COMPREHENSIVE NURSING VISIT RECORD

DATE_____ **TIME IN** _____ **TIME OUT**_____

TYPE OF VISIT: ❍ **Skilled:** ❑ Planned ❑ PRN ❍ **Skilled & Supervisory** ❍ **Supervisory Only** ❍ **Other,** specify _____

Homebound reason _____

Reason for visit _____

_____

Vital Signs: Temperature_____ ❍ Oral ❍ Axillary ❍ Tympanic ❍ Rectal Pulse_____ ❍ Radial ❍ Apical ❍ Brachial ❍ Regular ❍ Irregular

Resp_____ ❍ Reg ❍ Irreg BP: Right_____ ❍ Lying ❍ Standing ❍ Sitting Left_____ ❍ Lying ❍ Standing ❍ Sitting

Height_____ ❍ Actual ❍ Reported Weight_____ ❍ Actual ❍ Reported

Reported Weight Changes: Gain_____lb. X _____ ❍ day ❍ wk ❍ mo ❍ yr

Reported Weight Changes: Loss_____lb. X _____ ❍ day ❍ wk ❍ mo ❍ yr

NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS - Select All Applicable

CARDIOPULMONARY

Lung Sounds ❑ Clear ❑ Crackles/rales, location_____

❑ Rhonchi/wheeze, location_____

❑ Diminished ❑ Absent ❑ Other_____

Cough ❑ None ❑ Dry ❑ Acute ❑ Chronic

❍ Non-productive ❍ Productive Amount: ❍ Small ❍ Medium

❍ Large Color of secretions_____

❑ Hemoptysis frequency_____ Amount_____

❍ Able ❍ Unable to cough up secretions Suction: ❍ Yes ❍ No

Respiratory Status ❑ No problems ❑ Accessory muscles used

❑ Dyspnea: ❑ At rest ❑ With exertion/activity ❑ Orthopnea

❑ Stridor/retractions ❑ O_2 _____ LPM ❍ PRN ❍ Continuous

❑ O_2 saturation _____%

Chest Pain ❑ Denies ❑ Anginal ❑ Postural ❑ Localized

❑ Substernal ❑ Radiating ❑ Dull ❑ Aching ❑ Sharp/stabbing

❑ Viselike ❑ Other_____

Associated with: ❑ Shortness of breath ❑ Activity ❑ Rest

❑ Frequency/duration_____

Heart Sounds ❑ Normal ❑ Regular ❑ Irregular ❑ Murmur

❑ Abnormal, specify_____

Other

❑ Fatiqued ❑ Edema (specify below)

❑ Rt: ❑ Pedal ❑ Ankles ❑ Legs ❑ Lt: ❑ Pedal ❑ Ankles ❑ Legs

❑ Pitting: Rt ❍ +1 ❍ +2 ❍ +3 ❍ +4 Lt ❍ +1 ❍ +2 ❍ +3 ❍ +4

❑ Non-pitting: ❑ Right ❑ Left ❑ Dependent

❑ Cramps/claudication: ❑ Right ❑ Left

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

Comments_____

_____

_____

NEUROMUSCULAR

Grasp Right: ❍ Equal ❍ Unequal ❍ Other_____

Left: ❍ Equal ❍ Unequal ❍ Other_____

Pupils ❑ PERRLA: ❑ Right ❑ Left ❑ Both ❑ Other_____

Impairment ❑ Speech ❑ Hearing ❑ Visual

❑ Decreased sensitivity ❑ Tremors

❑ Numbness/tingling ❑ Vertigo ❑ Ataxia

❑ Fall(s) since last visit, specify_____

_____

❍ Balance WNL ❍ Unsteady gait

❑ Weakness, describe_____

❑ Change in ADL, explain_____

GASTROINTESTINAL

Appetite ❍ Good ❍ Fair ❍ Poor ❍ NPO

❑ Anorexia ❑ Nausea/vomiting ❑ Difficulty swallowing

❑ Special diet, specify_____

❑ Diet deficiency, specify_____

❑ Tube feeding, specify_____ ❍ Cont. ❍ Intermittent

Bowel Sounds ❑ Active ❑ Absent

❑ Hypoactive x ____ quadrants ❑ Hyperactive x ____ quadrants

❑ Abdominal pain ❑ Distention ❑ Flatulence

❑ Last BM_____

❑ Incontinence ❑ Diarrhea ❑ Constipation ❑ Impaction

❑ Enema administered (results)_____

❑ Patient tolerated procedure well

❑ Other_____

GENITOURINARY

Urine color:_____ ❑ Odor ❑ Burning

❑ Urgency ❑ Frequency ❑ Nocturia ❑ Oliguria ❑ Anuria

❑ Retention ❑ Incontinence

Urinary Catheter Type, specify_____ French_____

Bulb inflated_____mL sterile water Date changed_____

Irrigated with, specify _____amt _____mL

❑ Other_____

ENDOCRINE

❑ Diet/oral control, specify_____

❑ Insulin control, specify_____

Administered by: ❍ Self ❍ Caregiver ❍ Nurse

❍ Other, specify_____

❑ Hyperglycemia: ❑ Glycosuria ❑ Polyuria ❑ Polydipsia

❑ Hypoglycemia: ❑ Sweats ❑ Polyphagia ❑ Weak ❑ Faint ❑ Stupor

A1C _____% ❍ Today's visit ❍ Patient reported ❍ Lab reported

BS _____mg/dL Date_____ Time_____

❍ FBS ❍ Before meal ❍ Postprandial ❍ Random HS

❑ Blood sugar ranges_____ ❑ Patient/Caregiver Report

Monitored by: ❍ Self ❍ Caregiver ❍ Nurse

❍ Other, specify_____

Frequency of monitoring_____

Competency with use of Glucometer_____

❑ **Disease Management Problems (explain)**

_____

_____

_____

PATIENT NAME – Last, First, Middle Initial	ID#

NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS (Cont'd.)

MEDICATIONS

New or changed since last visit ❑ None ❑ Yes, Medication profile updated

Drug(s) _____

Dosage/frequency _____

Effective ❍ Yes ❍ No ❍ Other _____

❑ Orders obtained

Instructed on:

❑ Medication(s) names
❑ S/S allergic reaction
❑ Drug/food interactions
❑ Drug/drug interactions
❑ Expiration dates
❑ Missed doses/what to do
❑ Pill count (if applicable) _____
❑ S/E contraindications
❑ Ample supply
❑ Proper disposal of sharps
❑ Duration of therapy
❑ Other, specify _____
❑ Prescription refill by _____

❑ Administered by: ❍ Self ❍ Family/Caregiver ❍ Nurse
❍ Other, specify _____

❑ Medication(s) administered this visit (document in narrrative on last page)

Type of line: ❑ Peripheral ❑ PICC ❑ Central (type) _____
❑ Implanted port Location, specify _____
Site _____
Status of site _____
Catheter length _____cm Arm circumference _____cm
❍ No evidence of infection ❍ Infection present

❑ Dressing change performed by: ❍ Self ❍ Family/caregiver ❍ Nurse
❍ Other, specify _____

❑ Cap change performed by: ❍ Self ❍ Family/caregiver ❍ Nurse
❍ Other, specify _____

❑ Extension/tubing changed by: ❍ Self ❍ Family/caregiver ❍ Nurse
❍ Other, specify _____

❑ Line flushed with _____mL saline/sterile water

❑ Line flushed with _____unit/mL heparin

❑ Instructed patient/family/caregiver on infusion therapy

❑ Patient/family/caregiver demonstrates/verbalizes proper management of infusion(s)

Comments _____

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

EMOTIONAL/COGNITIVE STATUS

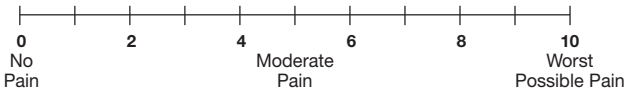
❑ Alert/oriented to person, place and time ❑ Confused
❑ Forgetful ❑ Lethargic ❑ Agitated ❑ Difficulty concentrating
❑ Feelings of helplessness/hopelessness/worthlessness
❑ Loss of interest in ADLs ❑ Loss of interest in activities ❑ Insomnia/sleep problems ❑ Trouble making decisions/coping ❑ Suicidal ideation
❑ Other, specify _____

PAIN

Pain reported by patient/caregiver: ❍ None ❍ Pain reported
❑ Pain does not interfere with movement or activities
Since last visit: ❍ Improved ❍ Worse
Origin _____
Location _____

PAIN (Cont'd.)

