SKILLED NURSE VISIT NOTE

Date:_____

❑ Q5001: Hospice or Home Health Care provided in patient's home/residence ❑ Q5009: Hospice or Home Health Care provided in place not otherwise specified
❑ Q5002: Hospice or Home Health Care provided in Assisted Living Facility

HOMEBOUND REASON: ❑ Needs assistance for all activities ❑ Residual weakness ❑ Requires assistance to ambulate
❑ Confusion, unable to go out of home alone ❑ Unable to safely leave home unassisted ❑ Severe SOB, SOB upon exertion
❑ Dependent upon adaptive device(s) ❑ Medical restrictions ❑ Other (specify) _____
Reason for Visit_____

TYPE OF VISIT:
❑ SN
❑ SN & Supervisory
❑ Supervisory only
❑ Other

SKILLED OBSERVATION / ASSESSMENT

(Mark all applicable with an "X". Circle appropriate item(s) separated by "/".)

Mental: ❑ No change ❑ Alert and oriented ❑ Confused / Forgetful ❑ Disoriented ❑ Agitated

Vitals: **Temperature**_____ ❑ Oral ❑ Axillary ❑ Tympanic ❑ Rectal **Pulse:**_____ ❑ Radial ❑ Apical ❑ Brachial
Respirations_____ ❑ Regular ❑ Irregular ❑ Regular ❑ Irregular

Blood Pressure: Right_____/_____ Left_____/_____ ❑ Lying ❑ Sitting ❑ Standing

Weight:_____ ❑ Actual ❑ Reported **Blood Sugar:**_____ ❑ Actual ❑ Reported

Appetite: ❑ Good ❑ Fair ❑ Poor ❑ NPO Hydration adequate: ❑ Yes ❑ No

Skin: (Temperature, Color, Turgor)_____ ❑ WNL

Breath Sounds: ❑ Clear ❑ Crackles / Rales ❑ Rhonchi / Wheeze ❑ Other_____
❑ Diminished ❑ Absent Location _____

O_2 saturation at _____%

Bowel sounds: ❑ Active / absent / hypoactive / hyperactive x____quadrants
Last BM_____ ❑ Incontinence ❑ Diarrhea ❑ Constipation ❑ Impaction

Pain: ❑ None ❑ Same ❑ Improved ❑ Worse Origin_____ Location(s)_____
Duration_____ Intensity 0-10_____ Other _____
Relief Measures_____

CARDIOPULMONARY

❑ **No Problem** ❑ Same

❑ Chest pain / palpitations
❑ Pedal edema: LUE +1 / +2 / +3 / +4 LLE +1 / +2 / +3 / +4
RUE +1 / +2 / +3 / +4 RLE +1 / +2 / +3 / +4
Other: _____
❑ Pedal pulses _____ present / absent
❑ Cough: ❑ Non-productive ❑ Productive
Color_____ Character_____
❑ Dyspnea ❑ Orthopnea ❑ Cyanosis
❑ O_2 _____ liters / minute via nasal cannula / mask / trach
❑ PRN ❑ Continuous
Comments:_____

NEUROMUSCULAR

❑ **No Problem** ❑ Same

Pupils: ❑ PERRLA ❑ Other_____
❑ Decreased sensation ❑ Tremors ❑ Headache
Grasp: Right ❑ Equal ❑ Unequal ❑ Other _____
Left: ❑ Equal ❑ Unequal ❑ Other _____
❑ Numbness / Tingling ❑ Vertigo / Ataxia
❑ Syncope ❑ Balance WNL ❑ Unsteady gait
❑ Reported fall(s) (describe)_____
❑ Weakness (describe) _____
❑ Change in ADL (describe)_____
Comments:_____

WOUND / OSTOMY CARE

❑ **No Problem**

❑ Wound care/dressing change performed by: ❑ Self ❑ Nurse
❑ Family/caregiver ❑ Other_____
❑ Soiled dressing removed/disposed of properly
❑ Wound cleaned (specify)_____
❑ Wound irrigated (specify) _____
❑ Type of dressing(s) used_____
❑ Wound debridement
❑ Drainage collection container emptied. Volume_____
❑ Patient tolerated procedure well
❑ Medicated prior to wound care
❑ Patient/family/caregiver instructed on wound care/ostomy/disposal of soiled dressing
❑ Patient/family/caregiver to perform wound care/ostomy/dressing change

(Measure per organizational guidelines)

WOUND	#1	#2	#3
Location			
Length			
Width			
Depth			
Drainage			
Tunneling			
Odor			
Stoma			

Comments:_____

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

GASTROINTESTINAL

❑ **No Problem** ❑ Same

❑ Anorexia ❑ Nausea/Vomiting ❑ Difficulty swallowing

❑ Tube feeding (specify) _____

❑ Continuous ❑ Intermittent

Comments: _____

_____

GENITOURINARY

❑ **No Problem** ❑ Same

❑ Burning ❑ Frequency/Urgency ❑ Retention/Hesitancy

❑ Odor ❑ Hematuria ❑ Incontinence

❑ Catheter (specify) type_____ French _____ml/balloon

Bulb inflated _____ml ❑ Changed ❑ Inserted ❑ Removed

Irrigated with (specify) _____

Comments: _____

MEDICATION

(New or changed since last visit)

❑ None ❑ Update Medication Profile ❑ Order obtained

❑ Administered by: ❑ Self ❑ Family/caregiver ❑ Nurse

❑ Other _____

❑ Medication administered this visit

Name _____

Dose _____ Route _____

Instructed on:

❑ Medication(s) names (list) _____

❑ S/S allergic reaction ❑ Pill count (if applicable) ____

❑ Drug/food interactions ❑ S/E contraindications

❑ Drug/drug interactions ❑ Ample supply

❑ Expiration dates ❑ Proper disposal of sharps

❑ Prescription refill by_____ ❑ Duration of therapy

❑ Missed doses/what to do ❑ Other _____

Medication setup for _____

❑ Prefill insulin syringes for _____ days

IV

❑ **Not Applicable** ❑ **No Problem**

Type of line: ❑ Peripheral ❑ PICC ❑ Central (type)_____

❑ Implanted port Location (specify) _____

Site (if appropriate)_____ Site (describe)_____

Catheter length _____cm Arm circumference _____cm

❑ No evidence of infection

❑ Dressing change performed by: ❑ Self ❑ Family/caregiver ❑ Nurse

❑ Other _____

❑ Cap change performed by: ❑ Self ❑ Family/caregiver ❑ Nurse

❑ Other _____

❑ Extension/tubing changed by: ❑ Self ❑ Family/caregiver ❑ Nurse

❑ Other _____

❑ Line flushed _____ml saline/sterile water

❑ Line flushed _____ml Heparin _____units/ml

❑ Instructed patient/family/caregiver on infusion therapy

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

INTERVENTIONS/INSTRUCTIONS

❑ Lab: ❑ None ❑ Blood drawn from _____ for _____

❑ Other _____ Delivered to _____

❑ Standard precautions ❑ Observed S/S

Observe/Teach:

❑ Disease process (specify) _____

❑ Diet

❑ Safety: ❑ Fall ❑ Medications ❑ Fire ❑ Other_____

When to call: ❑ Agency ❑ Physician

❑ Pain management

❑ Care of: ❑ Terminally ill ❑ Maternal child ❑ Trach

Teach/Administer:

❑ Tube feed (circle and document details) _____

_____

_____

❑ Enema

❑ Other (specify) _____

_____

_____

_____

SUMMARY CHECKLIST

Care Plan: ❑ Reviewed/Revised with patient involvement

❑ Outcome achieved ❑ PRN order obtained

❑ Discharge planning discussed

Plan for next visit: _____

_____

_____

Approximate next visit date: _____/_____/_____

Next physician visit: _____/_____/_____

Care coordination: ❑ Physician ❑ SN ❑ PT ❑ OT ❑ ST

❑ MSW ❑ Home Health Aide ❑ Other (specify)_____

❑ Regarding _____

Billable supplies recorded? ❑ Yes ❑ No

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/DATES

X _____

Nurse (Signature/Title)

Time In_____

Patient Signature (optional)_____ Date_____/_____/_____ Time Out_____

PATIENT NAME – Last, First, Middle Initial	ID#