MORNINGSTAR HOME HEALTH AGENCY, INC.

SKILLED NURSING VISIT NOTE

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS BEFORE SERVICE PROVIDED SG

SG Patient's Safety Goal

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

DATE OF VISIT

TIME IN _____ AM/PM OUT _____ AM/PM

TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance / device to ambulate ☐ Medical restrictions ☐ Confusion, unable to go out of home alone ☐ Unable to safely leave home unassisted ☐ Dyspnea on minimal exertion ☐ Bed / Chair bound ☐ Residual weakness ☐ Dependent upon adaptive device(s) ☐ Acute episodes of hyper/hypoglycemia yield unsafe ambulation ☐ Unable to drive ☐ Severe SOB, SOB upon exertion ☐ Other (specify)

MARK ALL APPLICABLE WITH AN X. CIRCLE APPROPRIATE ITEM MEDICARE ☐ MEDICAID ☐ MX ☐ OTHER ☐

VITALS

T _____ Wt _____ BS _____

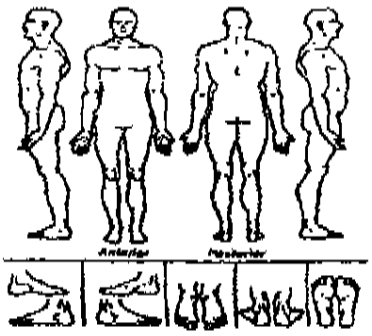
Resp. _____ ☐ Reg. ☐ Irregular

Pulse: A _____ R _____

☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

Denote Location / Size of Wounds / Measure Ext. Edema B/L



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

CARDIOVASCULAR

- Fluid Retention
- Chest Pain
- Neck Vein Distension
- Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Ascites
- Peripheral Pulses
- Arrhythmia
- Other:
- No deficit

RESPIRATORY

- Rales / Ronchi / Wheeze
- ☐ R. Lung ☐ L. Lung
- ☐ Cough ☐ Sputum
- ☐ Dyspnea ☐ SOB
- Orthopnea
- 02. LPM: VIA:
- No deficit ☐ Fire Prevention followed SG

DIGESTIVE

- Bowel Sound
- ☐ Nausea ☐ Vomiting
- ☐ Anorexia ☐ NPO
- Epigastric Distress
- Difficulty Swallowing
- Abdominal Distention
- ☐ Colostomy ☐ Ileostomy
- Bowel Incontinence
- ☐ Constipation ☐ Impaction ☐ Diarrhea
- Diet:
- Fluid Intake:
- Enteral Feeding Route:
- Type: Amount:
- Via:
- Flushing:
- Appetite: ☐ Good ☐ Fair ☐ Poor
- LBM: ☐ No Deficit

GENITOURINARY

- ☐ Burning ☐ Dysuria
- ☐ Distension ☐ Retention
- ☐ Frequency ☐ Urgency ☐ Hesitancy
- Hematuria
- Bladder Incontinance
- ☐ Catheter ☐ Ileoconduit
- Suprapubic Catheter
- Foley Catheter
- Size Fr. cc.
- Last Changed:
- Irrigation cc / nss
- Urine
- Output cc / hr.
- Color
- Consistency
- Odor
- ☐ Pain ☐ Discharge
- ☐ Cath. Leakage ☐ Dislodge
- Other
- No Deficit

SKIN

- ☐ Warm ☐ Dry ☐ No Deficit
- ☐ Cold ☐ Clammy
- ☐ Jaundice ☐ Pallor ☐ Cyanosis
- ☐ Turgor ☐ Hydration
- ☐ Rash ☐ Itching ☐ Discoloration
- ☐ Decubitus ☐ Wound ☐ Ulcer
- Chills
- Integrity
- Tube Insertion Site
- Other

ENDOCRINE

- ☐ Weakness ☐ Fatigue ☐ Tired ☐ No Deficit
- ☐ Sign/Symptoms of ☐ Polydipsia ☐ Polyphagia
- ☐ Sign/Symptoms of ☐ Hyperglycemia ☐ Hypoglycemia
- Other

No Deficit

MUSCULOSKELETAL

- Balance ☐ Unsteady gait ☐ Endurance
- Weakness ☐ Ambulates with Assistance
- Limited Movement ☐ Rom
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis
- No Deficit

NEUROSENSORY

- Syncope
- Headache
- Grasp ☐ Equal ☐ Unequal
  - Right:
  - Left:
- Movement
  - ☐ RUE ☐ LUE
  - ☐ RLE ☐ LLE
- Pupil Reaction
  - ☐ Right ☐ Left
- Hand Tremors
- Poor Hand-Eye coordination
- Poor Manual Dexterity
- Speech impairment
- Hearing Impairment
- Visual Impairment ☐ Blindness
- Tactile Sensation
- **No deficit**

EMOTIONAL STATUS

- Oriented ☐ T ☐ P ☐ P
- Forgetful ☐ Confused
- Disoriented ☐ T ☐ P ☐ P
- Lethargic ☐ Semi Lethargic
- Comatose
- Restless ☐ Agitated
- Anxious ☐ Depressed
- Other

No Deficit

PAIN / FALL MANAGEMENT SG

Frequency of pain interfering with patients activity or movement:

☐ 0 - Patient has no pain or pain does not interfere with activity or movement
☐ 1 - Less often than daily
☐ 2 - Daily, but not constantly
☐ 3 - All of the time
☐ Pain Management Teaching to patient / family

Intensity 0 1 2 3 4 5 6 7 8 9 10 (Low / High)

Current pain management & effectiveness: ☐ No deficit / Pain

Progress toward pain goal: _____ Patient's pain goal: _____

Primary Site(s):

Client is at risk for falls ☐ yes ☐ no **Fall assessment conducted** ☐ Yes ☐ N/A

Potential for falls: 0 1 2 3 4 5 6 7 8 9 10 Potential for falls has: Increased ☐ decreased ☐ SG

Compliant with fall prevention plan: ☐ Yes ☐ No ☐ N/A

INTERVENTIONS / INSTRUCTIONS

- ☐ Skilled Observation / Assessment
- ☐ Foley Change ☐ Foley irrigation
- ☐ Wound Care ☐ Dressing Change
- ☐ Venipuncture / Lab:
- ☐ Prep. / Admin. Insulin
- ☐ IM Injection ☐ SQ Injection
- ☐ Diabetic Observation / Care
- ☐ Observation / Inst Med. (N or C) effects / Side Effects
- ☐ Inst. Fall Prevention ☐ Emergency Prepar. SG
- ☐ Inst. Disease Process
- ☐ Diet. Teaching
- ☐ Safety Precautions/Factors Management Conducted
- ☐ Teach Infant / Childcare
- ☐ Peg / GT Tube Site Care
- ☐ Tracheostomy Care ☐ Suctioning

TECHNIQUES USED

- ☐ Universal Precautions/ Handwashing Tech. followed
- ☐ Aseptic Tech.used / Infection Control followed SG
- ☐ Quality Control of Glucometer Performed as per Agency P & P on:
- ☐ Glucometer Calib. on:
- ☐ Soiled Dressings Double Bagged
- ☐ Sharps Discarded Inside Sharps Container

INFUSION / IV SITE:

- ☐ IV Tubing Change
- ☐ Cap Change
- ☐ Central Line Dressing Change
- ☐ IV Site Dressing Change
- ☐ IV Site Change
- ☐ Infusion by Pump
- ☐ Infusion Med:
- ☐ Infusion Rate:
- Comments:
- ☐ Infusion Well Tol. by Pt.

☐ Patient unable to perform own W/C due to:

SKILLED INTERVENTION - TEACHING - Pt. RESPONSE - OUTCOMES

DME/SUPPLIES: ☐ Gloves ☐ Thermometer ☐ BP cuff ☐ Glucometer ☐ Alcohol pads ☐ 4x4 ☐ Sharp container ☐ Other:

PLAN FOR NEXT VISIT:

OTHER PROGRESS TOWARDS GOALS: ☐ PT / S.O. / CG verbalized understanding of inst. given ☐ Other:

☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure inst. on **DISCHARGE PLANNING DISCUSSED?** Yes ☐ No ☐ N/A ☐

☐ No S.O. or C/G able / willing for Inj. Adm. at this time ☐ Treatment well tolerated by Patient

☐ No S.O. or C/G able / willing for wound care at this time. ☐ Verification of Procedure Performed SG

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved

☐ PRN Order Obtained:

☐ Verification of Medication Performed Prior to Admin. SG

MEDICATION STATUS ☐ No Change ☐ Order Obtained:

SUPPLIES USED:

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ MSW ☐ SN ☐ C M ☐ HHA ☐

☐ Other:

NURSE SIGNATURE / PRINT NAME **RN / LPN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title)