**CLINICAL NOTE**

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| **ASSESSMENTS**:  **MENTAL:** ☒Oriented ☐Fair ☒Forgetful ☒Confused at times ☒Anxious at times☐Depressed ☐Other  **INTEGUMENTARY**:  ☐Wound ☐ Decub Stage☐1☐2☐3☐4  ☐Infected ☐ Foul odor drainage  **EENT**: ☐Legally blind ☒ Impaired, blurred vision  ☐Epistaxis ☐Dysphagia ☒ HOH R/L  ☐Prone to aspiration  **RESPIRATORY**:SOB☐Rest ☒ Mod. Exertion ☐Cough ☐Productive ☐Non-productive Sputum Color: Amount:\_\_\_\_\_ ☒Lung Sound: diminished/  **clear**  O2\_\_\_\_LPM/**96%**  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **cane, walker**  **PAIN**: ☐No ☒Yes Location: **Lower Back, Bilateral Shoulders, Joints**  Intensity: pain scale **4/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 500 mg, 1 capsule by mouth every 6 hours as needed for pain**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**04/01/25**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Low fat, Low cholesterol**  **NEUROLOGICAL**:  ☐Aphasic ☐Slurred speech ☐Seizures  ☐Headache ☐Tremors ☐Vertigo  ☒PERRLA ☒Weakness R☐ L☐  **CARDIOVASCULAR**:  ☐Chest pain ☐Palpitations ☐Dizziness  Pedal pulses: ☒Present ☐Absent  Edema: ☒Pitting ☐Non-pitting ☐ Pacer.  ☒1+ ☐2+ ☐3+ ☐4+ ☐ Dependent  Location: ☒Pedal R/L ☐Dorsum R/L  **GENITOURINARY**:  ☒Incontinent ☐Frequency ☐Urgency  ☐Pain ☐Nocturia☐Burning☐Retention  ☐Catheter ☐Condom ☐IFC☐  **ENDOCRINE**:  ☐Weak ☐Diaphoretic ☐Polyuria  ☐DM II | **Vital Signs**: T- 99.3 F, HR- 88 bpm, RR - 19 per min BS mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 143/67 mm/Hg Standing Repeat Wight lbs.  **HOMEBOUND STATUS**: ☒Poor/Limited Endurance ☒ Poor/Limited Strength ☒ SOBOE ☒Poor Unsteady Gait ☒Requires Assist with ADL ☐ Unable to Negotiate Uneven Surfaces or Steps ☐ Medical Restrictions ☐Non-wt. bearing ☐Ambulates \_18-20\_ ft then requires rest/stop ☐Requires assist with transfer ☒Requires assistive device to ambulate ☒Confusion ☒Unable to leave home without assistance ☐Bedbound ☐Paralysis UE/LE/both ☒Requires assist to ambulate ☒Poor coordination or balance ☐Partial wt. bearing ☒ Others: requires considerable, taxing effort to leave home even with Caregiver assistance. Patient is using solid and stable objects to move around the house.  **CLINICAL PROBLEM(S) / KNOWLEDGE DEFICIT / NURSING DIAGNOSES**:  ***(Problems/Significant Findings)*** Altered status due to Primary osteoarthritis, left shoulder. Knowledge deficit regarding measures to control Primary osteoarthritis, left shoulder and the medication Ibuprofen 600 mg, 1 tablet by mouth every 6 hours as needed for pain as ordered by MD.  **INTERVENTIONS:** (Specific to problems identified and who was given the instructions.) SN admitted the patient for comprehensive skilled nursing assessment, observation and evaluation of all body systems. SN to assess vital signs, pain level. SN performed to check vital signs and scale pain (1-10) every visit. Check O₂ saturation level with signs and symptoms of respiratory distress. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. Primary osteoarthritis of the shoulder is a gradual wearing of the articular cartilage that leads to pain and stiffness. As the joint surface degenerates, the subchondral bone remodels, losing its sphericity and congruity. The joint capsule also becomes thickened, leading to further loss of shoulder rotation. Osteoarthritis most often occurs in people who are over age 50. In younger people, it can result from an injury or trauma. SN instructed Patient/PCG regarding the medication Ibuprofen 600 mg. It is used to relieve pain from various conditions and reduces pain, swelling, and joint stiffness caused by arthritis. SN advised Patient/PCG to take medication Ibuprofen 600 mg, 1 tablet by mouth every 6 hours as needed for pain as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding precautions ☒Fall precautions ☒Clear pathways ☒Universal Precautions ☒911 protocol ☒Cane, walker Precautions  **PATIENT/PCG RESPONSE/PROGRESS TOWARDS TREATMENT/TEACHING/GOAL(S):**  ☒Verbalized fair understanding ☐Verbalized lack of understanding ☐Procedure(s) well tolerated ☐Return demonstration performed ☐Responding well to treatment ☒No side effects/ adverse reactions ☐Continues to have no willing/able/available PCG for injection(s)/treatment ☒Requires more instruction ☐BP/Pain decreased/increased ☒Patient has been identified with two forms of ID  ☐Other  **PLAN:** (for next visit): continue to implement plan of care as approved by PMD.  **COMMUNICATION**:☐MD ☐Supervisor ☐RN ☐PT ☐MSW ☐Other  Re:  **SN NAME: sd NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 156-001**  **PATIENT DATE TIME IN/OUT**   |  |  |  | | --- | --- | --- | | **FORD, HENRY** | **04/01/25** | **12:00** | |