Professional Home Health Care, Inc.

☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS BEFORE SERVICE PROVIDED SG

HIGH TECH SKILLED NURSING NOTE

PATIENT NAME - Last, First, Middle Initial | ID#

DATE OF VISIT

TIME IN _____ AM PM OUT _____ AM PM

TYPE OF VISIT: ☐ SN ☐ SN & Super. ☐ Super. Only ☐ Other

HOMEBOUND REASON: ☐ Needs assistance for all activities ☐ Requires assistance to ambulate ☐ Residual weakness ☐ Contusion, unable to go of home alone ☐ Unable to safely leave home unassisted ☐ Severe SOB, SOB upon exertion ☐ Dependent upon adaptive device(s) ☐ Medical restrictions ☐ Other (specify)

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

VITALS

T _____ Wt _____ BS _____

Resp. _____ ☐ Reg. ☐ Irregular

Pulse: A _____ R _____

☐ Reg. ☐ Irregular

B/P	LYING	SITTING	STANDING
RIGHT			
LEFT			

CARDIOVASCULAR

- Fluid Retention
- Chest Pain
- Neck Vein Distension
- Edema (specify): ☐ RUE ☐ LUE ☐ RLE ☐ LLE
- Ascites
- Peripheral Pulses
- Arrhythmia
- Other:
- No deficit

RESPIRATORY

- Rales / Ronchi / Wheeze
- ☐ R. Lung ☐ L. Lung
- Cough / Sputum
- Dyspnea / SOB
- Orthopnea
- 02. LPM: VIA:
- No deficit

DIGESTIVE

- Bowel Sound / LBM
- Nausea / Vomiting
- Anorexia / NPO
- Epigastric Distress
- **Difficulty Swallowing**
- **Abdominal Distention**
- **Colostomy / Ileostomy**
- **Bowel Incontinence**
- **Constipation / Impaction / Diarrhea**
- **Diet:** **Appetite:**
- **Fluid Intake:**
- **Enteral Feeding Route:**
- **Type:**
- **Amount:**
- Via:
- **Flushing:**
- No Deficit

GENITOURINARY

- Burning / Dysuria
- Distension / Retention
- Frequency / Urgency / Hesitancy
- Hematuria
- Bladder Incontinence
- Catheter / Ileoconduit
- Suprapubic Catheter
- Foley Catheter
- Size Fr. cc.
- Last Changed:
- Irrigation cc / nsa
- Urine
- Output cc / hr.
- Color
- Consistency
- Odor
- Pain / Discharge
- Cath. Leakage / Dislodge
- Other

SKIN

- **Warm / Dry**
- **Cold / Clammy**
- **Jaundice / Pallor / Cyanosis**
- **Integrity**
- **Chills**
- **Decubitus / Wound / Ulcer**
- **Rash / Itching / Discoloration**
- **Turgor / Hydration**
- **Tube Insertion Site**
- **Other**
- No Deficit

MUSCULOSKELETAL

- Balance / Unsteady gait / Endurance
- Weakness / Ambulates with Assistance
- Limited Movement / Rom:
- ☐ Chair Bound ☐ Bed Bound
- ☐ Contracture ☐ Paralysis
- No Deficit

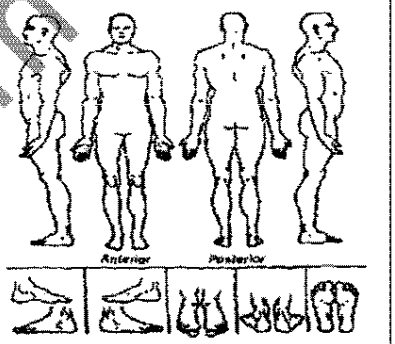
NEUROSENSORY

- Syncope
- Headache
- Grasp ☐ Equal ☐ Unequal
  - Right:
  - Left:
- Movement
  - ☐ RUE ☐ LUE
  - ☐ RLE ☐ LLE
- Pupil Reaction
  - Right Left
- Hand Tremors
- Poor Hand Eye coordination
- Poor Manual Dexterity
- Speech Impairment
- Hearing Impairment
- Visual Impairment / Blindness
- Tactile Sensation
- **No deficit**

EMOTIONAL STATUS

- **Oriented** ☐ A ☐ P ☐ P
- **Forgetful / Confused**
- **Disoriented** ☐ A ☐ P ☐ P
- **Lethargic / Semi Lethargic**
- **Comatose**
- **Restless / Agitated**
- **Anxious / Depressed**
- **Other**
- No Deficit

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



	#1	#2	#3	#4
length				
Width				
Depth				
Drainage				
Tunneling				
Odor				
Surr Tissue				
Edema				
Stoma				

PAIN

Frequency of pain interfering with patients activity or movement
- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ Pain Management Teaching to patient / family

Current pain management & effectiveness

Progress toward pain goal:

Patient's pain goal:

Primary Site:

Intensity 0 1 2 3 4 5 6 7 8 9 10
Low High ☐ No deficit

SUPERVISION

COMPLETE FOR SUPERVISORY VISIT CIRCLE Y/N
1-POOR 2- FAIR 3- GOOD

Supervisory visit Y N	Patient social needs met Y N
RN/LPN/AIDE Following care plan Y N	Universal & safety prec. followed Y N
Patient physical needs met Y N	Employee present Y N
Patient environmental needs met Y N	Patient satisfied with service Y N
Assignment update Y N	Rapport with patient / s.o. 1 - 2 - 3
Service change requested Y N	Clinical / Technical skill 1 -2 - 3
Patient mental needs met Y N	Patient response to Care 1 - 2 - 3

SKILLED INTERVENTION - TEACHING - PT. RESPONSE

☐ Infusion/IV Therapy order obtained/verified ☐ IV Therapy complication observed: ☐ Pain & Irritation ☐ Infiltration & extravasion ☐ Occlusion/Obstruction

Lumens: ☐ Single ☐ Double ☐ Triple ☐ Fluid overload ☐ Other, explain:

Flush Solution: Frequency: Patent: ☐ Yes ☐ No Site skin condition, explain:

Intravenous IV Port: ☐ Yes ☐ No Flush Ordered: ☐ Yes ☐ No ☐ Flushed today

PLAN FOR NEXT VISIT

☐ PT / S.O. / CG verbalized understanding of inst. given ☐ No S/O pr C/G able / willing for Inj. Adm. at this time ☐ Tx well tolerated by PT.
☐ PT / S.O. / CG able to return correct demonstration of Tech. / procedure Inst. on ☐ No S/O or C/G able / willing for wound care at this time.

INTERVENTIONS / INSTRUCTIONS

- ☐ **Skilled Observation / Assessment**
- ☐ **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
- ☐ Peg / GT Tube Site Care
- ☐ Trache. Care / Suctioning

TECHNIQUES USED:
- ☐ Universal Precautions Followed
- ☐ Aseptic 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 ☐ Peripheral Line ☐ Central line
- ☐ Cap Change ☐ Medline Catheter
- ☐ Central Line Dressing Change
- ☐ IV Site Dressing Change Insertion date:
- ☐ IV Site Change
- ☐ Infusion by Pump
- ☐ Infusion Med:
- ☐ Infusion Rate:
- Comments:
- ☐ Infusion Well Tol. by Pt.

☐ Patient unable to perform own W/C due to

CARE PLAN: ☐ Reviewed / Revised with patient / client involvement. ☐ Outcome achieved ☐ PRN Order Obtained:
MEDICATION STATUS ☐ No Change ☐ Order Obtained:
DISCHARGE PLANNING DISCUSSED? Yes ☐ No ☐ N/A ☐
SUPPLIES USED:

CARE COORDINATION: Physician ☐ PT ☐ OT ☐ ST ☐ SS ☐ SN ☐ CM ☐
☐ Other:

APPROXIMATE NEXT VISIT DATE

NURSE SIGNATURE / PRINT NAME **RN / LN** **DATE**

Signature / Date -Complete TIME OUT (above) prior to signing below (circle title) ___/___/___

QUALITY CARE NURSING SERVICES, INC.

DATE OF VISIT: _____

HIGH TECH NURSING PROGRESS NOTES ADDENDUM

Client's Name: _____ Med. Record # _____

☐ Infusion / IV Therapy order obtained, verified ☐ PT ID PERFORMED VIA NAME, DOB, AND ADDRESS BEFORE SERVICE PROVIDED SG

INFUSION / IV THERAPY

❑ Peripheral line ❑ Central line ☐ Medline catheter

Type/brand _____

Size: _____ Gauge: _____ Length: _____

❑ Groshong ❑ Non-Groshong ❑ Tunneled ❑ Non-funneled

Insertion site _____ Insertion date _____

Lumens: ❑ Single ❑ Double ❑ Triple

Flush solution: _____ Frequency: _____

Patent: ❑ Yes ❑ No

❑ Injection cap change ❑ Dressing change ❑ Sterile ❑ Clean

Performed by: ❑ Patient ❑ RN ❑ Caregiver ❑ Other: _____

Site/skin condition _____

External catheter length _____

Other/Comment: _____

IV Therapy complication observed: ❑ Pain & irritation ❑ Infiltration & exravasion ❑ Occlusion/obstruction ❑ fluid overload Other: _____

PICC Specific: X-ray verification

Circumference of arm _____ ❑ Yes ☐ No

IVAD Port Specific: Reservoir: ❑ Single ☐ Double

Huber gauge/length _____

Accessed: ❑ No ❑ Yes

Intravenous IV Port: ❑ Yes ☐ No *(vascular access device)* Flush Ordered: ❑ Yes ☐ No

Flushed today: ❑ Yes ☐ No

Epidural/Intrathecal Access:

Site/skin condition _____

Infusion solution (type/volume/rate) _____

Dressing _____

Other/Comment: _____

❑ IV-Infusion Medication(s) administered:

Drug Name: _____

Dose _____ Route _____

Duration of therapy _____

❑ IV-Infusion Medication(s) administered:

Drug Name: _____

Dose _____ Route _____

Duration of therapy _____

Comment/Plan: _____

❑ Pump: (type, specify) _____

Administered by: ☐ Patient ❑ Caregiver ❑ RN ❑ Other _____

Purpose of Intravenous Access: ❑ Lab draws _____

❑ Antibiotic therapy _____ ❑ Expand intravascular volume

❑ Chemotherapy ❑ Maintain venous access ❑ Pain control

❑ Hydration ❑ Parenteral nutrition (TPN) ❑ N/A

❑ Blood and its derivatives ❑ Other _____

❑ Infusion care provided during visit _____

Interventions/ Instructions/ Comments/ Problems Detected:

Removing line date (if know): _____ ❑ N/A

TECHNIQUES USED:

☐ Universal Precautions Followed

☐ Aseptic Tech. Used.

☐ Soiled Dressings Double Bagged

☐ Sharps Discarded Inside Sharps Container

☐ Infusion Well Tolerated by Patient

Comments: _____

Employee Name:

Signature/ Title: _____ Date: _____