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The following documentation worksheets are tools to assist in properly articulating the reason for skilled care. These sheets are organized by diagnosis and are only **guides**. They are **not part** of the medical record and should be placed in a separate binder at the nurse's station.

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Acquired Immunodeficiency Syndrome (AIDS) (1 of 2)

Daily Nursing Skills

High risk for infection related to immunosuppression (low T4 lymphocyte count or low T4 toT8 ratio). High risk for ineffective individual coping related to life threatening illness, potential loss of role, decisions regarding treatment or poor prognosis for long term survival. High risk for hypoxemia related to ventilation-perfusion imbalance, pneumonia, and weakness. High risk for sensory-perceptual alteration related to neurologic involvement. High risk for social isolation, impaired physical mobility related to fatigue, weakness, hypoxemia, depression, altered sleep patterns, medication adverse effects, and orthostatic hypotension. High risk for nutritional deficit, fluid, volume deficit altered oral mucus membrane related to opportunistic infections.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor CBC.
3. Assess for potential sites of infection daily particularly pulmonary infections.
4. Assess for neurologic infection: stiff neck, headache, visual or motor abnormalities, memory impairment, altered LOC. Record daily mental and neuro assessments.
5. Assess for signs of hypoxemia: tachycardia, restlessness, tachypnea, irritability, pallor, cyanosis. Monitor oxygenation and potential need for use of oxygen.
6. Assess for distal symmetrical sensorimotor neuropathy (common peripheral nerve complication in AIDS): involuntary movements, paresthesia, numbness, pain, weakness and atrophy of the extremities.
7. Document provision of nutritional assessments, and oral cavity assessments for signs of thrush lesions or bleeding.
8. Assess for pharyngitis, stomatitis, esophagitis: inflammation, ulceration, leukoplakia, pain, dysphagia or voice changes.
9. Assess daily for skin integrity. Ensure prompt treatment of pressure ulcers (immunosuppression makes effective treatment difficult).
10. Teach the patient and family about infection prevention measures.
11. Assess nutritional status daily.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.

Acquired Immunodeficiency Syndrome (AIDS) (2 of 2)

14. Teaching and training activities: discuss S&S that may indicate AIDS complications, review waste disposal, educate regarding spread of infection, early reporting of new symptoms, effects of immunosuppression, CBC recommendations, legal resources, community resources, disease and implications.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

ICD-10 Codes

Acquired – see also condition
- Immunodeficiency syndrome (AIDS) B20

AIDS (related complex) B20
ARC (AIDS-related complex) B20
Contact (with) - see also Exposure (to)
- AIDS virus Z20.6

Exposure (to) T75.89 - see also Contact, with
- AIDS virus Z20.6

Aggregate of Unskilled Services

Daily Nursing Skills

Management and evaluation of overall Plan of Care to promote recovery and medical safety. Observation and evaluation of medical condition given the likelihood of change to assess for the need for modification or initiation of additional interventions with the patient's treatment regimen is essentially stabilized.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Monitor and assess vital signs.
2. Administration of oral meds. Monitor for therapeutic or non-therapeutic effects.
3. General maintenance of colostomy and/or ileostomy following initial period.
4. Routine service to maintain satisfactory functioning of indwelling Foley catheter.
5. Changing of dressings, non-infected wounds. Assess for signs of delayed healing or infection secondary to immobility or decreased mobility secondary to medical status.
6. Prophylactic skin care.
7. Routine care of incontinent resident.
8. General maintenance area of a plaster cast.
9. Routine care of braces and splints.
10. Heat as a palliative measure.
11. Routine application of medical gases after initial and regulatory phase. Assess response to medical gases and need to titrate.
12. Assist with ADLs.
13. Turning of positioning
14. S/S of complications:
    A. Type: _____
    B. Observations: _____

Amputation

Daily Nursing Skills

Assess and evaluate for signs of complications including increased stump pain, hematoma, infection, suture/staple integrity and stump necrosis. Assess circulation of affected limb, wound care and observations, pain management, psychological manifestations of loss of limb. Signs of effective grieving of loss. Stump care, compression dressings to reduce edema and shape stump to accept prosthesis. Patient education regarding skin hygiene to prevent irritation and/or infection. Monitor nutritional intake and needs to promote healing. Educate need for dietary compliance. Pain management and safety measures post amputation. Monitoring and assessment of associated conditions that precipitated need for amputation (i.e., diabetic, PVD, injury).

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Wound site, treatment and frequency, change in wound status, size (width, color, depth) stage, color, odor, drainage, signs of healing, bleeding, hematoma formation.
3. Assessment for edema.
4. Assessment of CSM, both extremities.
5. Assessment of positioning, both extremities, signs of development of contractures.
6. Presence of callous formation on stump.
7. Signs of development of foot drop, unaffected extremity.
8. Assessment for pain: Site, description of intensity, duration, phantom pain, method of treatment, response, assessment for change or modification of medication or treatment of pain.
9. Presence and effect of use of stump shrinker, user of prosthetic device – type, skin condition.
10. Mobility: balance, assistance required, use of equipment, progress with ambulation and transfers and positioning.
11. Psychosocial adjustment.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Teaching and training activities. Patient education and caregiver training.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

Anemia

Daily Nursing Skills

To assess and evaluate cardiovascular system, signs and symptoms of blood loss, response to transfusions and signs of reaction to transfusion. Scheduling of activities to promote rest and optimize use of limited energy levels. Monitor patient for signs of excessive fatigue or shortness of breath with activities. Patient's area risk for infection, hemorrhage, increased fatigue and impaired skin integrity. Patient education in medical management and signs of complications.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs Q _____.
2. BP & Pulse Q shift.
3. Nutritional intake (vitamin therapy).
4. Edema: LE's/tingling (describe, degree).
5. Sore mouth.
6. Fatigue, pallor.
7. Dizziness/Faintness/Vertigo.
8. Headaches/Tinnitus.
9. Dyspnea (SOB).
10. Palpitations.
11. Pale mucous membranes, nail beds and conjunctiva.
12. Intake and output.
13. Lab work.

Anticoagulation Therapy: Subcutaneous Heparin/New to Coumadin Therapy

Daily Nursing Skills

Patient is at high risk or injury related to anticoagulation therapy. Risk for abnormal bleeding secondary to prolonged clotting times. Daily skilled assessment for signs of bleeding, lab work and evaluation of results, skilled monitoring with changes in dosage. Patient instruction in signs and symptoms to report to caregiver. Follow-up care. Instruction in proper administration of injections.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Presence or absence of active abdominal, joint pain or other pain.
3. Presence or absence of active signs of bleeding, (hematuria, petechiae, bruising, bloody stools, nose bleeds) at least Q day.
4. Presence or absence of signs of hemorrhage under the skin (oral mucosa and/or conjunctiva at least Q day).
5. Color-cyanosis or pallor.
6. Patient/resident/caregiver training.
   RE: S/S of anticoagulant complications, potential interactions.
7. Results of Pro-Times or PTs.
8. Any communication with the physician and reason.
9. Safety education (avoid razors, use soft bristle toothbrush). Potential interactions with over the counter medications. Instruction to consult healthcare provider with any changes in medication regimen. Observation of urine, stool, skin and sputum for signs of bleeding.

