NURSES' PROGRESS NOTE

Dates: From __________ thru __________

INSTRUCTIONS: Record resident's status/progress in each section. Identify reactions, interactions, response to care/treatment and all other pertinent comments on the reverse as appropriate.

COGNITION

LEVEL OF CONSCIOUSNESS: ❍ Coma ❍ Alert and oriented x 3

❍ Disoriented: ❑ Person ❑ Place ❑ Time

MEMORY: SHORT TERM: ❍ OK ❍ Problem

LONG TERM: ❍ OK ❍ Problem

DECISION-MAKING ABILITY: ❍ Independent ❍ Impaired ❍ Severely impaired

DISORGANIZED THINKING/DELIRIUM:

❑ Changing awareness ❑ Psychomotor retardation ❑ Incoherent speech

❑ Inattention ❑ Disorganized thinking ❑ Lethargic ❑ Vigilant

❑ Altered level of consciousness ❑ Stuporous ❑ Cannot be aroused

COGNITIVE STATUS: ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

COMMUNICATION

ABILITY TO HEAR: ❍ Adequate ❍ Impaired

Device(s) used:______________________ ❑ No hearing device

MODE OF EXPRESSION: ❑ Speech ❑ Writing ❑ Signs/gestures/sounds

❑ Other:______________________________

ABILITY TO UNDERSTAND/MAKE SELF UNDERSTOOD:

❍ Always ❍ Usually ❍ Sometimes ❍ Rarely/Never

COMMUNICATION/HEARING: ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

VISION

ABILITY TO SEE: ❍ Adequate ❍ Impaired ❍ Moderately impaired

❍ Highly impaired ❍ Severely impaired

Device(s) used:______________________ ❑ No device

VISION: STATUS: ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

PHYSICAL FUNCTIONING

SELF-PERFORMANCE CODES: **0** = Independent **1** = Supervision **2** = Limited assist **3** = Extensive assist **4** = Dependent **8** = Did not occur

SUPPORT CODES: **0** = No Assist **1** = Set-up Only **2** = Assist 1 **3** = Assist 2+ **8** = Did not occur

FUNCTION	SELF-PERFORMANCE	SUPPORT
BED MOBILITY	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
TRANSFER	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
LOCOMOTION	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
DRESSING	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
EATING	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
TOILET USE	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
PERSONAL HYGIENE	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8
BATHING	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 8	❍ 0 ❍ 1 ❍ 2 ❍ 3 ❍ 8

BODY CONTROL PROBLEMS: ❍ No ❍ Yes, specify:______________________________

DEVICE(S) USED: ❍ No ❍ Yes, specify:______________________________

TASK SEGMENTATION REQUIRED: ❍ No ❍ Yes

ADL FUNCTIONAL STATUS ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

BOWEL/BLADDER CONTINENCE

BLADDER: ❍ Continent ❍ Usually continent ❍ Frequently incontinent

❍ Always incontinent ❍ Catheter present

BOWEL: ❍ Continent ❍ Usually continent

❍ Frequently incontinent ❍ Always incontinent ❍ Ostomy present

B & B MANAGEMENT PROGRAM: ❍ No ❍ Yes, specify:______________________________

BLADDER CONTROL STATUS: ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

BOWEL CONTROL STATUS: ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

PSYCHOSOCIAL WELL-BEING

INVOLVEMENT: ❍ Involved, easily interacts with others

❍ Stays alone, does not interact ❍ Other:______________________________

RELATIONSHIPS: ❑ Happy, pleasant ❑ Unhappy, isolates self

❑ Angry, expresses conflict ❑ Does not react ❑ Other:______________________________

MOOD AND BEHAVIOR

MOOD: ❑ Sad ❑ Anxious ❑ Agitated ❑ Withdrawn

❑ Refuses food/meds/care ❑ Happy ❑ Other:______________________________

BEHAVIORS: ❍ No problem ❍ Problem (specify below)

Problem behavior(s):______________________________

Effective intervention(s):______________________________

MOOD/BEHAVIOR STATUS: ❍ No change ❍ Improved

❍ Deteriorated, specify:______________________________

SLEEP PATTERNS

❍ Normal for individual ❍ Altered (specify below)

ALTERED SLEEP:______________________________

INTERVENTION(S), IF NEEDED:______________________________

ACTIVITY PATTERNS

ACTIVITY PARTICIPATION: ❍ Most of the time ❍ Some of the time

❍ Refuses to participate

PREFERRED SETTING: ❑ Own room ❑ Small groups ❑ Large groups

❑ Inside facility ❑ Out of facility ❑ Other:______________________________

ORAL/NUTRITIONAL/DENTAL

❑ **No problems**

CHEWING/SWALLOWING/MOUTH/DENTAL PROBLEMS: (explain)

PROGRESS:______________________________

WEIGHT: ❍ Loss _____lbs. ❍ Gain _____lbs. ❍ Stable Current wt _________

AVERAGE % FOOD CONSUMED: ❍ 25% ❍ 50% ❍ 75% ❍ 100%

❍ Feeds self ❍ Requires assist ❍ Total dependence ❍ Tube Feeding

ORAL: ❑ Abnormal mouth tissue:______________________________

❑ Difficulty chewing ❑ Broken/loose teeth/dentures ❑ Mouth pain

RECORD ADDITIONAL NOTES AS NEEDED ON REVERSE

Nurse's Signature/Title: ______________________________ Date:______________

Reviewed By Signature/Title: ______________________________ Date:______________

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

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❑ Continued on Reverse

NURSES' PROGRESS NOTE (continued)

SKIN CONDITION

SKIN: ❍ Intact ❍ Condition present/treated:

PREVENTIVE MEASURES AND PROGRESS:

MEDICATION CHANGES

MEDICATION CHANGES AND RESIDENT RESPONSE:

INFECTIONS/HOSPITALIZATIONS

IDENTIFY INFECTION TREATED: ❑ No infection

HOSPITALIZED: ❍ No ❍ Yes, specify:

DISEASE DIAGNOSES/HEALTH CONDITIONS

PROGRESS ON ACUTE HEALTH CONDITIONS TREATED:

SPECIAL TREATMENTS AND PROCEDURES

THERAPY/RESTORATIVE PROGRAM(S) & RESPONSE:

ABNORMAL LAB RESULTS: ❍ No ❍ Yes, specify:

TREATMENT AND RESPONSE:

RESTRAINT USED: ❍ No ❍ Yes, specify:

REASON:

EFFECTIVENESS:

ALARMS USED: ❍ No ❍ Yes, specify:

ADDITIONAL NOTES (Include date, signature and title)

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NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed