliguria ❑ Anuria ❑ Retention
❑ Incontinence Frequency _____ ❑ Diapers ❑ Chux
❑ **No Urinary Elimination Issues**
Color: ❍ Yellow ❍ Straw ❍ Amber ❍ Brown
❍ Blood-tinged ❍ Other:_____
Clarity: ❑ Clear ❑ Cloudy ❑ Sediment ❑ Mucous
Odor: ❍ Yes ❍ No
Urinary Catheter: Type (specify)_____ French_____
Balloon inflated_____mL sterile water Date inserted_____
Date changed_____ ❑ No problem ❑ Other: _____
Foley/Irrigation type (specify) _____
Amt_____mL Frequency_____
Returns_____ ❑ Patient tolerated procedure well ❍ Yes ❍ No
❑ Intervention/Instructions:_____

_____
_____
_____
_____
_____

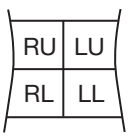
Bowel

Patient is experiencing (check all that apply):
❑ Flatulence ❑ Constipation ❑ Impaction ❑ Diarrhea
❑ Rectal bleeding ❑ Hemorrhoids
❑ Frequency of stools_____ Last BM_____
Bowel regime/program _____
❑ Laxative use: ❍ Daily ❍ Weekly ❍ Monthly ❍ PRN
❑ Enema use: ❍ Daily ❍ Weekly ❍ Monthly ❍ PRN
❑ Other: _____
❑ Incontinence Frequency _____ ❑ Diapers ❑ Chux
❑ Ileostomy ❑ Colostomy site (describe skin around stoma):

_____
_____
❑ Other_____ site (describe skin around stoma):

_____
❑ **No Bowel Elimination Issues**
Abdomen: ❑ **No Problem**
Patient is experiencing:
❑ Tenderness ❑ Pain ❑ Distention ❑ Ascites
❑ Notes:_____
NG/Enteral tube (type/size)_____

_____
❑ Bowel Sounds: Active_____
Absent_____
Hypoactive_____
Hyperactive_____



❑ Intervention/Instructions:_____

_____
_____
_____
_____

PATIENT NAME – Last, First, Middle Initial | ID#

SELF CARE DEFICIT/MOBILITY

Gait: ❍ Steady ❍ Unsteady

Patient is experiencing (check all that apply): ❑ Weakness

❑ Limited mobility/ROM ❑ Contractures ❑ Paralysis

Assistive devices needed: ❑ Walker ❑ Cane ❑ Crutches ❑ Wheechair

❑ Chairfast ❑ Bedfast ❑ Other: _____

❑ **ADL's:** ❍ Independent ❍ Needs minimal assistance

❍ Needs maximum assistance ❍ Dependent

Comments: _____

_____

Activity Level: ❑ Up as tolerated ❑ Transfer bed ❑ Chair ❑ Bedbound

Comments: _____

_____

Recent Fall: ❍ No ❍ Yes #_____

Describe: _____

_____

_____

❑ Referral/offered the following: ❑ Aide services ❑ Volunteers

❍ Accepted ❍ Refused ❑ Other: _____

❑ Instructed on safety with changes: _____

_____

_____

COPING/COMMUNICATION

Patient is experiencing (check all that apply):

	Least										Most
❑ Anxiety	❍ 0	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10
❑ Agitated	❍ 0	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10
❑ Depressed	❍ 0	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10
❑ Forgetful/ Confused	❍ 0	❍ 1	❍ 2	❍ 3	❍ 4	❍ 5	❍ 6	❍ 7	❍ 8	❍ 9	❍ 10

❑ Affect: ❍ Appropriate ❍ Flat ❍ Dull ❍ Other: _____

❑ Abnormal behavior (explain): _____

_____

_____

_____

❑ Communication: ❍ Effective ❍ Non-effective

Explain: _____

_____

_____

_____

❑ Patient ❑ Caregiver ❑ Family is coping/adjusting: ❍ No ❍ Yes

Explain: _____

_____

_____

_____

❑ Patient ❑ Caregiver ❑ Family educated on the following Hospice/ Community Resources: _____

_____

_____

_____

❑ Patient ❑ Caregiver ❑ Family stressed/overloaded: ❍ No ❍ Yes

Explain: _____

_____

_____

❑ Intervention/Instructions: _____

_____

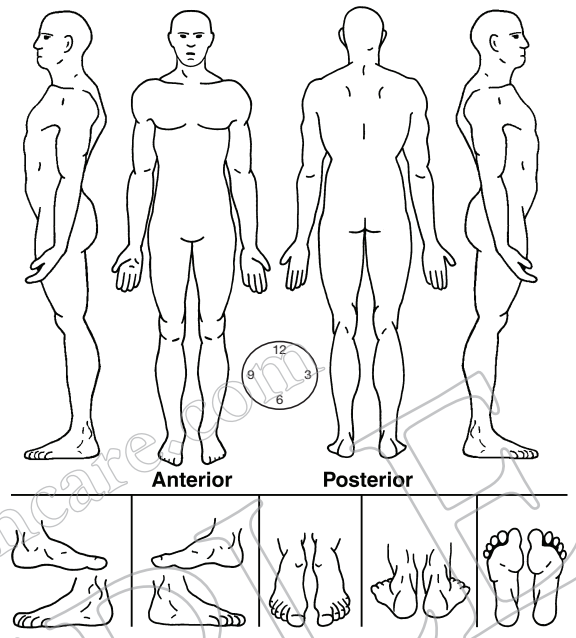
_____

_____

INTEGUMENTARY STATUS

❑ **N/A** – No wounds needing assessment or intervention by Hospice.

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart.



Wound Care Provided:

❑ Soiled dressing removed/disposed of properly

❑ Wound cleaned (specify) _____

_____

❑ Wound irrigated (specify) _____

_____

❑ Wound debridement (specify) _____

❑ Drainage collection container emptied: Volume _____

CONDITION	#1	#2	#3	#4
Type of Wound				
Size (cm) (LxWxD)				
Stage				
Tunneling/ Undermining				
Odor				
Surrounding Skin				
Edema				
Stoma				
Appearance of the Wound Bed				
Drainage/Amount	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large	❍ None ❍ Small ❍ Moderate ❍ Large
Color	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other	❍ Clear ❍ Tan ❍ Serosanguineous ❍ Other
Consistency	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick	❍ Thin ❍ Thick

PATIENT NAME – Last, First, Middle Initial	ID#

INTEGUMENTARY STATUS (Cont'd.)

❑ Patient tolerated procedure well: ❍ Yes ❍ No
❑ Medicated prior to wound care
❑ Wound care ❑ Dressing change performed by:
❑ Self ❑ RN ❑ Caregiver ❑ Family ❑ Other:_____
❑ Patient ❑ Caregiver ❑ Family ❑ Instructed on wound care
❑ Instructed on disposal of soiled dressing
❑ Patient ❑ Caregiver ❑ Family to perform ❑ Wound care
❑ Dressing change
❑ Other:_____

INFUSION

❑ **N/A** – No infusion therapy
Type of line: ❍ Peripheral ❍ PICC ❍ Central (type)_____
❍ Implanted port ❍ Subcutaneous
Location (specify) _____
Size (if appropriate)_____ Site (describe)_____
Catheter length _____cm Arm circumference _____cm
❑ No evidence of infection
❑ Dressing change performed by: ❑ Self ❑ Caregiver ❑ Family
❑ RN ❑ Other:_____
❑ Cap change performed by: ❑ Self ❑ Caregiver ❑ Family ❑ RN
❑ Other:_____
❑ Extension/Tubing changed by: ❑ Self ❑ Caregiver ❑ Family
❑ RN ❑ Other:_____
❑ Line flushed _____mL saline/sterile water
❑ Heparin _____unit/mL _____mL
❑ Instructed ❑ Patient ❑ Caregiver ❑ Family on infusion therapy
❑ Patient ❑ Caregiver ❑ Family ❑ demonstrates ❑ verbalizes proper management of infusion(s)
Comments:_____

Lab: ❑ None
❑ Blood drawn from _____ for _____
❑ Other:_____
Delivered to _____

AIDE SUPERVISORY VISIT (Complete if applicable)

AIDE: ❍ Present ❍ Not present
SUPERVISORY VISIT: ❍ Scheduled ❍ Unscheduled
AIDE CARE PLAN UPDATED? ❍ Yes ❍ No
CARE PROVIDED APPROPRIATE? ❍ Yes ❍ No
OBSERVATION OF: _____

TEACHING/TRAINING OF: _____

NEED FOR ADDITIONAL EQUIPMENT/SUPPLIES

❍ No ❍ Yes
(Check all that apply):
❑ Walker ❑ Wheelchair ❑ Cane/crutches
❑ Hospital bed ❑ Overbed table ❑ Bedside commode
❑ Lift chair ❑ Bath/shower bench ❑ Suction machine
❑ Nebulizer ❑ Oxygen
❑ Other supplies needed:_____

❑ Education provided: _____

SPIRITUAL/CULTURAL

❑ Using resources appropriately
❑ Declines hospice assistance at this time
❑ Chaplain/Clergy contacted: ❍ Yes ❍ No
❑ Intervention/Instructions:_____

SUMMARY CHECKLIST

CARE PLAN: ❑ Reviewed ❑ Revised with ❑ Patient ❑ Caregiver ❑ Family ❑ Reviewed with facility staff
❑ Outcome achieved ❑ PRN order obtained
Comments:_____

PLAN FOR NEXT VISIT _____

APPROXIMATE NEXT VISIT DATE _____
CARE COORDINATION: ❑ Attending Physician ❑ Medical Director
❑ RN ❑ MSW ❑ Chaplain/Clergy ❑ Aide ❑ Dietitian
❑ Therapy services ❑ Volunteer
❑ Other:_____

PATIENT NAME – Last, First, Middle Initial	ID#

INSTRUCTION

INSTRUCTION PROVIDED ON:

❑ Symptom management ❑ Disease progression ❑ Dying process ❑ Other:_____

Comments: _____

PATIENT/FAMILY/CAREGIVER RESPONSE: _____

CONCLUSION/SUMMARY OF VISIT (Include caregiver/facility participation in Plan of Care)

Symptoms controlled with current POC: _____

Symptoms needing to be further addressed by IDG: _____

Continued decline/six-month prognosis as evidenced by: _____

Clinician Signature/Title:_____ Date:_____

PATIENT NAME – Last, First, Middle Initial	ID#