Skilled Nursing Note

matrix HOME HEALTH CARE

Name of Patient: _____ Date: _____ □ Initial Assessment □ Follow up visit □ Supervisory visit

Vital Signs
Ht: _____ Wt: _____ Temp: _____ Pulse: A/R: _____ □ Regular □ Irregular Resp: _____ B/P: _____ □ Lying □ Sitting □ Standing □ Right □ Left

Nursing assessment and observation of signs/symptoms (Mark all applicable with an "X" or circle item(s) separated by "/"

CARDIOVASCULAR
□ WNL
□ Edema (Specify)
□ RUE □ LUE □ RLE □ LLE
1/2/3/4+ □ Pitting □ Non-pitting
□ Other:_____
_____

EMOTIONAL STATUS
□ WNL
□ Disoriented
□ Forgetful
□ Depressed
□ Other:_____
_____

NEUROSENSORY
□ WNL
□ Syncope/Vertigo
□ Visual Impairment
□ Other:
_____
_____

RESPIRATORY
□ WNL
□ Dyspnea/SOB
□ Cough/Sputum
□ Other:_____
_____

GENITOURINARY
□ WNL
□ Incontinence
□ Catheter/Size
□ Ileostomy
□ Other:_____
_____

MUSCULOSKELETAL
□ WNL
□ ROM:
□RUE □LUE □RLE □LLE □ Unsteady gait
□ Generalized weakness
Other:_____
_____

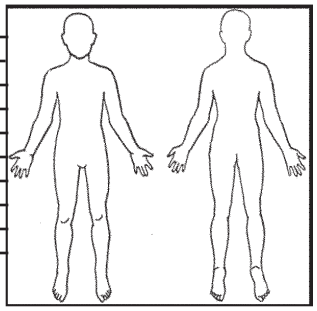
PAIN
□ None
□ Location:

Severity (0-10):
Other:_____
_____

DIGESTIVE
□ WNL
□ Nausea/Vomiting
□ Difficulty Swallowing
□ Diarrhea/Constipation
□ Colostomy
□ Incontinence
□ Last BM BM

SKIN
□ WNL □ Cellulitis □ Pressure sore
□ Rash □ Skin tear □ Wound □ Incision

	#1	#2	#3
Length			
Width			
Depth			
Drainage			
Tunneling			
Odor			
Sur tissue			
Wound bed			



Stoma:
□ Steri-strips □ Sutures □ Staples
□ JP drain □ IV line Type:_____

SAFETY CONCERNS: □ Clear pathways/safe ambulation □ Fall precautions □ Home safety □ Medication management □ IV safety □ Sharps disposal □ Oxygen safety □ Bleeding precautions □ Infection control □ Other: _____

SUPERVISORY VISIT: Follows Std Precautions □ Yes □ No Follows Plan of Care □ Yes □ No Performs Care Properly □ Yes □ No Patient satisfied □ Yes □ No HHA Present □ Yes □ No

Functional Needs (Circle): □Bathing □Grooming □Dressing □Eating □Transferring □Patient/client independent in ADL's / IADL's

Reason for Visit: □Assessment □Teaching/training □Wound care □IV Therapy □Lab draw □HHA/Companion services □PT/OT/ST/MSW services □Medication management □Other: _____

Homebound □No □Yes: Reason(must meet at least one of the following)
The patient: □Because of illness or injury, needs the aid of supportive devices such as crutches, canes, wheelchairs and walkers, the use of special transportation; or the assistance of another person in order to leave their place of residence

AND/OR □Has a condition such that leaving his or her home is medically contraindicated AND There exists a normal inability to leave home and it requires a considerable and taxing effort
□Severe SOB, SOB upon exertion □Confusion/Safety risk □Unsteady Gait
□Residual weakness □Other(specify)_____

Interventions/Instructions: Teaching/training re: □ Medication regimen, actions, side effects □ Disease process □ Bleeding precautions □ Wound/incision care □ IV therapy □ Infection control measures □ Complications to report □ Physician follow up □ Home safety □ Oxygen safety □ Diet □ Elevating legs to decrease edema □ Off loading techniques □ Sharps disposal □ Plan of care review □ Medication management □ Inability to void post foley removal □ Discharge instructions

Wound Care Performed: □ Aseptic technique □ Sterile technique □ Cleansed with NS □ Cleansed with: _____
Product applied: _____
Covered with: □ Gauze □ ABD pad □ Telfa □ Packed: _____ □ Wet to dry-NS □ Secured with tape/ace wrap/stockinette
□ Wound vac applied with □ Black □ White □ Silver foam □ Canister changed □ Constant suction □ Intermittent suction □ Pressure: _____mmHg □
Approx. drainage in canister: _____mls Color: _____

IV Therapy: Drug given: (name) _____ (dose) _____ (via) _____ (over) _____ minutes
Flushed line: □ NS _____ mls □ Before □ After meds/blood draw □ Final flush with Heparin _____u/cc _____ mls
Peripheral IV inserted (site): _____ using (catheter): _____ Site prepped with □ alcohol □ betadine □ choloraprep _____
line dressing changed on using sterile technique □ 3 alcohol swabs □ 3 provodine swabs □ chloraprep swab □ antimicrobial patch
Applied □ Occlusive dressing □ Gauze dressing □ Extension set □ Injection site □ Site free of complications □ Flushes easily □ Good blood return
□ Line removed (type) _____ □ Length _____cm □ Tip intact □ Pressure dressing applied
□ Lab draw of: _____ from (site): _____ Taken to (Lab name): _____
Administered: _____ □ IM □ SQ Site: _____ □ Pt/CG taught to administer: _____

Bowel Bladder: □ Foley catheter inserted _____ Fr _____ cc balloon using sterile technique with _____ return
Connected to □ Leg bag □ Bedside drainage bag □ Foley removed without incident □ Instructions given regarding complications to report
□ Bowel program performed □ Suppository used _____ □ Digital stimulation Results: _____
□Written instructions given re: _____
Other: _____
□ See communication sheet for addendum notes

Patient/Caregiver Response: □ Patient tolerated interventions well □ Patient /CG verbalized/demonstrated understanding of instructions provided Patient/Caregiver independent with: □ Wound care □ IV therapy □ Medication management □ Wound/ incision healing without complications
□ Tolerating medications without side effects or adverse reactions □ Patient will follow with physician as instructed
□ Discharge/no other nursing visits needed/ordered Other: _____ Next visit: _____
Patient/Caregiver unable to be independent in care due to: □ Physical limitations □ Learning limitations □ Refuses to learn □ N/A Pt/CG are independent

Patient Rights & Responsibilities:
□ Reviewed Advance Directives Any Changes □ Yes □ No □ POC Any Changes □ Yes □ No □ Rights for a Representative Any Changes □ Yes □ No
If yes, document on reverse

Patient/Designee: I certify that the Matrix Home Care Employee listed on this note worked the times indicated and the work was performed in a satisfactory manner.

I agree to the times regarding this slip. Time in: _____ □ am □ pm Time out: _____ □ am □ pm

Patient Signature: _____ Date: _____

Caregiver signature/title: _____ Date: _____ Rvsd 12/2022

matrix
HOME HEALTH CARE

Communications/Progress Notes

Patient/Client Name: _____

Date	Time	Progress Notes