NURSING NOTES GUIDELINES

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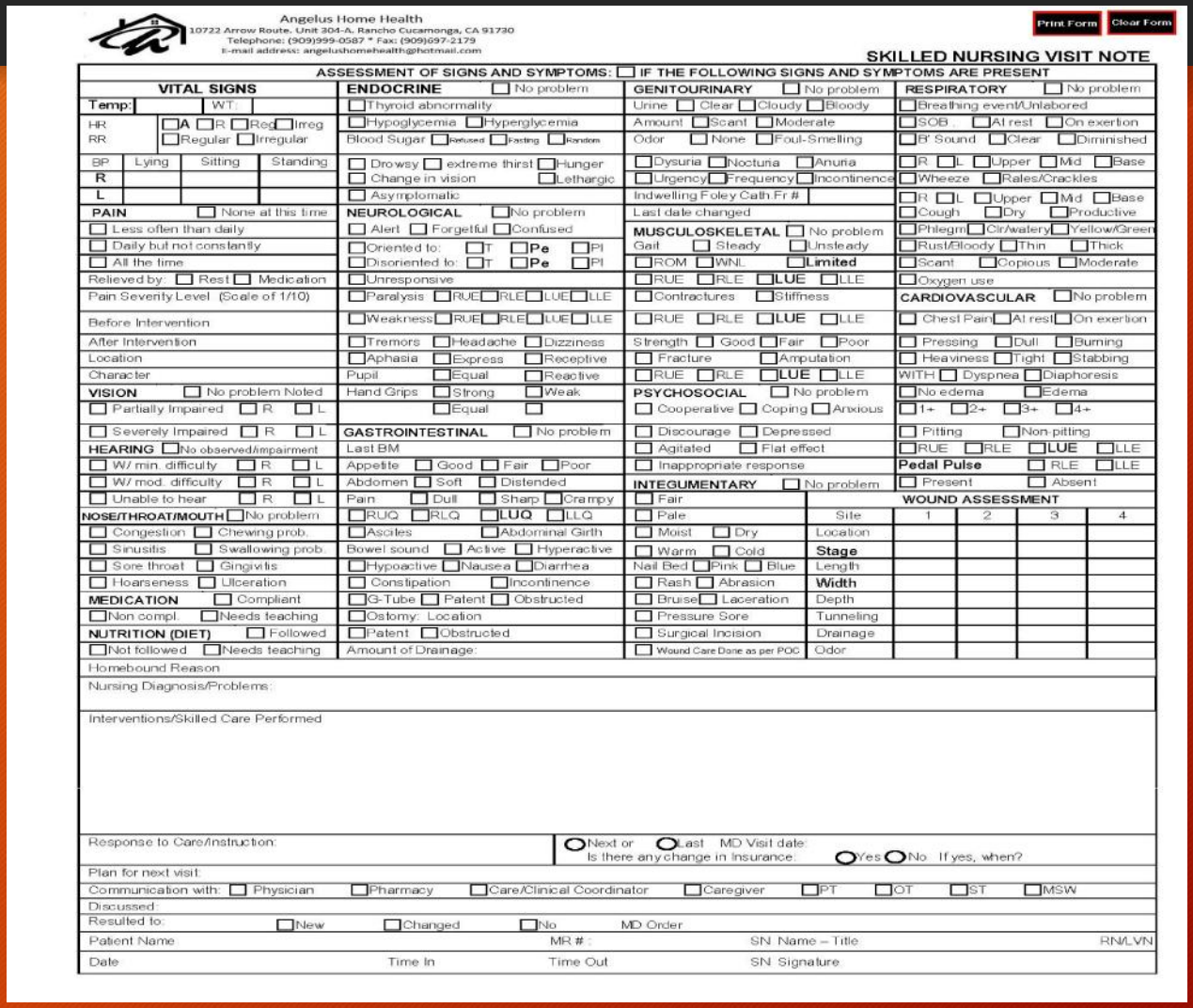
Angelus Home Health

Submission

- Please submit SN notes and route sheets on a **weekly basis every Monday**
- Send them either by fax (909) 697-2179 , e-mail (angelushomehealth@hotmail.com), mail or drop-off.
- If sending by fax, please mail or drop off originals in the office. If sending by e-mail, you will need to e-sign or sign the print outs when you come to the office for your paychecks.

