**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/**95**  **MUSCULOSKELETAL**:  Stiff joints ☒Weakness ☒Limited ROM ☐Contractures ☐ Foot drop  ☐Unsteady balance ☒Other: uses **can, walker**  **PAIN**: ☐No ☒Yes Location: **Lower back, Bilateral Knees, Multiple Joints**  Intensity: pain scale **5/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Tylenol 325 mg. 1 tablet by moiuth daily**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**03/02/25**  Appetite ☐Good ☒Fair ☐Poor  **Diet**: **NAS, Controlled Carbohydrate, Low Fat, Low Cholesterol, High Fiber, Low Sugar, Low Glycemic index, Nutrient-dense Diet,**  **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- 99.0 F, HR- 67 bpm, RR - 16 per min BS 140 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 143/65 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 Type 2 diabetes mellitus with hyperglycemia. Knowledge deficit regarding measures to control Type 2 diabetes mellitus and the medication Januvia 50 mg 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 record blood sugar test results checked by Pt/PCG during the visits and report any significant changes to MD. SN to perform diabetic foot exam upon every visit. PCG assumes DM responsibilities, is confident, capable, and competent in checking blood sugar daily. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. [Here, include a detailed summary of approximately 150–200 words that covers the disease’s causes, symptoms, diagnostic findings, and other relevant clinical information]. SN advised Patient/PCG to take medication Januvia 50 mg as ordered by MD.    **SAFETY MEASURES/INFECTION CONTROL MEASURES:**  ☒Bleeding Precautions ☒Fall Precautions ☒Clear pathways ☐Infection control measures  ☒Cane, walker Precautions ☒Universal Precautions ☒Other:911 protocols  **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: sheela jawani NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 032-006**  **PATIENT DATE TIME IN/OUT**   |  |  |  | | --- | --- | --- | | **PATTINSON, ROBERT** | **03/03/25** | **00:14-00:59** | |