Highlite Home Care
we are here for your every need

SKILLED NURSING PROGRESS NOTE

DATE OF VISIT ____/____/____

TIME IN _____ AM ☐ PM ☐ - OUT _____ AM ☐ PM ☐

MARK ALL APPLICABLE WITH AN X CIRCLE APPROPRIATE ITEM | MEDICARE ☐ MEDICAID ☐ MX OTHER ☐

TYPE OF VISIT ☐ SN ☐ SN/SUP. ☐ EMERGENCY VISIT Other. _____

T' _____ WT _____ BS _____
Resp. _____ Reg. ☐ Irreg. ☐
Pulse: A _____ R _____
☐ Regular ☐ Irregular

B/P	LYING	Sitting	Standing
Right			
Left			

CARDIOVASCULAR

- ☐ Fluid retention
- ☐ Chest pain
- ☐ Neck vein distension
- ☐ Edema (specify) ☐RUE ☐LUE ☐RLE ☐LLE
- ☐ Ascites
- ☐ Peripheral Pulse
- ☐ Arrhythmia
- ☐ Other
- ☐ No Deficit

RESPIRATORY

- ☐ Rales/Rhonchi/Wheeze
- ☐ R. Lung: ☐ L. Lung:
- ☐ Cough/Sputum
- ☐ Dyspnea/SOB
- ☐ Orthopnea
- ☐ O2: LPM: VIA:
- ☐ No Deficit

DIGESTIVE

- ☐ Bowel sounds LBM:
- ☐ Nausea/Vomiting
- ☐ Anorexia./NPO
- ☐ Epigastric distress/heart burning
- ☐ Difficulty swallowing
- ☐ Abdominal distention/tenderness
- ☐ Colostomy/Ileostomy
- ☐ Bowel incontinence
- ☐ Constipation/Impaction/Diarrhea
- ☐ Diet: Appetite: ☐ good ☐ Fair ☐ Poor
- ☐ Fluid Intake
- ☐ Enteral Feeding Route:
- ☐ Type:
- ☐ Amount:
- ☐ Via:
- ☐ Flushing:
- ☐ No Deficit:

GENITOURINARY

- ☐ Burning/Dysuria
- ☐ Distention/Retention
- ☐ Frequency/Urgency/Hesitancy
- ☐ Hematuria/Pyuria/Odor
- ☐ Bladder incontinence/continence
- ☐ Catheter/Ileostomy/Nefrostomy
- ☐ Suprapubic Catheter ☐ External ☐
- ☐ Foley Catheter
- ☐ Size Fr cc
- ☐ Last changed:
- ☐ Irrigation cc/nss
- ☐ Urine
- ☐ Discharge/Flank pain
- ☐ Cath Leakage/dislodgement
- ☐ Oliguria/Anuria/Poliuria
- ☐ Dialise Freq:
- ☐ AV Shunt Bruite Thrill
- ☐ Tesio / Quintom
- ☐ Other:
- ☐ No Deficit

SKIN

- ☐ Warm/Dry
- ☐ Cold/Clammy/Chills
- ☐ Jaundice/Pallor/Cyanosis
- ☐ Integrity
- ☐ Chills
- ☐ Decubitus/Wound/Ulcer/Surgical
- ☐ Stage ☐ I ☐ II ☐ III
- ☐ Rash/Itching/Discoloration
- ☐ Turgor/Hydration
- ☐ Staples/Stitches
- ☐ Echmosis/Bruises/Blister
- ☐ Redness/Scaling
- ☐ Skin Graft
- ☐ Other
- ☐
- ☐ No Deficit

MUSCULOSKELETAL

- ☐ Balance/Unsteady gait/Endurance
- ☐ Weakness/Ambulates With Assistance
- ☐ Assist device type:
- ☐ Limited movement/ROM
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis ☐ Atrophy
- ☐ No Deficit

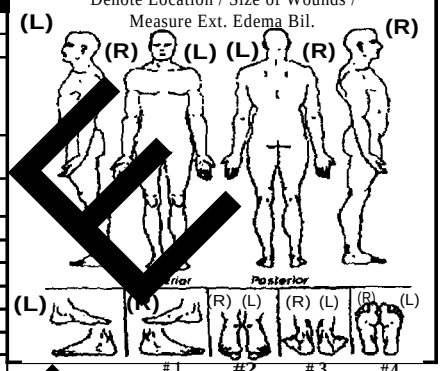
NEUROSENSORY

- ☐ Syncope/Vertigo/Dizziness
- ☐ Headache
- ☐ Grasp ☐ Equal ☐ Unequal
  Right: _____
  Left: _____
- ☐ Movement ☐RUE ☐LUE ☐RLE ☐LLE
- ☐ Pupil reaction Brisk ☐ Sluggish ☐ Right: Left:
- ☐ Hand Tremors
- ☐ Poor Hand-Eye Coordination
- ☐ .Poor Manual Dexterity
- ☐ Speech impairment
- ☐ Hearing impairment
- ☐ Visual impairment/Bli ss
- ☐ Tactile sensation/Ptosis
- ☐ No Deficit

EMOTIONAL STAT

- ☐ Orien T ☐ P ☐ PL
- ☐ F ful/C sed
- ☐ oriented P ☐ PL☐
- ☐ Lethargic/Fa e
- ☐ matose
- ☐ R gitated
- ☐ Anxi Depressed
- ☐ Other:
- ☐ Verbally a d

Denote Location / Size of Wounds / Measure Ext. Edema Bil.



	#1	#2	#3	#4
Length				
Width				
Depth				
Drainage Type:				
Drainage Amount:				
Tunneling				
Undermining				
Odor				
Surr Tissue				
Edema				
Stoma				

PAIN

Intensity 0 1 2 3 4 5 6 7 8 9 10

Frequency of Pain interfering with patient's Activity or movement:
- ☐ Patient has no Pain
- ☐ Patient has minimal/mild pain but not interfere with activity or movement

FREQUENCY OF PAIN
- ☐ 1 - less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 -All of the time

PAIN PROFILE- Aching ☐ Dull ☐ burning ☐
Primary Site. _____

Current: Pain ma m effectiveness
_____
_____

☐ Pain Management Teac to patient/family *(document below)*

Patient pain goal: _____

Pr toward pain goal: _____

☐ No Defi

SKILLED INTERVENTION / TEACHING / PT RESPONSE

INTERVENTIONS / INSTRUCTIONS CONT.
- ☐ Skilled Observation/Assesment
- ☐ Foley Change ☐ Foley irrigation
- ☐ Wound care/Dressing Change
- ☐ Venipuncture/Lab: _____
- ☐ Prep./Admin. Insulin
- ☐ IM injection/Sq Injection
- ☐ Diabetic. Observation/Care
- ☐ Observation/Inst. Med (N or C) effects/Side effects: _____
- ☐ Inst. Safety Precaution/Emergency Prep
- ☐ Inst. Disease Process
- ☐ Diet Teaching: _____

- ☐ Safety Factors Management Conducted
- ☐ Teach Infant/Childcare ☐ O2 Teaching
- ☐ Peg/GT Tube Site care
- ☐ Picc line Care

TECHNIQUES USED:
- ☐ Universal Precautions Followed
- ☐ Aseptic Tech. Used/sterile tech. used
- ☐ Quality control of Glucometer performed as per agency p & p
- ☐ Glucometer calib. On: _____
- ☐ Soiled Dressings double bagged
- ☐ Sharps discarded inside Sharps container

INFUSION/IV SITE: _____
- ☐ IV Tubing Change/Cap Change
- ☐ Central Line Dressing Change
- ☐ IV Site Dressing Change/IV Site Change

SAMPLE

APPROXIMATE NEXT VISIT DATE ____/____/____ PLAN FOR NEXT VISIT:

- ☐ PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O or CG able / willing for Inj. Adm. At this time ☐ Tx/well Tolerated by PT
- ☐ PT / S. 0. / CG able to return correct demonstration of tech. /Procedure Inst. On ☐ No s/o or CG able / willing for Wound Care at this time
- ☐ PT / S. 0. / CG needs reinforcement of inst. given. ☐ Written material supplied

CARE PLAN: ☐ reviewed / Revised with patient/ client Involvement ☐ Outcome achieved ☐ PRN
Order Obtained: ☐ Yes ☐ No
MEDICATION STATUS: ☐ No Change ☐ Order Obtained MD: _____
DISCHARGE PLANNING DISCUSSED? yes ☐ No ☐ N/A ☐
SUPPLIES USED: _____
CARE COORDINATION: ☐ Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ CM
☐ New Order:

HOMEBOUND STATUS:
- ☐ Gait instability
- ☐ Taxing effort to leave the home
- ☐ Require assistance of another to leave the home.
- ☐ SOB upon exertion, severe SOB
- ☐ Require use of assistive device (crutches, cane, wheelchair, walker)
- ☐ Dyspneic/Require use of O2
- ☐ Unable to safely leave Home unattended
- ☐ Needs assistance for all activities
- ☐ Other: _____

PART 1- **Clinical Record** | **PART 2- Employee**

PATIENT (CLIENT NAME (First, Middle Initial (Print))

SIGNATURE/DATE - Complete TIME OUT (above) prior to signing below. (circle title) RN/LPN

Nurse *(signature/title)* Print Name

Medical Record #: