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 fidge			
Thoughts of hurting self			
Other Concern(s) - *note on Side Two*			

BEHAVIOR PROBLEM	D	E	N
Hallucinations			
Delusions			
Physical beh hitting, king, etc.)			
Verbal be iors (s aming rsing, etc.)			
Other haviors (s y inap priate)			
Re s evaluat or care			
nders			
ther Co - *note on*			

PHYSIC. UNCTIONIN	D	E	N
Code SP: Self Performance = Independent Supervis 2 ance 3 = Extensi sistance 4 = Tot pendence 8 = ADL not			
Code SU: t Provided 0 = No set-up or physical help 1 = Set-up help only 2 = One person physical assist 3 = Two+ person physical assist 8 = ADL Did Not Occur			

	P	SU
Bed Mobility		
Transfer		
Locomotion		
Eating		
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 ons on foot			
Other Concern(*note on Side Two*			

GU	D	E	N
G NL			
U Concerns			
Bladder distentio /rete			
Frequen rgency			
urning			
charge			
Uri Color D:			
E:			
N:			
Uri onsistency			
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 swall ng			
Abdomina tention			
Bowel Sound			
Ac			
sent			
Hypoactive			
Hyperactive			
D ne			
nsti on			
B Cont			
Contin			
Incon ent			
Toileting gram for bowel contine			
t y device			
O er 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+			

RESPIRATO	D	E	N
ormal h ni			
Respi or onc s			
Labo reat g			
Shallow ra s			
Orthopn			
SOB:			
On exertion			
rest			
y at			
Lu sounds			
ales/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 Tw*			

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

Form # CP1621 (Rev. 10/10)

Reorder From: MED-PASS® 2019 800-438-8884

INH 022406-1(R)

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 intravenou… eding
☐ Enteral feeding comprisi… 26% o… daily calorie requirements … d provide… at least 501 mL of…luid per…y
☐ Naso-pha…geal an… rache…omy aspirati…
☐ In…tion, ste…ation/…lacement suprapu…meters
☐ …olication of dr…gs involv…g p…scription m…s/septic t…niques
☐ Treatment o…ressur…cer Stage 3 or wors…
☐ Treatment o…idespread 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 ☐ …derate ☐ …vere ☐ Very …ere

Signature/Title	…nature/Title	Date

Comments / Concerns EVENING S…t

Pain: ☐ …ul…ric: 0 (…) – 10 *(worst)* _____
☐ … ☐ …one ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

…nature/Title	Signature/Title	Date

…omments …oncerns 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