Provider Toolkit

Nurse

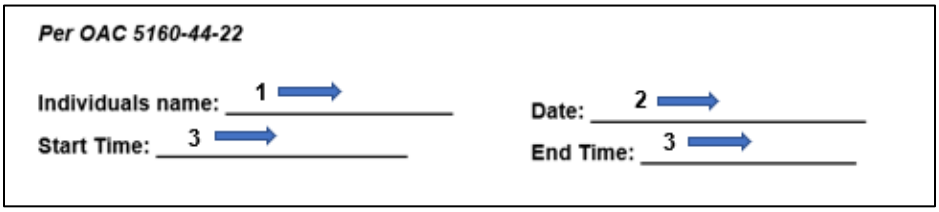
Skilled Nursing Progress Note – Extended Version

Document Overview

This form can be used to document daily nursing visits with an individual **per OAC 5160-44-22.** This form should be used to document only one visit. If you have multiple visits on a given day, use multiple copies of this document for each additional visit.

Instructions

How to complete the Skilled Nursing Visit Progress Note – Extended Version:



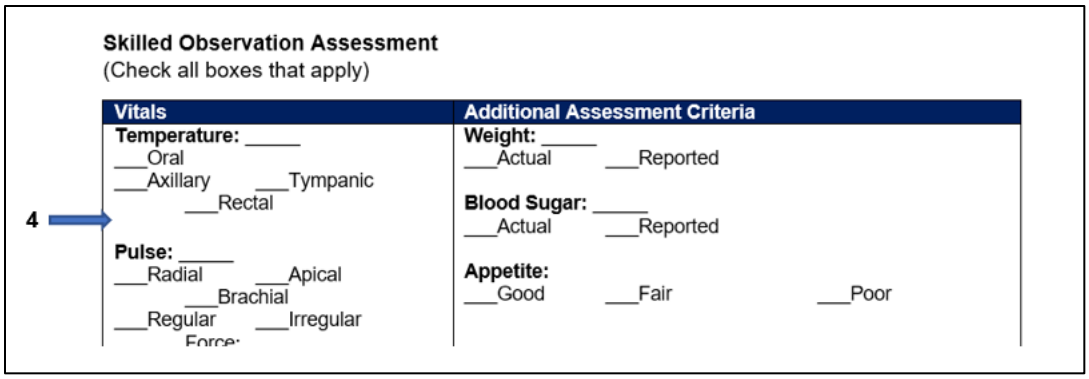
Per OAC 5160-44-22

Individuals name: _____ 1 →

Start Time: _____ 3 →

Date: _____ 2 →

End Time: _____ 3 →



Skilled Observation Assessment

(Check all boxes that apply)

Vitals	Additional Assessment Criteria
Temperature: _____ ___Oral ___Axillary ___Tympanic ___Rectal **Pulse:** _____ ___Radial ___Apical ___Brachial ___Regular ___Irregular Force:	**Weight:** _____ ___Actual ___Reported **Blood Sugar:** _____ ___Actual ___Reported **Appetite:** ___Good ___Fair ___Poor

4 →

5 **Wound Assessment/Ostomy Care:**

Wound care/dressing change performed by: ___self ___nurse ___other

Measure wounds weekly unless otherwise indicated by physician:

WOUND	#1	#2	#3
Type			
Location			
Length			
Width			
Depth			
Edges			
Color			
Staging (if applicable)			
Drainage			
Tunneling			
Odor			
Stoma			
Sutures/Staples/#			

Wound Care Provided:

_____

_____

Additional wound care observations and comments:

_____

_____

6 IV Therapy: ___Yes ___No IV Type: _____

Location: _____ Insertion Site Description: _____

+See Addendum for full IV Assessment and Therapy

Narrative:

_____

_____

7 _____

_____

_____

_____

_____

Individuals Signature: 8 _____ **Date:** _____

Nurse Signature (include title): 9 _____ **Date:** _____

1. Enter the individual's name
2. Enter the date of your visit
3. Enter the start and end times of your visit
4. Complete all the boxes in the Skilled Observation Assessment that are pertinent to your observations during the visit. Add comments where needed to explain the individual's

condition and to ensure that other team members who read your assessment will fully understand the individual's status.