Atrial Fibrillation (New Onset) (1 of 2)

Daily Nursing Skills

Atrial fibrillation is the most common form of irregular heartbeat. Irregular heartbeats are caused by abnormal **electrical activity of the heart**. There is a high risk for impaired blood flow to the heart muscle and to the rest of the body. Atrial fibrillation may be caused by an underlying heart disease, such as: Problems with the heart valves, Impaired blood flow to heart muscle (ischemia), weakened heart muscle (cardiomyopathy), and damage to the heart from long-standing, untreated high blood pressure (hypertensive heart disease). Infection processes, endocrine, and pulmonary disease may cause atrial fibrillation. **Anticoagulant medications** may be needed to prevent blood clots and lessen the risk of stroke. Patient is at high risk for abnormal bleeding with anticoagulant therapy. Other medications can control the heart rate with increased risk for adverse drug effects. **Heart failure** may develop if the heart rate cannot be controlled. Atrial fibrillation often causes shortness of breath, dizziness, confusion, or lightheadedness, especially during physical activity. For this reason people with atrial fibrillation may have a decreased activity tolerance with complications related to decreased mobility. There is a high risk for **stroke** caused by atrial fibrillation.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Full Vital Signs: Assessment of findings including Apical Pulse rate and rhythm.
2. Signs and symptoms of shortness of breath, dizziness, confusion, activity intolerance, and signs of decreases oxygen saturation levels.
3. Skilled assessment of lung sounds, edema, chest pain, and signs of pulmonary, cardiac and neurological changes.
4. Cardiac medications with parameters. Documentation of doses held secondary to AP, BP not within established parameters. Signs of adverse effects of medications, laboratory findings.
5. Anticoagulation therapy: Effects, signs of unusual bleeding, abnormal lab results, and changes in dosage.
6. Underlying processes such as infection, endocrine, pulmonary conditions with current treatments and response.
7. Activity tolerance, signs of postural hypotension, increased HR or shortness of breath with physical exertion.
8. Communication with physician and outcome, consults such as cardiology, endocrine, and pulmonary.
9. Rehabilitation services and progress.

Atrial Fibrillation (New Onset) (2 of 2)

10. Teaching and training: Self-monitoring of pulse rate and proper administration of medications. Signs and symptoms to report to health care provider.
11. Discharge planning.

Cardiovascular Disease

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Complete vital signs.
2. Pain (location).
3. Presence or absence of SOB, dyspnea cough, orthopnea, ascites.
4. Factors that precipitate or relieve SOB, dyspnea and pain, (i.e., exercise, positioning).
5. Edema 1+ - 4+.
6. Activity tolerance.
7. Weight.
8. Strength and regulatory of pulse.
9. Diaphoresis.
10. Neck vein distention.
11. I & O.
12. Response to medication.
13. Color (skin, nails, lips).
14. Diet (sodium restricted).
15. Oxygen (rate, how often).
16. Significant changes in blood pressure.

Cast Care and Observation

Daily Nursing Skills

Fracture healing starts with the bleeding, tenderness, and swelling. Assess and evaluate pain levels, skin integrity, pulses, posture, positioning in and out of bed, edema, color, odor of the affected limb and safety with mobility.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Edema
   - CMTS
3. Muscular Skeletal Condition:
   - Location of case
   - Therapeutic positioning
4. Skin Condition:
   - Appearance of skin under cast
   - Hygiene of area surrounding cast
5. Transfer:
   - Mobility restrictions
   - Amount of assist needed
6. Locomotion:
   - Mobility restrictions
   - Amount of assist needed
7. Personal Hygiene:
   - Amount of assist needed
8. Toilet Use:
   - Amount of assist needed
9. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
10. Mood:
    - Mood pattern

Cellulitis

Daily Nursing Skills

Cellulitis is an infection that spreads from the skin to underlying tissue. Cellulitis is caused by bacteria that invade an area of broken skin. The most common types of bacteria are streptococcus and staphylococcus. Cellulitis also can be caused by other types of bacteria, which may affect people with **impaired immune systems** Infection may occur at areas where the skin has been broken, by trauma or infection. Cellulitis can cause tenderness, pain, swelling, and redness at the site of the infection, and fever and chills throughout the body. In adults, infection usually occurs on the legs, face, or arms, but can occur on other areas. Cellulitis can spread infection through the body quickly. There is a high risk for bacteremia (presence of bacteria in the blood) or **sepsis** (infection in the blood). Other high risk complications, such as **thrombophlebitis** or rarely **gangrene** can develop, especially in older adults. Treatment for cellulitis includes antibiotics, taken either orally or intravenously, and local skin care.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Full vital signs and assessment of findings.
2. Detailed assessment of affected skin areas.
3. Presence of drainage, blisters, erythema, signs of necrosis, increased pain, warmth or tenderness.
4. Antibiotic therapy administered: I.V., I.M., or oral route.
5. Edema and pain management
6. Response to treatments.
7. Current rehabilitation services and progress.
8. Communication with physician and outcome, including changes in medication, treatments, and overall Plan of Care.
9. Discharge teaching regarding medication, activity, treatments, and signs of complication to report to healthcare provider.
10. Discharge planning.

Cerebral Vascular Accident (CVA) (1 of 2)

Daily Nursing Skills

High risk for further cerebral injury related to interrupted blood flow (embolus, thrombus, or hemorrhage), and complications from impaired physical mobility related to motor cortex or motor pathways. High risk for sensory-perceptual alteration and complications related to cerebral injury. High risk for impaired communication due to cerebral injury.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess neurologic status (LOC, orientation, grips, leg strength, papillary response).
3. For Occlusive: Administer anticoagulants as ordered. Monitor prothrombin time and partial thromboplastin time. Check current results before each dose. Observe for S&S's of bleeding. Monitor for S&S's of gastric irritation.
4. Administer medications as ordered for blood pressure, assess for signs of decreased cerebral perfusion.
5. For Hemorrhagic: Administer medications for blood pressure, report any signs of neurologic deterioration. Observe for hypotension, bradycardia, or signs of thrombus formation. Monitor for optimal fluid status, observe fluid restrictions. Monitor osmotic diuretics, maintain accurate I&O.
6. Maintain functional alignment, describe needs for bed mobility, and positioning.
7. Provide ROM, document collaboration with PT.
8. Document rehab nursing (encouragement for the patient to perform as much as possible during ADL and transfers); amount of assistance required with ADLs, safety awareness.
9. Record application of anti-embolism stockings, assess for signs of thromboembolic complications, and record any discussion with MD.
10. Record daily skin assessment, presence of edema.
11. Maintain adequate elimination.
12. Record bladder or bowel program, and patient's response, or alteration of program and reason.
13. Assess daily for adaption to visual and/or sensual impairment, balance problems and effect.
14. Assess communication regime for appropriateness, document collaboration with ST.
15. Observe patient's compliance with therapy techniques, document progress with therapy.
16. Review of laboratory studies for abnormal values (review is skilled, even for negative results).