SN Note Template



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Print Form | Clear Form

SKILLED NURSING VISIT NOTE

ASSESSMENT OF SIGNS AND SYMPTOMS: ☐ IF THE FOLLOWING SIGNS AND SYMPTOMS ARE PRESENT

VITAL SIGNS
Temp: | WT:
HR ☐A ☐R ☐Reg ☐Irreg
RR ☐Regular ☐Irregular
BP | Lying | Sitting | Standing
R
L
PAIN ☐ None at this time
☐ Less often than daily
☐ Daily but not constantly
☐ All the time
Relieved by: ☐ Rest ☐ Medication
Pain Severity Level (Scale of 1/10)
Before Intervention
After Intervention
Location
Character
VISION ☐ No problem Noted
☐ Partially Impaired ☐ R ☐ L
☐ Severely Impaired ☐ R ☐ L
HEARING ☐No observed/impairment
☐ W/ min. difficulty ☐ R ☐ L
☐ W/ mod. difficulty ☐ R ☐ L
☐ Unable to hear ☐ R ☐ L
NOSE/THROAT/MOUTH ☐No problem
☐ Congestion ☐ Chewing prob.
☐ Sinusitis ☐ Swallowing prob.
☐ Sore throat ☐ Gingivitis
☐ Hoarseness ☐ Ulceration
MEDICATION ☐ Compliant
☐Non compl. ☐Needs teaching
NUTRITION (DIET) ☐ Followed
☐Not followed ☐Needs teaching

ENDOCRINE ☐ No problem
☐Thyroid abnormality
☐Hypoglycemia ☐Hyperglycemia
Blood Sugar ☐Refused ☐Fasting ☐Random
☐ Drowsy ☐ extreme thirst ☐Hunger
☐ Change in vision ☐Lethargic
☐ Asymptomatic
NEUROLOGICAL ☐No problem
☐ Alert ☐ Forgetful ☐Confused
☐Oriented to: ☐T ☐Pe ☐Pl
☐Disoriented to: ☐T ☐Pe ☐Pl
☐Unresponsive
☐Paralysis ☐RUE ☐RLE ☐LUE ☐LLE
☐Weakness ☐RUE ☐RLE ☐LUE ☐LLE
☐Tremors ☐Headache ☐Dizziness
☐Aphasia ☐Express ☐Receptive
Pupil ☐Equal ☐Reactive
Hand Grips ☐Strong ☐Weak
☐Equal ☐
GASTROINTESTINAL ☐ No problem
Last BM
Appetite ☐ Good ☐ Fair ☐Poor
Abdomen ☐ Soft ☐ Distended
Pain ☐ Dull ☐ Sharp ☐Crampy
☐RUQ ☐RLQ ☐LUQ ☐LLQ
☐Ascites ☐Abdominal Girth
Bowel sound ☐ Active ☐ Hyperactive
☐Hypoactive ☐Nausea ☐Diarrhea
☐ Constipation ☐Incontinence
☐G-Tube ☐ Patent ☐ Obstructed
☐Ostomy: Location
☐Patent ☐Obstructed
Amount of Drainage:

GENITOURINARY ☐ No problem
Urine ☐ Clear ☐ Cloudy ☐ Bloody
Amount ☐Scant ☐ Moderate
Odor ☐ None ☐Foul-Smelling
☐Dysuria ☐Nocturia ☐Anuria
☐Urgency ☐Frequency ☐Incontinence
Indwelling Foley Cath.Fr #
Last date changed
MUSCULOSKELETAL ☐ No problem
Gait ☐ Steady ☐Unsteady
☐ROM ☐WNL ☐**Limited**
☐RUE ☐RLE ☐**LUE** ☐LLE
☐Contractures ☐Stiffness
☐RUE ☐RLE ☐**LUE** ☐LLE
Strength ☐ Good ☐Fair ☐Poor
☐ Fracture ☐Amputation
☐RUE ☐RLE ☐**LUE** ☐LLE
PSYCHOSOCIAL ☐ No problem
☐ Cooperative ☐ Coping ☐ Anxious
☐ Discourage ☐ Depressed
☐ Agitated ☐ Flat effect
☐ Inappropriate response
INTEGUMENTARY ☐ No problem
☐ Fair
☐ Pale
☐ Moist ☐ Dry
☐ Warm ☐ Cold
Nail Bed ☐Pink ☐ Blue
☐ Rash ☐ Abrasion
☐ Bruise ☐ Laceration
☐ Pressure Sore
☐ Surgical Incision
☐ Wound Care Done as per POC

RESPIRATORY ☐ No problem
☐Breathing event/Unlabored
☐SOB ☐At rest ☐On exertion
☐B' Sound ☐Clear ☐Diminished
☐R ☐L ☐Upper ☐Mid ☐Base
☐Wheeze ☐Rales/Crackles
☐R ☐L ☐Upper ☐Mid ☐Base
☐Cough ☐Dry ☐Productive
☐Phlegm ☐Clr/watery ☐Yellow/Green
☐Rust/Bloody ☐Thin ☐Thick
☐Scant ☐Copious ☐Moderate
☐Oxygen use
CARDIOVASCULAR ☐No problem
☐ Chest Pain ☐At rest ☐On exertion
☐ Pressing ☐Dull ☐Burning
☐ Heaviness ☐Tight ☐Stabbing
WITH ☐ Dyspnea ☐Diaphoresis
☐No edema ☐Edema
☐1+ ☐2+ ☐3+ ☐4+
☐ Pitting ☐Non-pitting
☐RUE ☐RLE ☐**LUE** ☐LLE
Pedal Pulse ☐ RLE ☐LLE
☐ Present ☐ Absent

WOUND ASSESSMENT

Site	1	2	3	4
Location				
Stage				
Length				
Width				
Depth				
Tunneling				
Drainage				
Odor				

Homebound Reason
Nursing Diagnosis/Problems:
Interventions/Skilled Care Performed
Response to Care/Instruction:
○Next or ○Last MD Visit date:
Is there any change in Insurance: ○Yes ○No If yes, when?
Plan for next visit:
Communication with: ☐ Physician ☐Pharmacy ☐Care/Clinical Coordinator ☐Caregiver ☐PT ☐OT ☐ST ☐MSW
Discussed:
Resulted to: ☐New ☐Changed ☐No MD Order
Patient Name MR # SN Name – Title RN/LVN
Date Time In Time Out SN Signature

SN Notes / QA

- Are to be typewritten using the given template to make revisions easier
- If you are unable to save your notes, please bring your laptop in the office and we will install the program
- All notes will be checked by QA **prior to posting** your visit to ensure complete and accurate documentation.
- All notes go through the QA process, thus expect some revisions and corrections. You have a week to resubmit revised notes to the office

Guidelines

- Make sure that date, time, VS and BS on your route sheet matches your notes.
- Make sure your times do not overlap or conflict with another patient.
- Put a 5-10 minute interval between patients even if they are in the same house/facility
- You need to write the date and time while at the patient's house because the route sheet has a duplicate copy that is left at the patient's house.

Guidelines

- Make sure notes are **COMPLETELY** filled out.
  - Common areas not filled out are the LBM, pain assessment, NANDA, wound assessment, MD visit date and change in insurance
- Please use the 485/POC as a guide when doing your notes.
  - It will tell you the things that need to be reflected on your notes, parameters that are reportable to the agency/MD, detailed wound treatment and patient's diagnoses and medications that you can discuss

Guidelines

- If VS, BS or pain is out of normal range
  - Do your intervention/teaching then recheck it.
  - Do not leave the patient with abnormal/unstable readings without reporting to MD/case manager
  - Address the problem for that day and document any interventions, teachings or new MD orders in your notes.

NANDA Nursing Diagnosis

- Please ensure that NANDAs and interventions match and that they reflect the findings from your head to toe assessment. (ex. If BP is high that day, then discuss HTN management; if pt had a fall, then discuss fall/safety measures).
- If your patient has a new medication noted or a new diagnosis, please discuss and focus on that (ex. Antibiotics or UTI).

What to Discuss

- Do not repeat the same NANDA and intervention on your notes. Discuss a different problem, diagnosis or medication each visit.
  - tip: use your 485 as a guide. Even having a daily/BID patient is not an excuse to have the same teaching all the time.
- Be careful of copying & pasting teachings as your intervention/teaching should be personalized for your patient.
- If you have problems thinking of teachings/NANDAs, please seek help from the case managers.

What to Discuss

- Use negative reporting in your notes.
- Make sure each visit is a skilled visit.
- Provide **detailed** documentation of all procedures/interventions done (ex wound care).
- Use Medicare approved abbreviations only
- **Remember: If it's not documented, then it wasn't done !!!**

PAIN

- Always assess pain and indicate where and what pain levels.
- If pt has pain meds and pt states they have no pain, ask where they usually have pain and document it as controlled.
- Pain should be part of your vital signs

Accuracy of Notes

- When verbally reporting to the office (ex: wound sizes, VS, cough, constipation) make sure they will be the same information on your notes for that day.
- We fax communication notes and orders to the MD offices and once it has been sent, then it cannot be revised.
- If you submit your notes with different information, then you will have to revise your notes.

Signature

- Make sure to sign your notes
- Don’t forget to write your position (RN, LVN)