Intensity: 0-10_____ Type: ❍ Acute ❍ Chronic



Does patient avoid movement or activities that cause or exacerbate pain: ❍ No ❍ Yes

Relief measures _____

Is patient satisfied with the level of control without further intervention? ❍ No ❍ Yes

Comments _____

INTEGUMENTARY STATUS

❑ No problem-skin intact
Skin color: ❑ Normal for patient/ethnicity ❑ Pale ❑ Flush ❑ Jaundice
Turgor: ❍ Good ❍ Fair ❍ Poor
Temperature: ❍ Warm ❍ Hot ❍ Cool ❍ Cold
Moisture level: ❍ Dry ❍ Clammy ❍ Diaphoretic
❑ Rash, specify _____
Location _____
❑ Itchy ❑ Burning ❑ Painful ❑ Weeping

WOUND CARE PROVIDED:

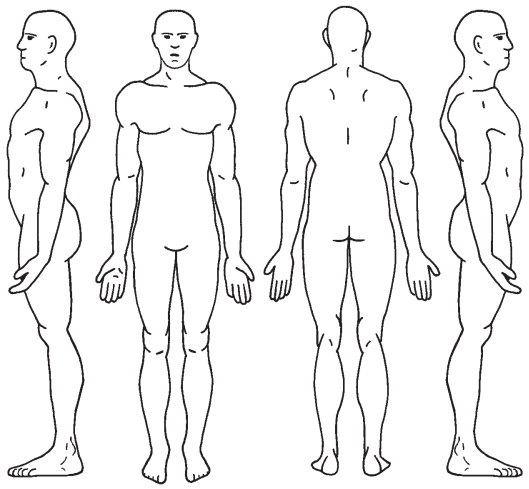
❑ Soiled dressing removed/disposed of properly
❑ Wound cleaned, specify _____
❑ Wound irrigated, specify _____
❑ Type of dressing(s) used _____
❑ Wound debridement
❑ Drainage collection container emptied, volume _____mL
❑ Patient tolerated procedure well
❑ Medicated prior to wound care
❑ Wound care/dressing change performed by: ❍ Self ❍ Nurse
❍ Family/caregiver ❍ Other, specify _____
❑ Patient/family/caregiver educated for wound care/dressing change
❑ Patient/family/caregiver instructed for disposal of soiled dressing

DIABETIC FOOT EXAM: Date of last foot exam _____
Frequency of diabetic foot exam _____
Done by: ❍ Patient ❍ Caregiver (name) _____
❍ RN/PT ❍ Other: _____
Exam by clinician this visit: ❍ Yes ❍ No
Integument findings _____
Pedal pulses: ❑ Present: ❑ Right ❑ Left ❑ Absent: ❑ Right ❑ Left
Comment _____
Loss of sense of: ❑ Warmth: ❑ Right ❑ Left ❑ Cold: ❑ Right ❑ Left
Comment _____
Neuropathy present: ❑ Right ❑ Left
Ascending calf: ❑ Right for _____cm ❑ Left for _____cm
❑ Tingling: ❑ Right ❑ Left ❑ Burning: ❑ Right ❑ Left
Leg hair: ❑ Present: ❑ Right ❑ Left ❑ Absent: ❑ Right ❑ Left

NURSING ASSESSMENT AND OBSERVATION SIGNS/SYMPTOMS (Cont'd.)

INTEGUMENTARY STATUS

Record Location / Size of Wound(s) / Pressure Injury(ies)
Measure Extremity Edema Bilaterally



WOUND/LESION (specify)	#1	#2	#3	#4
Location				
Type	❍ Press. ulcer/injury ❍ Venous stasis ulcer ❍ Arterial ❍ Mechanical ❍ Malignancy ❍ Diabetic foot ulcer	❍ Press. ulcer/injury ❍ Venous stasis ulcer ❍ Arterial ❍ Mechanical ❍ Malignancy ❍ Diabetic foot ulcer	❍ Press. ulcer/injury ❍ Venous stasis ulcer ❍ Arterial ❍ Mechanical ❍ Malignancy ❍ Diabetic foot ulcer	❍ Press. ulcer/injury ❍ Venous stasis ulcer ❍ Arterial ❍ Mechanical ❍ Malignancy ❍ Diabetic foot ulcer
Size (cm) (LxWxD)				
Tunneling/ Undermining (cm)				
Stage **(pressure ulcers/ injuries only)**				
Odor				
Surrounding skin				
Edema				
Stoma				
Appearance of 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