Cerebral Vascular Accident (CVA) (2 of 2)

17. Assessment for therapeutic response to medication or discontinuance of medication.
18. Teaching and training activities: Disease process and implications, medications, dose schedule, adverse effects, need for follow up lab tests, signs of cerebral impairment, signs of infection, signs of thromboembolic or other complications, activity and positioning recommendations and mobility aids, food and fluid intake recommendations, bowel and bladder control program, risk factors, safety measures and skin care.
19. Describe current rehabilitation services and progress.
20. Discharge planning.

Chronic Obstructive Pulmonary Disease (COPD) (1 of 2)

Daily Nursing Skills

High risk for respiratory failure related to ventilation-perfusion imbalance, ineffective breathing pattern related to emotional stimulation, fatigue or blunting of respiratory drive, nutritional deficit and activity intolerance related to SOB and adverse effects of medications, inactivity-resultant risk for loss of function exercise related hypoxemia, fatigue from sleep disturbance secondary to bronchodilator's stimulant effect, SOB, anxiety, depression. High risk for S&S indicating impending exacerbation. High risk of infection related to stasis of secretions, reduced activity and decreased motility in lungs.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess for need for (or response to) use of oxygen. Titration of oxygen in response to pulse oximetry readings.
3. Administer pharmacologic agents (bronchodilator, antibiotics, corticosteroids, and expectorants).
4. Monitor therapeutic levels of medications as ordered.
5. Perform bronchial hygiene measures as ordered.
6. Pulmonary assessment.
7. Report effectiveness of pulmonary treatment.
8. Maintain adequate fluid intake, monitor I&O.
9. Monitor for signs of infection or further deterioration in respiratory status.
10. Reduce or eliminate environmental irritants.
11. Monitor the patient's reduction of work of breathing, to lessen depletion of oxygen reserves.
12. Monitor nutritional intake and weight.
13. Monitor the use of breathing techniques during ADL.
14. Monitor response to increased activity and recovery breathing after activity.
15. Consult with MD to adjust medications for sleep to optimize bronchodilation and minimize stimulant effects. Monitor the patient's use of bronchial hygiene before sleep, as needed during nocturnal dyspnea.
16. Monitor periods of sleeplessness, including the degree of shortness of breath, pulse rate and rhythm, respiratory rate and breathing sounds.
17. Assess use of relaxation techniques.
18. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).

Chronic Obstructive Pulmonary Disease (COPD) (2 of 2)

19. Assessment for therapeutic response to medication or discontinuance of medication.
20. Teaching and training activities: S&S's if impending exacerbation, avoid over medication, practical energy conservation and breathing techniques, S&S's infection. Medication purpose, dose, schedule, adverse effects requiring medical attention. Bronchial hygiene measures. Prevention dehydration, cleaning of respiratory equipment, dietary restrictions, weight monitoring, exercise prescriptions.
21. Describe current rehabilitation services and progress.
22. Discharge planning.

Colostomy (1 of 2)

Daily Nursing Skills

High risk for stomal necrosis, complications related to the surgical procedure, bowel wall edema, retraction of stoma related to mucocutaneous separation, peristomal skin breakdown related to fecal contamination. Patient instruction in colostomy care. Troubleshooting potential complications and proper fit of appliances. Instruction in avoidance of foods that are not well tolerated. Signs if impaired coping with changes in body image. Instruction in management of control of odors, prevention of leakage to promote increased acceptance and dignity with change in body image.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess stoma color and document.
3. Document any signs or symptoms of necrosis.
4. Assess viability of proximal bowel.
5. Assess for signs of abdominal distention.
6. Assess and document the integrity of the mucocutaneous suture line at each dressing/pouch change.
7. Document the nutritional support measures for the patient at risk for nutritional deficiency.
8. Document any need for alteration of pouch position for prevention of fecal contamination.
9. Document effectiveness of pouch system and contour to abdominal wall, and reason effectiveness of any changes to system.
10. Document the efficiency of the pouch in proper seal, and protection of skin from stool and tape.
11. Assess for signs of burning, leakage or itching.
12. Assess patient's candidacy for bowel function regulation by irrigation.
13. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
14. Assessment of therapeutic response to medication or discontinuance of medication.

Colostomy (2 of 2)

15. Teaching and training activities odor control measures, measures to control flatus, how to conceal pouch under clothing, discuss normal emotional response to colostomy, include helpful coping strategies refer to United Ostomy Association, or local community support group, colostomy impact on bowel function, normal stoma characteristics and function, pouch care, skin care.
16. Describe current rehabilitation services and progress.
17. Discharge planning.

Compression Fractures (1 of 2)

Daily Nursing Skills

Fracture may be displaced or non-displaced. Patient is at high risk related to displaced fragments that may place pressure upon spinal nerves or injure the spinal cord itself. Such pressure will result in partial or complete dysfunction of the body parts innervated from the level of injury. Patient is at high risk for neurological complications related to potential spinal cord involvement. Manifestations may include numbness and tingling of extremities, temporary or permanent dysfunction, and changes in bowel and bladder function. Nursing interventions are geared towards maintaining stability of the fracture, preventing neurocirculatory problems, and promoting comfort; both physical and psychological. Patient may be at further risk of circulatory complications, GI complications and skin integrity compromise related to decreased physical mobility.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor color, sensation, and movement of extremities.
3. Assess for signs of circulation complications such as thrombophlebitis or DVT with increased edema, pain, redness or positive Homan sign.
4. Positioning measures and tolerance to position changes.
5. Pain assessment including intensity, duration, frequency, factors that increase pain, factors that alleviate complaints of pain. Pharmacological and non-pharmacological measures and response.
   Document any changes in pain management regimen and patient's response.
6. Changes in bowel and bladder function, including new onset incontinence, signs of urinary retention, and constipation. Address interventions to maintain function and relief of complications.
7. Daily skin assessment and signs of development of pressure related areas. Document preventative measures in place and effects.
8. Address signs of impaired coping with pain and physical limitations related to decreased mobility, increased dependence upon others, and pain effects.
9. Assess for decreasing intensity and frequency of pain to evaluate ability to increase physical activity as compression fractures may be treated with bed rest until the pain subsides.
10. ROM exercises to non-affected extremities.
11. Document any discussion with physician include reason for interaction and outcome.

Compression Fractures (2 of 2)

12. Patient may be at increased risk for dehydration and weight loss secondary to decreased desire to consume adequate amounts with decreased physical activity and pain. Maintain accurate intake and output monitoring until quantities are proven to be of sufficient amounts.
13. Document tolerance to increased activity level as progressed.
14. Describe current rehabilitation services and progress.
15. Discharge planning.

Congestive Heart Failure (1 of 2)

Daily Nursing Skills

High risk for decreased cardiac output related to cardiac contractility, altered heart rhythm, fluid volume overload, increased afterload, cardiogenic shock, pulmonary edema, AMI, arrhythmias, thrombolytic complications, liver failure, decreased renal perfusion, increased salt and water retention, renal failure. At risk for activity intolerance due to decreased cardiac output, nocturnal dyspnea. High risk for recurrence of CHF (anticipate prolonged period of observation and assessment because there is a high risk for non-compliance with medical regimen, chronicity and complexity: low sodium diet, with increased appetite, need for changes in lifestyle, including medication, activity).

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Heart rate, rhythm, heart sounds, blood pressure, pulse pressure.
3. Presence or absence of peripheral pulses, compare to baseline assessments.
4. Observe response to medication, both therapeutic, VS ranges, side effects.
5. Inotropic agents (digitalis derivatives) monitor for anorexia, pulse below 60, above 100, irregular pulse, nausea, vomiting, visual disturbances. Record all contact with MD.
6. Diuretics – monitor for hypovolemia, hypokalemia, fluid and electrolyte imbalances.
7. Monitor and record all S&Ss of hypoxemia, confusion, restlessness, dyspnea, arrhythmias, tachycardia, and cyanosis.
8. Monitor for the need of oxygen, presence of nocturnal dyspnea (record any precipitating activity, vital signs effects of oxygen use).
9. Observe positioning, Semi or high Fowler's and patient response in breathing.
10. Monitor and record accurate daily I&O, weights and report abnormal.
11. Monitor activity closely, group activities and therapeutic interventions to conserve energy. Assess patient's response to increased activity.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assess pulmonary status for crackles, decreased breath sounds, changes in breath sounds.
14. Assess for dependent edema, increasing dyspnea.
15. Assess for signs of dehydration and confusion.
16. Assess for signs of thrombophlebitis or pulmonary embolism.

Congestive Heart Failure (2 of 2)

17. Assessment for therapeutic response to medication or discontinuance of medication.
18. Teaching and training activities for energy conservation and work simplification strategies.
19. Describe current rehabilitation and progress.
20. Discharge planning: Medication teaching, follow-up care, signs to report to caregivers, dietary instruction, instruction to report increased fatigue, dyspnea and weight gain.

Coronary Artery Disease/Coronary Artery Bypass Graft (CABG) (1 of 2)

Daily Nursing Skills

CABG is performed for significant narrowing and blockages of the coronary arteries due to coronary artery disease. CABG surgery creates new routes around narrowed and blocked arteries, allowing sufficient blood flow to deliver oxygen and nutrients to the heart muscles. Potential postoperative complications may include heart attacks, arrhythmias, electrolyte imbalance, bleeding, infection, lung complications, stroke and renal complications. The daily skills of the nurse are required to observe, assess, teach, train and provide the overall management of care plan to ensure medical safety and promote recovery.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Frequent monitoring of vital signs as ordered, blood pressure, temperature, apical pulse describing any dysrhythmias, and respiratory rate and effort.
2. Monitoring of abnormal fluid balances by assessing respiratory status including oxygen saturation dyspnea, adventitious breath sounds and presence of edema.
3. Assess response to coughing and deep breathing exercises or use of Incentive Spirometry
4. Assess for signs of hypoxemia: tachycardia, restlessness, tachypnea, irritability, pallor and cyanosis.
5. Monitor oxygenation and potential need for use of supplemental oxygen.
6. Record assessments of SA02 with titration or weaning of nasal oxygen.
7. Assessment of daily weights with monitoring for peripheral edema with a description of amount of fluid if present or absence of edema.
8. Monitoring of peripheral pulses in all extremities.
9. Description of surgical wounds including staple/suture integrity, drain sites, color of wound bed if visible, wound edges, amount, color and odor of any exudate or drainage.
10. Assess for potential sites of infection daily including urinary post Foley catheter.
11. Assess for neurologic changes such as headache, visual or motor abnormalities, memory impairment, altered LOC.
12. Monitoring of pain with a clear description of interventions offered and their effect.
13. Monitoring of new drug regimens for desired effect and any adverse effects.
14. Assessment for symptoms of dehydration including skin turgor, color and clarity of urine output and condition of mucus membranes.
15. Assess laboratory results including: CBC, electrolytes, drug levels and coagulation studies, review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
16. Assess nutritional status daily.

Coronary Artery Disease/Coronary Artery Bypass Graft (CABG) (2 of 2)

17. Teaching and training activities: discuss signs and symptoms that may indicate cardiovascular complications, review medication schedule, educate in cardiac and sternal precautions, early reporting of signs of infection, effects of cardiac medications, anticoagulation therapy if applicable, community resources, disease and implications.
18. Describe current rehabilitation services and progress.
19. Discharge planning including community resources and physician follow up.

COVID-19 (1 of 2)

Daily Nursing Skills

Observe and assess for signs and symptoms of related to:

- Exacerbation of cardio complications.
- Exacerbation of pulmonary complications.
- Fever
- Rash
- Cognitive changes
- Infection control
- Isolation
- Pulse Oximetry
- Cough,
- Shortness of breath,
- Difficulty breathing,
- Or at least two of the following symptoms:
    - chills,
    - shaking with chills,
    - muscle pain,
    - headache,
    - sore throat, and
    - loss of taste or smell.
- Symptoms can range from mild to severe and may **appear up to two weeks after exposure** to the virus, according to the CDC. Some patients with COVID-19 do not display any symptoms.
- HHI recommends a **medical review of all COVID-19 patients** to assess for skilled services, MDS accuracy and proper **infection control measures** (Isolation and Quarantine).

COVID-19 (2 of 2)

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Document daily pulmonary assessment.
3. Monitor for need of oxygen or patient's response to medical gases.
4. Record maintenance of oxygen during activity.
5. Observe tolerance of activity. Pulmonary response to physical activity and needs for increased liter flow of oxygen to compensate.
6. Administer antibiotic therapy as ordered, and results of blood level studies.
7. Monitor and report any adverse effect.
8. Document: LOC, sputum character and color, presence or absence of cough, temperature, pulse, respiratory rate, skin color, breath sounds, and activity level.
9. Document non-invasive measures to promote airway clearance: Deep breathing, coughing, incentive spirometer.
10. Document any postural drainage, percussion or vibration, and the patient's response to the treatment.
11. Assess for need by pulmonary assessment, record gurgling, heard over major airways and any nasotracheal suctioning performed. Record any increase in supplemental oxygen used before and during airway clearance procedures. Describe results and patient's response.
12. Maintain adequate hydration, record I&O.
13. Document patient's progress with mobility, and compliance with recommended rest periods.
14. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.
16. Teaching and training activities: Pulmonary hygiene, avoidance of infection and irritants, importance of rest, importance of prompt reporting of signs of recurrence of pneumonia and medication regimen.
17. Describe current rehabilitation services and progress.
18. Discharge planning.

Decubitus Ulcers

Daily Nursing Skills

Assess and evaluate decubitus ulcer response to treatment, signs and symptoms of infection. Local infection of wound, osteomyelitis, signs of sepsis. Control and management of pain, drainage and odors of decubitus ulcer. Skilled ulcer care, assessment for possible modification to treatment to promote healing. Nutritional intake and supports to promote healing.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs, presence of fever.
2. Location on body. Description of wound bed.
3. Odor present.
4. Drainage with color and amount.
5. Communications to physicians with reason and outcome.
6. Complaint of pain. Location, severity and effectiveness of medication and positioning.
7. Nutritional intake, supplements to promote healing.

Weekly

1. Location.
2. Stage.
3. Size (width, length, depth).
4. Odor.
5. Discharge, color and amount, redness, erythema surrounding wound.
6. Description of tissue, signs of granulation or necrosis.
7. Frequency and type of treatments being rendered.
8. Healing progress of decubitus.
9. Use of special equipment: Water mattress, gel pad, air fluidized therapy bed.
10. If not progressing, document call to physician for review and new treatment orders, any consults and results.

Deep Vein Thrombosis (DVT)

Daily Nursing Skills

DVT is an acute, potentially life-threatening condition that necessitates hospitalization. The current standard of care for treatment is with anticoagulation therapy with Heparin followed by long-term oral anticoagulation therapy. The most common factors that lead to development of DVT are venous stasis, vessel wall injury, and hypercoagulability of the blood. Stasis can occur with incompetent valves or inactive muscles. Familial deficiencies of anticlotting factors contribute to hypercoagulation states. Risk factors for development of DVT include, age, prior history of DVT, coagulation abnormalities, and major abdominal /pelvic surgeries and orthopedic procedures of the lower extremities. Other risk factors include obesity, limb trauma, heart disease, advanced neoplasms, post thrombotic syndrome, and Estrogen and oral contraceptive use.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Presence of ankle edema
3. Color of affected limb, sensation and movement.
4. Assessment of pulses of extremities.
5. Calf circumference measurements and assessment of findings.
6. Increased resistance or pain on voluntary dorsiflexion of the foot.
7. Skilled assessment for signs of rapid swelling of the entire limb.
8. Engorged collateral veins of the thigh.
9. Increased skin temperature.
10. Skilled assessment of lung sounds and observation for complaints of sudden onset chest pain, dyspnea, or rapid breathing that may indicate pulmonary emboli.
11. Administration of anticoagulants oral, I.V. or subcutaneous. Skilled observation and assessment for signs of unusual bleeding or potential interactions.
12. Review of laboratory data including PT, I.N.R., and partial prothrombin time.
13. Activity level per physician orders and tolerance.
14. Use of antiembolism stockings or compression wraps.
15. Any referrals or consultations and outcomes
16. Physician visits, order changes, and outcomes
17. Current rehabilitation services and progress
18. Patient education and caregiver training/teaching regarding aftercare, including medication action and precautions, when and how to contact physician with signs of complication or reoccurrence, activity level and future DVT prevention.

Dehydration (1 of 2)

Daily Nursing Skills

Dehydration occurs when the body loses too much fluid. It also occurs with decreased intake of fluids or loss of large amounts of fluids through diarrhea, vomiting, sweating, or strenuous exercise. The body's cells absorb fluid from the blood and other body tissues. By the time the patient become severely dehydrated, there is no longer enough fluid in the body to get blood to the organs, and the patient may begin to go into shock, which is a life-threatening condition. Medications such as antihypertensives, cathartics, and diuretics increase the risk for dehydration. Skilled nursing assessment for the early signs of dehydration is critical with conditions and diseases that cause high fever, vomiting, or diarrhea. The early symptoms of dehydration include dry mouth, sticky saliva, and reduced urine output with dark yellow urine and change in mentation. Symptoms of moderate dehydration include: Extreme thirst. Dry appearance inside the mouth and the eyes don't tear, Decreased urination, or half the normal number of urinations in 24 hours (usually 3 or fewer urinations). Urine is dark amber or brown. Lightheadedness; relieved by lying down. Severe dehydration is life threatening. Symptoms that require emergency care (even if only one of them is present) include: Altered behavior, such as severe anxiety, confusion, or not being able to stay awake. Faintness that is not relieved by lying down or lightheadedness that continues after standing for 2 minutes. Changes in pulse rate and rhythm that is weak or rapid. Skin that is cold and clammy or hot and dry. Decreased or absence of urination. Change in level of or loss of consciousness. There is a high risk for kidney failure and circulatory collapse related to dehydration.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs with skilled assessment of findings.
2. Intake and Output monitoring with skilled assessment of findings. Urine color, concentration, and quality.
3. Skilled assessment of barriers to adequate intake and modifications made to treatment plan with outcomes.
4. Skilled assessment of conditions impacting risk for dehydration. Presence of fever, diarrhea, vomiting and interventions to reduce episodes. i.e., fever reduction, antiemetics, and antidiarrheals with outcomes.
5. Current treatment of dehydration: I.V. hydration, fluid challenges, medication modifications, and response.

Dehydration (2 of 2)

6. Laboratory results **(review is skilled, even with negative results.)**
7. Skilled assessment of mental status, skin turgor, mucous membranes, postural changes in vital signs.
8. Skilled assessment of skin integrity with preventative measures and outcomes.
9. Physician interventions and outcomes.
10. Current rehabilitation services and progress
11. Discharge teaching for self-monitoring, medication effects, signs and symptoms to report to health care providers.
12. Discharge planning.

Enteral Feeding: NG/Gastrostomy/ Jejunostomy/PEG Tube (1 of 2)

Daily Nursing Skills

Patient is at high risk for aspiration related to placement of feeding tube, positioning and other related diagnosis prompting feeding tube placement. Daily skilled nursing for frequent and periodic checking for tube placement and monitoring of gastric residuals to prevent aspiration. Monitor effectiveness of the feeding and assess the patient's tolerance to the tube and the feeding. Special mouth care is essential to maintain a healthy oral mucosa. Daily assessment of feeding tube site to prevent irritation or complication of infection. Assessment of weights, vital signs, pain, diarrhea and tolerance of any oral intake.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs.
2. Type of tube (NGT, G-Tube, J-Tube).
3. I&O.
4. Replacement of tube, reason.
5. Lung sounds.
6. Signs of electrolyte imbalance, review of abnormal lab results.
7. Complications:
   a. Nausea/vomiting.
   b. Cough/SOB/rales/diarrhea.
   c. Placement and patency of feeding tube.

   Aspiration precautions, positioning, signs of increased residual.
8. Patient teaching on care and management of feeding tube if indicated.

Weekly

1. Skin integrity/problems.
2. Weight change (weigh q week).
3. Type of tube.
4. Amount/type of feeding.
5. Method of administration (gravity, pump or bolus).
6. Signs/symptoms of intolerance.
7. Patient/resident's mental state – pulling out tube/compliance to oral restrictions.
8. Body image concern.

Enteral Feeding: NG/Gastrostomy/ Jejunostomy/PEG Tube (2 of 2)

If patient/resident is taking oral food/fluids, document daily.

1. Specific amounts nutrition/hydration.
   a. Food in percentage.
   b. Fluid in number of CCs.
2. Auscultate lungs after each feeding with findings.
3. Amount of assistance required.
4. Participating at optimal level.
5. Motivated to succeed.

Fluid and Electrolyte Imbalance (1 of 2)

Daily Nursing Skills

Elderly persons are particularly vulnerable to fluid and electrolyte disorders. The elder experiences less total body water as a result of less lean body mass and more fat. The decline in the function of vital regulatory organs and a higher incidence of chronic illnesses also increase risk factors. The elder experiences a diminished ability to reestablish homeostasis when an imbalance has occurred. Elderly persons readily become dehydrated when they experience physiologic stressors from fluid restrictions, fever, diarrhea, infections and diuretic therapy. Fluid imbalance may go unnoticed by the patient as a result of a blunted thirst sensation, swallowing difficulties, misinterpretation of the need for fluids, self-imposed restrictions secondary to fears of incontinence or frequent need to urinate. Fluid loss and electrolyte imbalance is exhibited by the elder is a variety of ways. Symptoms may include changes in behaviors, confusion, apathy, headache, thirst, dry mucous membranes, anorexia, nausea, vomiting, dry and decreased skin turgor, changes in pulse and respiration rate and rhythm, muscle weakness, diarrhea, constipation, abdominal distention and abdominal cramps. With excessive fluid loss hemoconcentration occurs, and the hematocrit, hemoglobin, BUN, and electrolyte levels are increased.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Assessment of vital signs including pulse rate changes, dysrhythmias, and postural hypotension.
2. Intake and Output monitoring and skilled evaluation of findings.
3. Assessment and observation of skin turgor and mucous membranes.
4. Skilled administration of I.V. hydration with observation and documentation of tolerance to fluid replacement, signs of fluid overload with I.V. therapy. Skilled assessment of I.V. site and potential complications of infiltration or inflammatory reaction.
5. Skilled administration of fluids and nutrition via the feeding tube. Free water flushes per physician orders. Assess for signs of intolerance with increased residuals. Replacement of fluids obtained with residual checks to prevent further electrolyte imbalance.
6. Skilled observation and assessment of conditions that further place patient at risk for fluid loss and electrolyte imbalance including fever, diarrhea, excessive wound drainage, increases in respiratory rate, persistent nausea and vomiting. Document interventions to reduce episodes and conditions.
7. Treatment for vomiting and diarrhea. Antiemetics and antidiarrheals administered with assessment of response.

Fluid and Electrolyte Imbalance (2 of 2)

8. Skilled assessment of mental status changes including confusion, apathy and listlessness.
9. Skilled assessment of respiratory status including breath sounds increased respiratory rate and effort. Document interventions used to reduce increased respiratory effort and distress.
10. Skilled assessment of abdomen including bowel sounds, tenderness, pain, and cramping.
11. Document interventions to relieve symptoms and improve fluid intake.
12. Review of laboratory results **(review without negative results are still skilled)**.
13. Document physician interventions, changes in physician orders and outcome. Discontinuance or changes in diuretic therapy and/or electrolyte replacement.
14. Describe current rehabilitation efforts and progress.
15. Discharge teaching, planning and caregiver education.

Fractured Hip

Daily Nursing Skills

High risk for post-operative complications related to the initial trauma injury, surgical intervention or immobility, inadequate fluid replacement, blood loss, neurovascular compromise, impaired oxygenation of tissue, compartment syndrome, pulmonary embolism, fat embolism, thrombophlebitis, aseptic necrosis of the femoral head, non-union of the affected portions, osteomyelitis, pneumonia, arthritic deformities, pressure ulcers secondary to reduced physical mobility and exacerbation of preexisting conditions secondary to surgical intervention.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Assess vital signs: Tachycardia, hypotension, distal pulses.
2. Monitor continually for signs of pain. Record pharmacologic and non-pharmacologic pain strategies, and patient's response.
3. Assess neurovascular status note: Weakened or absent pulses, mottling, cyanosis, paresthesia, loss of sensation, significant increase in edema.
4. Observe for signs of compartment syndrome: Excessive pain exacerbated by stretching, sensory deficits, paralysis, tense or hard swelling, decreasing distal pulses.
5. Document/Prevent signs of complications related to immobility: Encourage ROM exercises, apply and describe use of anti-embolism stockings as prescribed.
6. Record coughing and deep breathing compliance, and daily respiratory assessment for pulmonary complications.
7. Document fluid intake and output, and when indicated the urging of forcing fluids.
8. Assess the adequacy of frequent positioning in both pain management and proper body alignment to prevent skin breakdown. Record proper alignment usually avoid adduction, external rotation, and acute hip flexion.
9. Record and assess skin condition daily for signs of complication due to immobility and self-positioning.
10. Observe incision for adequate healing and signs of infection.
11. Observe for any sudden sharp pain, shortening or rotation of the affected limb, or persistent muscle spasm.
12. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Teaching and training activities.
15. Describe current rehabilitation services and progress.

Gastrointestinal Bleeding (1 of 2)

Gastrointestinal Bleeding Overview:

The many causes of gastrointestinal (GI) bleeding are classified into upper or lower, depending on their location in the GI tract.

Upper gastrointestinal bleeding: Upper GI bleeding originates in the first part of the GI tract—the esophagus, stomach, or duodenum (first part of the intestine). Bleeding can come from ingestion of caustic poisons or stomach cancer. Most often, upper GI bleeding is caused by one of the following: Peptic ulcers, Gastritis, Esophageal varices and Mallory-Weiss tears.

Lower gastrointestinal bleeding: Lower GI bleeding originates in the portions of the GI tract farther down the digestive system—the segment of the small intestine farther from the stomach, large intestine, rectum, and anus. Diverticular disease, angiodysplasia, polyps, hemorrhoids, and anal fissures most commonly cause the bleeding. Blood in the stool can result from cancers, inflammatory bowel disease, and infectious diarrhea.

Daily Nursing Skills Assess and evaluate for vomiting of blood, bloody bowel movements, or black, tarry stools. Blood may look like "coffee grounds." Assess for signs and symptoms associated with blood loss including the following: fatigue, weakness, shortness of breath, abdominal pain, pale appearance, vomiting of blood usually originates from an upper GI source. Bright red or maroon stool can be from either a lower GI source or from brisk bleeding at an upper GI source. Long-term GI bleeding may go unnoticed or may cause fatigue, anemia, black stools, or a positive test for microscopic blood.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and prn. Be sure to include mental status and postural changes with VS.
2. Statements made directly by the patient (if possible) quoted. For instance: "I have been having some cramping in my belly but it feels more like gas."
3. Statements reported by caregivers, quoted: For instance: "Mrs. Smith seems somewhat more lethargic today, unable to participate in her therapy and she became very pale and c/o nausea when she attempted to stand."

Gastrointestinal Bleeding (2 of 2)

4. Intake and Output Monitoring. Extremely important to monitor for dehydration secondary to treatments associated with GI bleeding.
5. Assessment of Gastrointestinal System, including:
    a. Presence or absence of bowel sounds (active, inactive) and in which quadrants.
        a. Observe stool sample for presence of blood and test stool for presence of occult blood (guaiac), if ordered.
        b. Complaints of nausea/vomiting, cough, lethargy, fatigue, poor appetite.
        c. Assessment of hydration status including skin turgor, mucous membranes, characteristics of urine output, and toleration of current diet.
        d. Medications that impact diagnosis. For instance: Prilosec to reduce stomach acidity, as well as if medications are being held related to bleeding like Coumadin.
        e. Lab values.
        f. IV Fluid or blood product administration. (Where, when, medication or fluid delivery with administration.)
6. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

Example shift note:

Mrs. Smith continues to receive ongoing skilled observation and assessment for the ongoing signs/symptoms of GI bleeding. Physical therapist reported that during therapy that "Mrs. Smith seemed somewhat more lethargic today, unable to participate in her therapy and she became very pale and c/o nausea when she attempted to stand." She required assist of 2 to transfer from wheelchair to bed and then to reposition while in bed. When she returned to her room, her VS were gathered. BP= 90/62 (baseline 136/84) and her VR= 116 (baseline 84). She refused her regular diet that had been advanced yesterday but tolerated her clear fluids. No bowel movements since yesterday and bowel sounds are present and very active. She denies nausea, cramping, abdominal pain or lightheadedness at this time. A fingerstick BG was assessed to rule out hypoglycemia. BG = 88. Dr. Noitall was informed of findings and a stat Hgb/Hct was ordered. Awaiting lab to draw blood. Will report lab results directly to MD and continue to monitor patient closely for presence of ongoing GI bleeding complications.

