HomeCare Resource, LLC

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SKILLED NURSE VISIT REPORT

Client Name: _____ **Visit Date:** _____

Employee Name: _____ RN / LPN

VISIT TYPE	Visit Start Time	Visit Ended At:
New Visit		
Continuing Visit		
Non-Billable Visit		
Discharge Visit		

HOMEBOUND STATUS (check only one):

☐ **NOT HOMEBOUND**

☐ **HOMEBOUND**, *specify*:

REASON:
- ☐ Bedbound
- ☐ SOB w/AMB > 10 Ft.
- ☐ MAX Assistance in all activities
- ☐ Weak with Poor Endurance
- ☐ Other, *Specify*: _____

VITAL SIGNS: ☐ Client Refused V/S; RN CM Notified.

Temperature: _____˚F → *Oral / Tympanic* Pulse: _____ → *Apical / Radial* Respiratory Rate: _____
Blood Pressure: _____ → *R Arm / L Arm* → *Sitting / Standing / Lying* Pulse Ox: N/A -or- ____ % @ ___L
Weight: _____ → *Actual / Per Client* Blood Glucose: N/A / _____ mg/dL @ _____ AM / PM

Relevant Medical Diagnoses: _____

PHYSICAL ASSESSMENT:

NEURO:
ALERT & ORIENTED: ☐ Person ☐ Place ☐ Time
Behavior Appropriateness: ☐ Yes ☐ No
Speech Clear / Understandable: ☐ Yes ☐ No
Comments: _____

CARDIO:
CYANOSIS, PALPITATIONS and/or **CHEST PAIN**: ☐ Yes ☐ No
☐ L Pedal Edema ☐ R Pedal Edema ☐ None
Comments: _____

RESP:
LUNG SOUNDS: ☐ Clear ☐ Equal ☐ Wheezing ☐ Rales ☐ Rhonchi
☐ Fine Crackles ☐ Coarse Crackles ☐ Other: _____
Location: ☐ RU ☐ RM ☐ RL ☐ LU ☐ LL
Comments: _____

GI / GU:
DATE OF LAST BM: _____
Abdomen: ☐ Flat ☐ Rounded ☐ Protrubent ☐ Scaphoid ☐ Other: _____
Bowel Sounds: ☐ HYPOactive ☐ NORmal ☐ HYPERactive
☐ RUQ ☐ RLQ ☐ LUQ ☐ LLQ
Urinary Continence: ☐ Continent ☐ Incontinent
Comments: _____

MSK / MS:
JOINT SWELLING / TENDERNESS: ☐ Yes ☐ No
ROM all joints (within client's normal): ☐ Normal ☐ Abnormal
Comments: _____

PAIN:
PAIN: ☐ N/A ☐ Sharp ☐ Dull ☐ Aching ☐ Throbbing
☐ Stabbing ☐ Burning ☐ Other: _____
Location: _____ Frequency: ☐ Constant ☐ Intermittent
Pain Rate (0 = No Pain, 10 = Worst Pain): _____ Comments: _____

Client Name / Date: _____

NUTRITION

APPETITE: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Fluid Intake: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
Mucous Membranes: ☐ WNL ☐ Other: _____
Skin Warm / Dry / Intact: ☐ WNL ☐ Other: _____
Skin Description: ☐ Rash ☐ Itching ☐ Bruising ☐ Petechiae
☐ Lesions ☐ Other: _____
Skin Tugor: ☐ WNL ☐ Other: _____
Comments: _____

NUTRITIONAL SCREENING TOOL:

Nausea?	☐ Yes: 4pts	☐ No
Illness/condition req. change in kind and/or amt. eaten?	☐ Yes: 2pts	☐ No
Eats ≤ 2 meals/day	☐ Yes: 3pts	☐ No
Eats few fruits, vegetables, milk products?	☐ Yes: 2pts	☐ No
Has ≥ 3 drinks (beer, liquor, wine) almost QD?	☐ Yes: 2pts	☐ No
Tooth / mouth problems making it hard to eat?	☐ Yes: 2pts	☐ No
NOT enough money to buy needed food?	☐ Yes: 4pts	☐ No
Eats alone most of time	☐ Yes: 1pt	☐ No
Takes ≥ 3 prescription or OTC drugs / day?	☐ Yes: 1pt	☐ No
Lost/gained 10lbs over last 6 months w/o wanting to?	☐ Yes: 2pts	☐ No
Not always able to shop, cook and/or feed self?	☐ Yes: 2pts	☐ No

SCORE (2 or more "yes" answers and/or involuntary weight-loss may signify a moderate to high nutritional risk): _____ **TOTAL**

***For 2 or more 'yes' answers: RN Case Manager Notified* ☐
Ongoing issue for Client; RN CM aware: ☐

WOUND ASSESSMENT (multiple wounds, attach separate page):

WOUND TYPE: ☐ **NONE** ☐ Abrasion ☐ Laceration ☐ Burn
WOUND: ☐ Bruise ☐ Pressure Ulcer ☐ Stasis Ulcer
☐ Puncture Wound ☐ Surgical Wound ☐ Other: _____

Wound Location: ☐ None ☐ Anterior Trunk ☐ Posterior Trunk
☐ Left Leg ☐ Right Leg ☐ Sacrum / Buttocks
☐ Left Foot ☐ Right Foot ☐ Perineum
☐ Left Arm ☐ Right Arm ☐ Head / Neck
☐ Left Hand ☐ Right Hand ☐ Other: _____

Wound Description: Length: _____ Width: _____ Depth: _____
Tunneling? ☐ Yes ☐ No Comments: _____
Undermining? ☐ Yes ☐ No Comments: _____

Drainage (check all): ☐ None ☐ Clear ☐ Purulent ☐ Mucoid
☐ Serosanguinous ☐ Bright Red ☐ Dark Red ☐ Brown
☐ Black ☐ Green ☐ Yellow ☐ Tan
☐ Grey ☐ Blue / Green ☐ Other: _____

Drainage Amount: ☐ None ☐ Dried ☐ Scant ☐ Moderate
☐ Large ☐ Copious ☐ Other: _____

Tissue Within: ☐ Intact ☐ Gaping ☐ Pink ☐ Red ☐ Black
(check all that apply) ☐ White ☐ Yellow ☐ Tan ☐ Brown ☐ Grey
☐ Blue ☐ Pale ☐ Dusky ☐ Erythema ☐ Edematous
☐ Supple ☐ Friable ☐ Denuded ☐ Keloid ☐ Beefy
☐ Stringy ☐ Plump ☐ Macerated ☐ Crusty ☐ Mushy
☐ Firm ☐ Indurated ☐ Malleable ☐ Cool ☐ Warm
☐ Hot ☐ Other: _____

Tissue Surrounding: ☐ Intact ☐ Gaping ☐ Pink ☐ Red ☐ Black
(check all that apply) ☐ White ☐ Yellow ☐ Tan ☐ Brown ☐ Grey
☐ Blue ☐ Pale ☐ Dusky ☐ Erythema ☐ Edematous
☐ Supple ☐ Friable ☐ Denuded ☐ Keloid ☐ Beefy
☐ Stringy ☐ Plump ☐ Macerated ☐ Crusty ☐ Mushy
☐ Firm ☐ Indurated ☐ Malleable ☐ Cool ☐ Warm
☐ Hot ☐ Other: _____

Skin Temperature: ☐ WNL ☐ Warm ☐ Hot ☐ Cool ☐ Cold

Wound Status: ☐ Fully Granulated ☐ Early / Partially Granulated
☐ Not Healing / No Granulation ☐ N/A – No observable Stasis Ulcer

WOUND (continued)**:**

Wound Comments: _____

Picture of Wound:

☐ Picture(s) Sent to RN Case Manager

CHART TO CARE PLAN:

CARE PLAN INTERVENTIONS – INCLUDE TEACHING & RESPONSE: _____

_____

_____

_____

_____

_____

_____

Care Plan **INTERVENTIONS** Reviewed & Updated:

☐ Reviewed with Client	☐ Services Satisfactory	☐ No Rx interactions / side effects
☐ Care Plan followed	☐ Care Plan Changed	☐ Compliant with Rx regime
☐ Services Appropriate	☐ Progressing towards goals	☐ Pain assessment: No Pain
☐ Client verbalizes understanding.	☐ Further teaching needed.	☐ Instructions/Information provided.

MEDICATION(S):

☐ Medication review completed with client/care giver **ANY MEDICATION CHANGES?** ☐ Yes ☐ No

(If yes was selected please document any Medication changes below and notify RN Case Manager)_____

_____

_____

☐ Client denies any additional prescription, over-the-counter or supplements

Is Client Compliant with Medication Regime? ☐ Yes

☐ No, explain: _____

☐ RN Case Manager Notified

CHANGE IN CONDITION (Document within visit note)

VISIT NOTE: _____

_____

_____

_____

_____

Employee Signature / Title **Date**

HomeCare Resource, LLC

PCA/ HHA SUPERVISION

(If client is receiving PCA/HHA services, Supervision is REQUIRED)

DATE:	
TIME IN	**TIME OUT**

PCA/HHA EMPLOYEE NAME: _____ ☐ PCA ☐ HHA

CLIENT NAME: _____

RN / LPN EMPLOYEE NAME: _____

Supervision Method:
☐ Direct (RN) ☐ Indirect (LPN)

PCA / HHA Care Plan Reviewed? ☐ Yes

SUPERVISION ACTIVITY (Supervision Key is below; must do at least ONE)**:**

Category #1:	Category #2:	Category #3:
Activity:	Activity:	Activity:
Rating:	Rating:	Rating:
Comments:	Comments:	Comments:

Client Satisfaction: ☐Very Satisfied ☐ Satisfied ☐ Uncertain ☐ Dissatisfied ☐ Very Dissatisfied ☐ Not Assessed

COMMENTS:

_____

_____

_____

_____

PCA/HHA Supervision Key

(Categories are labeled as numbers 1-6; Activities are labeled as letters below each category)

1- GENERAL:
- A - Hand Washing
- B - Safety Techniques
- C - Practices Universal Precautions
- D - Verbal / Nonverbal Communication w/ Family
- F - Maintains Confidentiality
- G - Cooperates with Client and Others
- H - Demonstrates Positive Attitude towards Duties
- I - Demonstrates Knowledge Client Health/Condition
- J - Charts / Observes Skills
- K - Other, *Specify*

2 – PERSONAL CARE:
- A - Sponge / Bed Bath
- B - Tub Bath / Shower
- C - Nails / Skin Care
- D - Shampoo / Set
- E - Bed Shampoo
- F - Oral Hygiene
- G - Assists with Dressing / Undressing
- H -Shave
- I – Backrub
- J - Perineal Care
- K – Other, *Specify*

3 – TRANSFERING / AMBULATION:
- A - Uses Proper Body Mechanics
- B - Transfers: Lying / Sitting / Standing
- C - Transfers: Bed to Wheelchair
- D - Assists w/ Walker
- E - Assists w/Cane
- F - Active ROM
- G - Passive ROM
- H - Proper Positioning of Client in Bed
- I - Other, *Specify*

4 – HOUSEHOLD MANAGEMENT:
- A - Homemaking Chores
- B - Cleans Equipment Used
- C - Housekeeping
- D - Puts Away Supplies
- E - Show Respect for Client / Privacy / Property
- F - Meal Preparation Consistent w/ Diet
- G - Shops
- H- Other, *Specify*

5 - EQUIPMENT USE:
- A - Personal Assistive Devices
- B - Hoyer Lift
- C - Bedpan / Urinal
- E - Transfer / Gait Belt
- F - Prosthetics / Orthotics
- G - Feeding Tube
- H- IV's
- I - Medication Box
- J - Walker
- K - Cane
- L - Catheter
- M - Sliding Board
- N - Other, *Specify*

6 - SPECIAL SKILLS:
- A - Vital Signs
- B - Blood Pressure
- C - Pulse
- D -Respirations
- E - Temp (Oral / Rectal / Axillary)
- F - Records I & O
- G - Weight
- H - Catheter Care
- I - Foley Insertion
- J - External Catheter Application
- K - Bladder / Bowel Care
- L - Rectal Exam
- M - Ostomy Care
- N - Gastrostomy Care
- O - Heat / Cold Treatment
- P - Simple Wound Care
- Q - Dressings (unsterile)
- R - Tube Feedings
- S - Parenteral Nutrition
- T - Wound / Dressing Care (sterile)
- U - Foot Care
- V - Chest Physiotherapy
- W - Other, *Specify*

Last, Choose an Activity Rating:
- 1 - Instructed
- 2 - Verbalized Understanding
- 3 - Demonstrates Safe Performance
- 4 - Needs Additional Instruction
- 5 - Other – *Specify*

Employee Signature / Title **Date**