MUSCULOSKELETAL

❑ No problem
❑ Fracture, location_____
❑ Swollen, painful joints, specify_____
❑ Contractures: Joint_____
Location_____
❑ Atrophy_____ ❑ Poor conditioning
❑ Decreased ROM_____ ❑ Paresthesia_____
❑ Shuffling ❑ Weakness_____
❑ Wide-based gait

❑ Amputation: ❑ BK ❑ AK ❑ UE: ❑ R ❑ L
_____
_____
_____
❑ Hemiplegia: ❍ R ❍ L ❑ Paraplegia ❑ Quadriplegia
❑ Other, specify_____
_____
_____
_____

INTERVENTIONS/INSTRUCTIONS - Select All Applicable

❑ Skilled observation & assessment
❑ Foley care
❑ Urine testing
❑ Wound care
❑ Diabetic foot care
❑ Venipuncture
❑ Post-cataract surgery care
❑ Bowel training
❑ Bladder training
❑ Digital exam with manual removal
❑ Enema
❑ Chest physiology
❑ Postural drainage
❑ Change NG/G tube
❑ Administration of Vitamin B_{12}
❑ Prep/administer insulin
❑ Teach/administer IVs
❑ Teach/administer clysis
❑ Teach ostomy care
❑ Teach ileal conduit care
❑ Teach/administer tube feedings
❑ Teach/administer care of trach.
❑ Teach/administer inhalation Rx
❑ Teach care - terminally ill
❑ IM injection
❑ Psychiatric intervention
❑ Observe S/S infection
❑ Diabetic observation
❑ Teach diabetic care
❑ Observe/teach medication use
❑ Physiology/disease process teaching
❑ Observe ADLs
❑ Evaluate diet/fluid intake
❑ Diet teaching
❑ Safety factors
❑ Prenatal assessment
❑ Post-partum assessment
❑ Teach infant care
❑ Teach child care
❑ Pain management
❑ Other:_____
❑ Other:_____
❑ Other:_____
❑ Other:_____

INTERVENTIONS/INSTRUCTIONS (Cont'd.)

❑ Contacted physician or physician designee to report clinical findings
❑ Contacted physician or physician designee to request orders
❑ Revise plan of care for _____
_____
❑ Interdisciplinary communication note update
❑ Referral for _____
Reviewed/reinforced action plan for exacerbation of symptoms (e.g. when to call homecare nurse vs. seek emergent services): ❍ No ❍ Yes
Patient/caregiver appeared to understand all educational information given during this visit: ❍ No ❍ Yes
Did the patient receive the flu or pneumonia vaccine during this visit? ❍ No ❍ Yes, specify _____
Did caregiver availability change since the last visit? ❍ No ❍ Yes, specify _____

ANALYSIS/INTERVENTIONS/INSTRUCTIONS/PATIENT RESPONSE/ADDITIONAL NOTES _____

SUMMARY CHECKLIST

CARE PLAN: ❑ Reviewed ❑ Revised with patient involvement
❑ Outcome achieved ❑ PRN order obtained
PLAN FOR NEXT VISIT: _____
_____
APPROXIMATE NEXT VISIT DATE: _____
NEXT PHYSICIAN VISIT: _____
DISCHARGE PLANNING DISCUSSED? ❍ Yes ❍ No ❍ N/A
BILLABLE SUPPLIES RECORDED? ❍ Yes ❍ No ❍ N/A
CARE COORDINATION: ❑ Physician ❑ PT ❑ OT ❑ ST
❑ MSW ❑ SN ❑ Other, specify _____

AIDE SUPERVISORY VISIT (Complete if applicable)

AIDE: ❍ Present ❍ Not present
SUPERVISORY VISIT: ❍ Scheduled ❍ Unscheduled
IS PATIENT/FAMILY SATISFIED? ❍ Yes ❍ No, Explain:
_____
AIDE CARE PLAN UPDATED? ❍ Yes ❍ No
OBSERVATION OF: _____
_____
TEACHING/TRAINING OF: _____
_____
NEXT SCHEDULED SUPERVISORY VISIT: _____

SIGNATURE/DATE – Complete **TIME OUT** (on first page) prior to signing below.

Nurse (Signature and Title)_____ Date_____

Patient Signature_____ Date_____