Date: _____

SKILLED DAILY NURSES NOTE

DIRECTIONS: ✓ all applicable boxes each shift. Circle appropriate item(s) separated by "/". Record specific comments on reverse side, including date, time, signature and title of nurse for corresponding shift. For 12 hour shifts, do not code "E" boxes. Draw a line through those boxes.

Vital Signs

D: T_____ P_____ R_____ B/P_____ ❑ Abnormal

E: T_____ P_____ R_____ B/P_____ ❑ Abnormal

N: T_____ P_____ R_____ B/P_____ ❑ Abnormal

	D	E	N
Hearing/Speech/Vision			
Unable to Hear			
Hearing Aid: Rt			
Lt			
Unable to Speak			
Unclear Speech			
Unable to Make Self Understood			
Unable to Comprehend			
Unable to See			
Corrective Lenses: (Y/N)			
Cognitive Patterns			
Alert/Oriented X 3			
Disoriented			
Person			
Place			
Time			
Long-term Memory Dx. Unable to Recall Long Past			
Short-term Memory Dx. Unable to Recall Last 5 Minutes			
Inattention			
Disorganized Thinking			
Vigilant			
Lethargic			
Stuporous			
Comatose			
Mood			
Little Interest/Pleasure in Doing Things			
Depressed/Hopeless			
Abnormal Sleep Patterns			
Tired/Little Energy			
Poor Appetite			
Overeating			
Feeling Bad About Self			
Trouble Concentrating			
Restless/Fidgety/Anxious			
Self-deprivation/Suicidal Thoughts			
Short-tempered/Easily Annoyed			
Behavior			
Hallucinations			
Delusions			
Inappropriate Physical Behaviors (hitting, kicking, scratching, pushing)			

	D	E	N
Behavior (Cont'd.)			
Inappropriate Verbal Behaviors (screaming, cursing, threatening)			
Inappropriate Sexual Behaviors			
Inappropriate Social Behaviors (throwing food)			
Wandering			
Rejects Care			
Intrudes on Privacy of Others			
Disrupts Care/Living Environment			
Puts Others at Risk for Injury			
Functional Status			
CODE 1: SELF-PERFORMANCE **Activity 3 or More Times** 0. Independent 1. Supervision 2. Limited Assistance 3. Extensive Assistance 4. Total Dependence **Activity 2 or Less Times** 7. Activity Occurred 1 or 2 Times 8. Activity Did Not Occur Entire Shift/Non-Facility Staff **Code 1**			
Bed Mobility			
Transfer			
Walk In Room			
Walk In Corridor			
Locomotion On Unit			
Locomotion Off Unit			
Dressing			
Toilet Use			
Personal Hygiene			
Eating			
Bathing			
CODE 2: SUPPORT PROVIDED 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire shift/Non-Facility Staff **Code 2**			
Bed Mobility			
Transfer			
Walk In Room			
Walk In Corridor			
Locomotion On Unit			
Locomotion Off Unit			
Dressing			
Toilet Use			
Personal Hygiene			
Eating			
Bathing			
Bowel & Bladder			
Catheter Type:			
Scheduled Toileting Program			

	D	E	N
Bowel & Bladder (Cont'd.)			
Bladder Training			
Prompted Voiding			
Burning			
Distention/Retention			
Frequency/Urgency			
Hematuria			
Discharge			
Bladder Incontinence			
Urine			
Color:			
Consistency:			
Odor:			
Dialysis			
Briefs/Pads Utilized			
Bowel Incontinence			
Ostomy, Type:			
Diarrhea			
Constipation/Impaction			
Bowel Sounds:			
Present			
Absent			
Hyperactive			
Hypoactive			
Bowel Training Program			
GI			
Nausea			
Vomiting			
Epigastric Distress			
Difficulty Swallowing			
Difficulty Chewing			
No Dental/Mouth c/o			
Poor Fitting Denture/Partial			
Abnormal Mouth/Gum Tissue			
Edentulous			
Abdominal Distension			
Pain			
No Complaints of Pain			
Origin:			
Location:			
Intensity (0-10):			
Cardiovascular			
Regular Rhythm			
Radial/Apical Irregular			
Capillary Refill Sluggish			
Neck Vein Distention			
Chest Pain			
Edema (Y/N)			
Dependent			

	D	E	N
Cardiovascular (Cont'd.)			
Edema (cont'd.)			
Pedal: Lt / Rt (L/R/B)			
Pitting: +1			
+2			
+3			
+4			
Abnormal Peripheral Pulses			
Change in Vital Signs			
Abnormal Heart Sounds/ Murmur Present (Y/N)			
Dizziness When Standing			
Increased Fatigue			
Increased Weight			
Respiratory			
No Problems			
Labored Breathing			
Shallow Respirations			
Rales/Rhonchi			
Wheezing			
Cough			
Orthopnea			
Dyspnea/SOB Exertion			
Dyspnea/SOB At Rest			
Dyspnea/SOB Lying Flat			
O_2 _____ LPM			
❑ PRN			
❑ Continuous			
SaO_2 ____% ____% ____%			
Nebulizer Tx			
Suctioning			
Tracheostomy Care			
Ventilator/Respirator			
BiPAP/CPAP			
Fever			
Isolation			
Neuro/Muscular System			
Syncope			
Headache			
Abnormal Pupil Reaction			
Right			
Left			
Tremors			
Vertigo			
Decreased Grasp Rt			
Lt			
Decreased Movement			
❑ RUE ❑ LUE			
❑ RLE ❑ LLE			

Signature/ Title:	D:	E:	N:

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed

SKILLED DAILY NURSES NOTE (Cont'd.)

	D	E	N
Musculoskeletal			
Steady Gait			
Gait Unsteady			
Problem With Balance			
Paralysis/Weakness			
Skin			
Skin Color Normal/No Problems			
Jaundiced			

	D	E	N
Skin (Cont'd.)			
Cyanosis			
Pallor			
Clammy			
Chills			
Flushing of Skin			
Rash/Itching			
Abnormal Turgor/Elasticity			
Bruise(s)			

	D	E	N
Skin (Cont'd.)			
Desensitized to Pain/ Pressure			
Open Lesions(s)			
Diabetic Ulcer(s)			
Pressure Injury(ies)			
Length			
Width			
Depth			

	D	E	N
Skin (Cont'd.)			
Unstageable Pressure Injury			
Deep Tissue Injury			
Venous/Arterial Ulcer(s)			
Medical Device Related Injury			
Mucosal Membrane Injury			
Surgical Wound(s)			
Skin Tear/Laceration(s)			
Burn(s)			
Moisture Associated (MASD)			

SERVICES PROVIDED

- ❑ Skilled Observation & Assessment
- ❑ Manage Evaluate Resident Care Plan
- ❑ Dehydration/Fluid Intake
- ❑ Chemotherapy Management/ Teaching
- ❑ Dialysis Management
- ❑ Observe for/Teach Medication Effects/Side Effects
- ❑ Observe S/Sx infection
- ❑ Teaching Diabetic Care (Insulin, Diet, Foot-care, etc.)
- ❑ Gait Training/Prosthesis Care
- ❑ Self-administration of Injectable Meds
- ❑ Teach Ostomy/Ileal Conduit Care
- ❑ Hospice Care
- ❑ Diet Teaching
- ❑ Bowel & Bladder Training
- ❑ Trach/IV Catheter Sites Care
- ❑ Surgical Wound Care/Dressings
- ❑ Pressure Injury Tx/Management
- ❑ Stasis Ulcers Tx/Management
- ❑ Central/Peripheral IV Therapy
- ❑ Tracheostomy Care/Suctioning
- ❑ IV Medication
- ❑ Intramuscular Injections
- ❑ Tube Feeding (must meet requirements)/IV Feeding
- ❑ Pain Management
- ❑ Therapy (PT, OT, ST, RT)
- ❑ Nursing Rehabilitation/Restorative Program(s)
- ❑ Chest Physio/Postural Drainage
- ❑ Ventilator/Respirator
- ❑ Teach Inhalation Rx
- ❑ Braces, Casts, Splints, Orthotics, etc. Care/Teach
- ❑ _____
- ❑ _____
- ❑ _____

DATE/TIME	COMMENTS	SIGNATURE/TITLE

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NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed