**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/  **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 **3/10**  ☐Sharp ☒Dull ☐Radiating ☐Burning  Controlled ☐No ☒Yes by rest/relaxation, repositioning, massage, diversion, and medication  **Ibuprofen 600 mg, 1 tablet by mouth every 6 hours as needed for pain**  **GASTROINTESTINAL**:  ☐Nausea ☐Vomiting ☐Diarrhea  ☐Constipation ☐Impaction ☐ Abd.Dist.  ☐Incontinent ☒Last BM:**03/13/25**  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- 98.3 F, HR- 95 bpm, RR - 20 per min BS 194 mg/dl per patient/PCG F ☐ R ☒ Repeat **BP**: R / **L** Lying \_\_ Sitting 145/86 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 hematology status related to Iron deficiency anemia. Knowledge deficit regarding measures to control Iron deficiency anemia and the medication Ferrous Sulfate 325 mg, 1 tablet by mouth 2 times daily 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. SN to evaluate therapeutic response to current/new medications and compliance to medication/diet regimen, home safety issues and psychosocial adjustment. Iron deficiency anemia is a common type of anemia, a condition in which blood lacks adequate healthy red blood cells. Red blood cells carry oxygen to the body's tissues. Without enough iron, your body can't produce enough hemoglobin, which is essential for oxygen transport. Symptoms may include fatigue, weakness, and shortness of breath. Diagnosis often involves blood tests to measure hemoglobin and ferritin levels. SN instructed Patient/PCG regarding the medication Ferrous Sulfate 325 mg. This medication is an iron supplement used to treat or prevent low blood levels of iron. SN advised Patient/PCG to take medication Ferrous Sulfate 325 mg, 1 tablet by mouth 2 times daily 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: Davit NEXT MD APPOINTMENT**  **SN SIGNATURE** **MR# 156-001**  **PATIENT DATE TIME IN/OUT**   |  |  |  | | --- | --- | --- | | **FORD, HENRY** | **03/13/25** | **21:41-22:26** | |