5. Identify any wound care you provided. Be sure to be thorough in your description of the wound and the care provided. If wound care is not part of your visit enter N/A.
6. Document IV care. If IV was not provided enter N/A
7. Add any information not captured above regarding the individual's condition or status
8. Have the individual sign and date the progress note
9. Sign your name and enter the date

Skilled Nursing Visit Progress Note – Extended Version

Per OAC 5160-44-22

Individuals name: _____ **Date: _____**

Start Time: _____ **End Time: _____**

Skilled Observation Assessment
(Check all boxes that apply)

Vitals	Additional Assessment Criteria
Temperature: _____ ___Oral ___Axillary ___Tympanic ___Rectal **Pulse: _____** ___Radial ___Apical ___Brachial ___Regular ___Irregular Force: _____ **Blood Pressure:** Right _____ /_____ Left _____ / _____ ___lying ___sitting ___standing	**Weight: _____** ___Actual ___Reported **Blood Sugar: _____** ___Actual ___Reported **Appetite:** ___Good ___Fair ___Poor **Hydration adequate:** ___Yes ___No **Fluid Restrictions:** ___Yes ___No Describe: _____
Cognitive	**Neuromuscular**
___Alert and oriented ___Confused/Forgetful ___Disoriented ___Agitated ___Depression ___Anxiety ___Other	**Pupils:** ___Equal ___Unequal ___Reactive to Light ___Left Eye ___Right Eye ___Both **Grasp:** <u>Right</u> ___Equal ___Unequal Other: _____ <u>Left</u> ___Equal ___Unequal Other: _____ ___Numbness/Tingling ___Tremors ___Vertigo/Ataxia ___Unsteady Gait ___Balance Challenges **Seizure:** ___Yes ___No

	Type: _____ Frequency: _____ Duration: _____ **Risk for Falls:** Ambulation device(s) needed (list):_____ Reported Fall(s) (describe): _____ _____ Comments _____ _____
Pulmonary	**Cardiovascular**
Lung Sounds: ___Clear ___Crackles ___Wheezing ___Diminished ___Absent ___Cough ___Sputum color/consistency: _____ Other: _____ ___Right upper lobe ___Left upper lobe ___Right lower lobe ___Left Lower lobe **O2 Use:** ___Yes ___No LPM: _____ (If Yes) Method: ___Nasal Cannula ___Mask Type: _____ Frequency/Duration: _____ O2 Saturation: _____% ___Room Air ___Oxygen ___C-Pap ___Bi-Pap ___Other SOB: _____ ___Yes ___No ___no exertion ___minimal exertion ___moderate exertion **Comments:** _____ _____ _____ _____	___Chest Pain Location:_____ Type:_____ Intensity:_____ ___Palpitations ___Dizziness ___Syncope ___Pedal Edema ___Left Pitting/Grade: _____ ___Right Pitting/Grade: _____ **Comments:** _____ _____ _____

Gastrointestinal	Genitourinary
Bowel Sounds: ___Active ___Absent ___Hypoactive ___Hyperactive ___Tenderness **Frequency:** _____ **Last BM Date/Time:** _____ ___Incontinence ___Diarrhea ___Constipation ___Impaction **Tube Feed:** ___Yes ___No Tube Type: _____ Site Description: _____ Nutrition Type: _____ Amount: _____ Frequency: _____ Delivery:_____ Provided by: ___Nurse ___Self ___Family ___Other Tube Placement Verified: ___Yes ___No HOB elevation: Degrees: _____ Duration: _____ Tube Flush: ___Yes ___No Describe: _____ **Comments:** _____ _____	**Urinary Frequency:** _____ **Discomfort Upon Urination:** ___Yes ___No **Color:** _____ **Clarity:** _____ **Incontinence:** ___Yes ___No Frequency: _____ **Stress Incontinence:** ___Yes ___No **Catheter:** ___Yes ___No Type/Size: _____ Date of Last Change: _____ (If straight catheter) frequency: _____ Comments: _____ _____
Pain	**Skin**
Location: _____ **Pain Scale (0-10):** _____ **Pain Description:** _____ **Relief Measures:** _____ **Comments:** _____ _____	___pale ___cool ___dry ___clammy ___warm ___hot ___red ___other **Skin Integrity:** _____

Wound Assessment/Ostomy Care:

Wound care/dressing change performed by: ___self ___nurse ___other

Measure wounds weekly unless otherwise indicated by physician:

WOUND	#1	#2	#3
Type			
Location			
Length			
Width			
Depth			
Edges			
Color			
Staging (if applicable)			
Drainage			
Tunneling			
Odor			
Stoma			
Sutures/Staples/#			

Wound Care Provided:

_____

_____

Additional wound care observations and comments:

_____

_____

IV Therapy: ___Yes ___No IV Type: _____

Location: _____ Insertion Site Description: _____

+See Addendum for full IV Assessment and Therapy

Narrative:

_____

_____

_____

_____

_____

_____

Individuals Signature: _____ Date: _____

Nurse Signature (include title): _____ Date: _____