Nursing Clinical Progress Note **Paloma Home Health Agency, Inc**

Visit ☐ Billable ☐Non-Billable ☐SN ☐SN& Sup ☐Sup Only ☐PRN

Date: **Arrival Time**: **Departure Time**:

Patient Name:				
Vital Signs	Temp:	Respirations:	Apical Pulse:	Radial Pulse:
	B/P:	☐Lying ☐Sitting ☐Standing	Weight :	

Physical Assessment (Check those areas that pertain to patient)

Respiratory	**Gastro Intestinal**
☐ No Problem ☐ Apnea ☐ Dyspnea/Extent	☐ No Problem ☐Appetite Decreased
☐Respiration Uneven ☐ Cough ☐ Sputum	☐ Weight Loss/Gain: Amount:
☐ Rales	☐ Constipation ☐ Incontinent
Breath Sounds:☐ Clear ☐ Rhonchi ☐ Wheezing	☐ Date of Last BM:
☐ Oxygen	☐ Nausea ☐Vomiting ☐Diarrhea☐ Dysphagia
Neurological	☐ Abdomen: ☐Soft ☐ Firm ☐ Distended
☐ No Problem ☐ Alert ☐ Lethargic ☐ Forgetful	☐ Diet Compliance: ☐ Yes ☐ No
☐ Disoriented ☐ Dizziness ☐ Tremors ☐ Agitated	☐ Ostomy Care Taught/Performed
☐ Grasps: ☐ R ☐ L :	**Ears/Eyes/Nose/Throat**
☐ Pupils equal/reactive to light	☐ No Problem ☐Impaired Vision ☐Cataract/Glaucoma
☐ Oriented to:☐ Time☐ Place☐ Person	☐ Deaf ☐ Impaired Speech ☐ Blind
Other:	☐ Tinnitus ☐ Epistaxis ☐ Congestion
	☐ Impaired Hearing

Musculoskeletal	**Circulatory**
☐No Problem ☐Bedbound ☐Chair bound	☐No Problem ☐Heart Irregular
☐Ambulatory Aid ☐Unsteady Balance/Gait	☐ Gallop ☐ Murmur ☐ Edema
☐Amputations ☐Joint Pain/Stiffness ☐Contracture	☐Peripheral Pulses: LR: RR: LP: RP:
☐Paralysis ☐Arthritis ☐ Falls Date of last fall:	☐ Chest Pain -Describe:

Skin Condition	**GU Status**
☐No Problem ☐Warm ☐Cool ☐ Cold ☐ Clammy	☐ No Problem ☐ Incontinent ☐ Retention
☐Turgor: ☐Diaphoretic ☐ Skin Broken	☐Dysuria – Frequency:
☐Pale ☐Jaundice ☐Cyanotic ☐ Dry	☐ Catheter ☐ Hematuria ☐ Bladder Program
	☐ Foley Insertion ☐ Teaching Catheter care
	Output: ☐Urine ☐Clear ☐Cloudy ☐Odor
	☐Sediment ☐Other:

Pain Assessment: ☐ No pain Location: Duration:
Intensity: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐ 8 ☐9 ☐10

Current pain medication/s:

Glucometer: Control ☐Results: FSBS obtained from: Finger using aseptic technique.
Results: ☐ FBS ☐ RBS

Skilled Nursing Care Performed:

Additional clinical findings:

Progress Toward Goals on POC:

New Identified Problems/Goals:

Universal Precautions followed: ☐Hand washing ☐Gloves Worn ☐Sharps Disposal ☐Alcohol gel/hand cleanser
☐ Other:

Homebound Status:

Coordination of Care: ☐ RN. ☐ LVN ☐Therapist ☐HHA ☐MSW Discussion:

Physician contact: ☐ N/A ☐ Yes Discussion:

Discharge Planning:

5day discharge notice given to patient/ physician ☐

LVN/HHA Supervision

☐ Patient/Caregiver satisfied with care ☐ Change in ADL needs assessment ☐ Care provided according to assignment
☐ Employee courteous, respectful ☐ Continue frequency at:
☐ Supervisory Visit Onsite

Employee Name: ☐ LVN ☐ HHA

Instructed in:

Date:

☐ NA **Wound Care:**

Site 1:
Width: Length: Undermining: Tunneling: Depth:

Drainage: ☐ Serous ☐ Serosanguinous. ☐ Purulent Amount: ☐ Small ☐ Moderate ☐ Large
Wound Bed Appearance: ☐ Granulation ☐ Slough ☐ Eschar:
Surrounding Tissue: ☐ Erythematic ☐ Indurations ☐ Maceration
Odor: ☐ None ☐ Mild ☐ Foul

Signs/Symptoms of Infection: ☐ Fever ☐ Redness ☐ Swelling ☐ Warmth ☐ Other:

Dressing Change:
☐ Teaching of Wound Care

Site 2:
Width: Length: Undermining: Tunneling: Depth:

Drainage: ☐ Serous ☐ Serosanguinous. ☐ Purulent Amount: ☐ Small ☐ Moderate ☐ Large
Wound Bed Appearance: ☐ Granulation ☐ Slough ☐ Eschar
Surrounding Tissue: ☐ Erythematic ☐ Indurations ☐ Maceration
Odor: ☐ None ☐ Mild ☐ Foul

Signs/Symptoms of Infection: ☐ Fever ☐ Redness ☐ Swelling ☐ Warmth ☐ Other:

Dressing Change:
☐ Teaching of Wound Care

Additional comments

Nurse's Signature:
Date: