SIDE TWO

DAILY SKILLED NURSE'S NOTE

SIGN ALL ENTRIES

SERVICES PROVIDED
(✓ appropriate response)
☐ Management/Evaluation of Resident Care Plan
☐ Observation/Assessment of Resident's Condition
☐ Teaching/Training to Manage Resident's Treatment Regimen:
☐ Self-Administration of Injectable Meds
☐ Diabetic Care (diet, foot care, etc.)
☐ Self-Administration of Medical Gases
☐ Gait Training/Prosthesis Care
☐ Ostomy/Ileo Care
☐ Use and Care of Braces, Splints, Orthotics
☐ Proper Care of Specialized Dressings/Skin Treatments
☐ Self-Catheterization/ Self-Administration of gastrostomy feedings
☐ Care/Maintain central venous lines
☐ Monitor Fluid Intake to Prevent Dehydration
☐ IV, IM injections and intravenous feeding
☐ Enteral feeding comprising ≥ 26% of daily calorie requirements and provides at least 501 mL of fluid per day
☐ Naso-pharyngeal and tracheotomy aspirations
☐ Insertion, sterile irrigation/replacement of suprapubic catheters
☐ Application of dressings involving prescription meds/aseptic techniques
☐ Treatment of pressure ulcer Stage 3 or worse
☐ Treatment of widespread skin disorder
☐ Institution/supervision of bowel/bladder training program
☐ Therapy (PT, OT, ST)

Provide statement regarding residents skilled services and address issues related to diagnoses, wound care, pain, progress in therapy, condition changes and nursing interventions.

Comments/Concerns DAY Shift

Pain: ☐ **Numeric:** 0 *(none)* – 10 *(worst)*
☐ **Verbal:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Signature/Title	Signature/Title	Date

Comments/Concerns EVENING Shift

Pain: ☐ **Numeric:** 0 *(none)* – 10 *(worst)* _____
☐ **Verbal:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Signature/Title	Signature/Title	Date

Comments/Concerns NIGHT Shift

Pain: ☐ **Numeric:** 0 *(none)* – 10 *(worst)* _____
☐ **Verbal:** ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Signature/Title	Signature/Title	Date

Resident's Name Last	First	Initial	ID #	Room #	Attending Physician

SIDE ONE

Date:

DAILY SKILLED NURSE'S NOTE

VITAL SIGNS

D:	E:	N:
Temp: _____ Pulse: _____ ☐ Unstable	Temp: _____ Pulse: _____ ☐ Unstable	Temp: _____ Pulse: _____ ☐ Unstable
Resp: _____ B/P: _____ ☐ Unstable	Resp: _____ B/P: _____ ☐ Unstable	Resp: _____ B/P: _____ ☐ Unstable
Pain: ☐ No ☐ Yes *Describe on Side Two*	Pain: ☐ No ☐ Yes *Describe on Side Two*	Pain: ☐ No ☐ Yes *Describe on Side Two*

DIRECTIONS: For each shift, check (✓) all applicable boxes. Document specifics regarding Other Concerns and changes in condition on Side Two or per facility policy. After completion, sign under appropriate shift. Identify Services Provided on Side Two.

COGNITIVE	D	E	N
Alert			
Comatose			
Memory problems			
Short-term (unable to recall after 5 minutes)			
Long-term			
Memory/Recall problems			
Current season			
Location of own room			
Staff names and faces			
That he/she is in nursing home			
Impaired decision making			
Exhibiting signs/symptoms of delirium			
Inattention			
Disorganized thinking			
Altered level of consciousness			
Psychomotor retardation			
Other Concern(s) - *note on Side Two*			

SENSORY/SPEECH	D	E	N
Unable to hear			
Difficulty seeing			
Difficulty in speaking			
Other Concern(s) - *note on Side Two*			

MOOD PROBLEMS	D	E	N
Little interest/pleasure in doing things			
Feeling down, depressed, hopeless			
Trouble falling/staying asleep/sleeping too much			
Tired/has little energy			
Poor appetite or overeating			
Feeling bad about self			
Trouble concentrating			
Moving/speaking slowly or fidgety			
Thoughts of hurting self			
Other Concern(s) - *note on Side Two*			

BEHAVIOR PROBLEMS	D	E	N
Hallucinations			
Delusions			
Physical behaviors (hitting, kicking, etc.)			
Verbal behaviors (screaming, cursing, etc.)			
Other behaviors (socially inappropriate)			
Rejects evaluation or care			
Wanders			
Other Concern(s) - *note on Side Two*			

PHYSICAL FUNCTIONING		D	E	N
Code SP: Self Performance	**SP**			
0 = Independent	Bed Mobility			
1 = Supervision	Transfer			
2 = Limited assistance	Locomotion			
3 = Extensive assistance	Eating			
4 = Total dependence	Toilet Use			
8 = ADL did not occur				
Code SU: Support Provided	**SU**			
0 = No set-up or physical help	Bed Mobility			
1 = Set-up help only	Transfer			
2 = One person physical assist	Locomotion			
3 = Two+ person physical assist	Eating			
8 = ADL Did Not Occur	Toilet Use			

SKIN	D	E	N
Skin WNL			
Skin Concerns			
Itching			
Rash			
Abnormal turgor			
Abnormal skin color			
Unusual temperature *colder/warmer than adjacent skin*			
Desensitized to pain or pressure			
Pressure Ulcer			
Skin Tear/Cut			
Surgical Wound			
Bruise			
Venous or arterial ulcer			
Other open lesion			
Diabetic foot ulcer			
Infection of foot			
Other open lesions on foot			
Other Concern(s) - *note on Side Two*			

GU	D	E	N
GU WNL			
GU Concerns			
Bladder distention/retention			
Frequency/urgency			
Burning			
Discharge			
Urine Color			
D: _____			
E: _____			
N: _____			
Urine Consistency			
D: _____			
E: _____			
N: _____			
Urine Odor			
D: _____			
E: _____			
N: _____			
Catheter, type: _____			
Bladder Control			
Continent			
Incontinent			
Pads/Briefs used			
Bladder training or Toileting program			
Dialysis			
Other Concern(s) - *note on Side Two*			

GI	D	E	N
GI WNL			
GI Concerns			
Poor Appetite			
Poor or restricted fluid intake			
Nausea/vomiting			
Difficulty chewing			
Difficulty swallowing			
Abdominal distention			
Bowel Sounds			
Active			
Absent			
Hypoactive			
Hyperactive			
Diarrhea			
Constipation			
Bowel Control			
Continent			
Incontinent			
Toileting program for bowel continence			
Ostomy device			
Other Concern(s) - *note on Side Two*			

CARDIOVASCULAR	D	E	N
Regular rhythm/WNL			
Radial/Apical irregular			
Capillary refill sluggish			
Neck vein distention			
Chest pain			
Abnormal peripheral pulses			
Other Concern(s) - *note on Side Two*			
Edema *(if ✓, complete below)*			
Location 1: _____			
Dependent			
Pulmonary			
Pitting: 1+			
2+			
3+			
4+			
Location 2: _____			
Dependent			
Pulmonary			
Pitting: 1+			
2+			
3+			
4+			

RESPIRATORY	D	E	N
Normal breathing			
Respiratory Concerns			
Labored breathing			
Shallow respirations			
Orthopnea			
SOB:			
On exertion			
At rest			
Lying flat			
Lung sounds			
Rales/rhonchi			
Wheezing			
Cough *(if ✓, describe)*			
D: _____			
E: _____			
N: _____			
O_2 needed			
D: O_2 sats _____			
E: O_2 sats _____			
N: O_2 sats _____			
Nebulizer Treatment			
Suctioning			
BiPAP/CPAP			
Tracheotomy			
Ventilator/respirator			
Other Concern(s) - *note on Side Two*			

NEURO/MUSCULAR	D	E	N
Gait steady			
Gait unsteady			
Balance problem			
Paralysis weakness			
Syncope			
Decreased grasp			
Right			
Left			
Decreased movement			
RUE			
LUE			
RLE			
LLE			
Abnormal pupil reaction			
Right			
Left			
Tremors			
Vertigo			
Other Concern(s) - *note on Side Two*			

D: Assessor's Signature/Title	E: Assessor's Signature/Title	N: Assessor's Signature/Title

Resident's Name Last | First | Initial | ID # | Room # | Attending Physician