Hemiplegia, Hemiparesis, Paraplegia, Quadriplegia (1 of 2)

Definition: Paraplegia is paralysis in both legs, below the waist. It is usually caused by a spinal cord injury or illness. **Quadriplegia** is paralysis below the neck and is also usually the result of a spinal cord injury. In strokes, the paralysis is on one side of the body and is called **hemiparesis** when there is complete paralysis of the affected side. **Hemiplegia** is defined as partial paralysis or weakness on one side of the body and is the term most commonly used in stroke survivors. It is often used instead of hemiplegia even when there is complete paralysis.

Daily Nursing Skills

Patient is at high risk for sensory-perceptual alterations and complications related to impairment of physical mobility from cortex and motor pathway injury. Assess and evaluate for signs and symptoms of Depression, Skin Integrity alterations, muscle atrophy with eventual contractures, immobility, weight loss, neurogenic bladder, infections. This is not an exhaustive list of risk factors. It becomes vital for the nursing team to closely monitor and report any deterioration in condition before they become acute.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and PRN. Be sure to include mental status and postural changes with VS.
2. Assess neurologic status (LOC, orientation, grips, leg strength, papillary responses).
3. Administer medications as ordered especially anti-hypertensive, anti-spasmodic, pain meds and anti-coagulants. Monitor and document effectiveness of medications. Report any side effects immediately.
4. Monitor Intake and Output in detail.
5. Maintain functional alignment; describe needs for bed mobility and positioning.
6. Provide ROM, document collaboration with PT.
7. Document rehab nursing; amount of assistance required with ADLs, safety awareness, and level of participation.
8. Record daily skin assessments. Include presence of edema and the presence of skin breakdown. Stage pressure ulcers using NPUAP guidelines. Remember, MDS completion requires reverse staging.
9. Maintain adequate elimination.
10. Record bladder or bowel program, and patient's response, or alteration of program and reason.

Hemiplegia, Hemiparesis, Paraplegia, Quadriplegia (2 of 2)

11. Assess daily for adaptation to visual and/or sensual impairment, balance problems and effect.
12. Observe patient's compliance with therapy techniques, document progress with therapy.
13. Describe current rehab services and progress.
14. Teaching and training activities: Disease process and implications, mediations, dose schedule, adverse effects, need for follow up lab tests, signs of cerebral impairment, signs of infection, activity and positioning recommendations and mobility aids, food and fluid intake recommendations, bowel and bladder control program, skin care and safety measures.
15. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

** As with any diagnosis, multi-system assessments are necessary to accurately encompass all aspects of the patient's condition and response to treatment.

Hypertension

Daily Nursing Skills

To assess and evaluate full vital signs, complaints of headaches, especially pulsating behind the eyes that occur early in the morning, visual disturbances, nausea and vomiting. Uncontrolled high blood pressure may damage the delicate lining of the blood vessels, which may promote the formation of plaque leading to arthrosclerosis. Blood flow through the blood vessels may be reduced. Decreased blood flow, over time to certain organs can cause damage leading to heart disease, heart attack, renal failure, peripheral vascular disease, retinopathy and stroke. Nursing to monitor effectiveness of antihypertensive regimen, titration of medication and parameters to hold medications. Assess for and report signs of adverse responses to medications including unstable vital signs, abnormal lab values, changes in mental status, changes in gait and fall risk.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Blood pressure with each dose of hypertensive medication.
3. Weekly weight.
4. Blurred vision or vertigo.
5. Confusion.
6. Irritability.
7. Sleepiness (side effect of medication).
8. If severe hypertension, lying and standing BP's or BP's before and after activity.
9. Comment on balance when ambulating.
10. Diet restrictions.
11. Headache.
12. Describe current rehabilitation services and progress.
13. Discharge teaching to patient and caregivers: Medications use, action and schedule, dietary compliance, activity level and signs and symptoms to report to healthcare providers.
14. Discharge planning.

Insulin-Dependent Diabetes Mellitus (IDDM)

Daily Nursing Skills

High risk for hyperglycemia related to inadequate endogenous insulin, prevent or minimize complications while establishing treatment regimen to control altered glucose metabolism, hypovolemia, hyperglycemia, sensory-perceptual alteration, complications of decreased tissue perfusion, cerebral dehydration, hypoxemia, acidosis. Diabetic foot care and inspection as diabetes can damage nerves and reduce blood flow to the feet. Complications may lead to amputation.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor for signs of dehydration, maintain I&O.
3. Monitor fingerstick and blood glucose levels.
4. Monitor urine ketone levels.
5. Observe for signs of hypoglycemia.
6. Observe for signs of ketoacidosis.
7. Monitor level of activity and rest daily.
8. Monitor for signs and symptoms of infection.
9. Assess daily for vascular complications of DM.
10. Observe skin and foot condition daily, record any changes.
11. Assess for signs of urinary tract infection or renal impairment.
12. Assess circulatory status of extremities.
13. Observe for changes in vision.
14. Review of laboratory studies for abnormal (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.
16. Observe for dietary compliance.
17. Teaching and training activities: Diet, exercise, administration of insulin, hypoglycemia, hyperglycemic S&S's, susceptibility to infection and avoidance methods, foot and skin care, circulatory, vision, care. Importance of prompt treatment for any above symptoms.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

Insulin-Dependent Diabetes Resident Unable to Administer Own Insulin

Daily Nursing Skills

High risk for hyperglycemia related to inadequate endogenous insulin, prevent or minimize complications while establishing treatment regimen to control altered glucose metabolism, hypovolemia, hyperglycemia, sensory-perceptual alteration, complications of decreased tissue perfusion, cerebral dehydration, hypoxemia, acidosis. Diabetic foot care and inspection as diabetes can damage nerves and reduce blood flow to the feet. Complications may lead to amputation.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
   - I&O
   - Blood sugar check results
2. Circulatory Condition:
   - Edema
   - Radial and pedal pulses and any change in sensation noted to extremities
3. Urinary Condition:
   - Characteristics of urine (frequency, amount and color)
4. Endocrine Condition:
   - Hypo or hyperglycemia (action and response)
   - Sliding scale insulin given
4. Eating:
   - Nutritional status, percent of food eaten and appetite
   - Diet currently receiving
5. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
6. Mood:
   - Mood pattern
7. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

IV Therapy

Daily Nursing Skills

Administration of IV therapy, inspection and care of IV site, observation for signs of phlebitis, infiltrate or infection at the site or systemic. Skilled monitor of condition for which the IV therapy was initiated to treat. Monitor signs for fluid overload, full vital signs and patient's tolerance to therapy. Review of pertinent lab results.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

Daily

1. Vital signs.
2. I&O.
3. IV site, condition of site (redness, tenderness, swelling, drainage).
4. Insertion:
   a. Cannula type, size, length.
   b. Fluid type, rate, ml/hr, flow device, if used.
5. Maintenance:
   a. Q hour inspection of resident (infusion on time).
   b. S/S infiltration (swelling, skin temperature, absence of flash back sluggish flow rate).
   c. Container change or flow rate change.
   d. ml/hr; flow controller device, if used.
6. Discontinuation:
   a. Cannula type, size length – was cannula intact.
   b. Amount of fluid remaining in IV bag.
   c. Condition of insertion site – redness, swelling, tenderness.
   d. Shift note assessment of hydration status, pain status, or infection status post discontinuation of IV
   e. Therapy. Document any signs of exacerbation of conditions recently treated with IV therapy.
7. Patient/Resident Controlled Analgesia (PCA) Pump.

   Utilize previous IV therapy guidelines plus:
   1. Amount of pain medication used q shift.
   2. Patient/resident's response to pain medication (adverse and therapeutic).
   3. Patient/resident/family caregiver's understanding of PCA system.

Joint Replacement: Hip/Knee (1 of 2)

Daily Nursing Skills

High risk for postoperative complications (hypovolemic shock, neurovascular damage, or thromboembolic phenomena) related to surgical trauma, bleeding, edema, improper positioning, or immobility.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Maintain patency of wound drainage device.
3. Assess for neurovascular damage: Monitor pedal pulses, capillary refill time, toe temperature, skin color, foot sensation, and ability to move the toes, dorsiflex the ankle. Compare findings to the other extremity, as well as base line and earlier findings.
4. Documentation notification of MD for regarding positive neurovascular findings: absent or unequal pedal pulses, capillary filling time greater than 3 seconds, cold toes, pale skin, foot numbness, tingling or pain, inability to move toes.
5. Assess for thromboembolic phenomena: response to leg exercises, presence of calf pain, positive Homan's sign, redness and swelling.
6. Record use of elastic stockings, and reapplication.
7. Monitor for signs of fat embolism: Sudden onset of dyspnea, tachycardia, pallor, cyanosis, or pleuritic pain.
8. Administration of anticoagulants: Record clotting studies, record the reporting of findings outside therapeutic range. Document observation for melena, petechiae, epistaxis, hematuria, ecchymosis, or other unusual bleeding.
9. Record maintenance of affected extremity to: Prevent dislocation of the prosthesis, increase mobility through implementation of the rehabilitation plan, and education of the patient concerning rehabilitation. Record progress with progressive ambulation schedule, use of devise and patient response to activity.
10. Assess pain, treatment given for pain and patient response.
11. ROM to unaffected joints.
12. Assess for signs of infection: Fever, chills, purulent drainage, incisional swelling, redness, increasing tenderness.
13. Adherence to hip flexion and adduction restrictions while transferring and ambulating.
14. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.

Joint Replacement: Hip/Knee (2 of 2)

16. Teaching and training activities.
17. Describe current rehabilitation services and progress.
18. Discharge planning.

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Leg Ulcerations

Daily Nursing Skills

Most leg ulcers result from chronic venous insufficiency, post thrombotic syndrome and/or severe varicose veins. Less commonly, they develop from arterial obstruction. Other causes include burns, trauma, and neurogenic disorders. There is a high risk for secondary bacterial infections of ulcerations. There is a high risk for delayed healing related to secondary infections, compromised circulation, and increased edema. Daily nursing skills include circulation monitoring, wound care, management of pain, management of secondary infections, and edema management.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Description of ulceration in detail: Presence of slough or necrosis, color of wound bed, surrounding tissue integrity, stage, drainage, erythema, odor, and response to current treatment regimen.
3. Pain to affected extremity and response to pain management techniques.
4. Circulation assessment of extremities: Color, sensation, movement, presence or absence of peripheral pulses.
5. Degree of edema and effects of current treatment to reduce edema (medications, positioning, compression).
6. Signs of local or systemic infection.
7. Response to body positioning:
   a. For arterial ulcer: elevate head of bed on 3-6 inch blocks.
   b. For venous ulcer: elevate lower extremities above heart level to decrease edema.
8. Teaching and training: Education in ways to promote comfort, prevent infection, wound care, signs and symptoms to report to healthcare professional, edema management, positioning, activity level and restrictions. Nutritional interventions to promote healing.
9. Modifications in medication and treatment regimen and outcomes.
10. Physician interventions and outcome, referrals and outcomes.
11. Current rehabilitation services and progress.
12. Discharge planning.

Liver Failure

Daily Nursing Skills

High risk for hepatorenal failure, disseminated intravascular coagulation, bleeding esophageal varices. Encephalopathy from decreased nitrogen and glucose metabolism and cerebral blood flow, decreased oxygen saturation, and accumulation of nitrogen substances the liver cannot break down (restrict intake of protein). High risk for toxic accumulation of metabolic substances leading to kidney impairment. High risk for fevers and UTI's, respiratory aspiration and pneumonia, spontaneous peritonitis, ascites from cardiovascular and pulmonary compromise.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive **Weekly Notes** should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs monitor daily.
2. Document daily neurological assessments to monitor for encephalopathy.
3. Assessment of pulmonary status daily.
4. Record intake of protein.
5. Observe for signs of UTI; describe output urine color and quality.
6. Monitor for any signs of infection.
7. Gastrointestinal assessment: Auscultate bowel sounds for signs of spontaneous peritonitis.
8. Cardiovascular: Assess for increased peripheral edema and presence of ascites. Closely record fluid and electrolyte balance, record reports to the physician.
9. Document activity, rest increases the kidney perfusion, and excretion of excess fluid.
10. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
11. Assessment for therapeutic response to medication or discontinuance of medication.
12. Daily skin assessment particularly in presence of vascular spiders. Prolonged prothrombin time increases the risk of skin bleeding and breakdown. Malnutrition and ascites predispose pressure ulcers. Puritis from jaundice can cause discomfort and scratching.
13. Musculoskeletal: Assess muscle wasting and joint pain.
14. Teaching and training activities: Diet compliance, relationship between alcohol and exacerbation of the disease, changes in neurologic status, effects of ascites, need to avoid use of diuretics.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

Lung Cancer (Chemotherapy) (1 of 2)

Daily Nursing Skills

High risk for hypoxemia related to aberrant growth of lung tissue, bronchial obstruction, increased mucus production, or pleurisy. High risk for hemorrhage related to depression of platelet production by chemotherapy. High risk for pain associated with involvement of peripheral lung structures, metastasis, or chemotherapy. High risk for infection related to immunosuppression from chemotherapy and malnutrition. High risk for gastrointestinal complications related to chemotherapy: nausea, vomiting, and diarrhea with increased risk for fluid and electrolyte imbalance.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assess daily for hypoxemia.
3. Observe for need and effectiveness of oxygen, and need for elevated head of bed during dyspneic episodes.
4. Assess breath sounds, respiratory rate, and chest movements.
5. Observe for dyspnea, complaints of difficulty breathing, SOB, flailing nostrils, and intercostals retractions on inspiration, or bulging on expiration. Teach patient and family reasoning is not increasing the rate of oxygen or concentration over prescribed levels.
6. Encouraged pursed lip breathing, and relaxation techniques, huff coughing, cascade coughing and document practice of techniques taught by therapists in energy conservation techniques and effectiveness.
7. Observe for signs of bleeding, petechiae, ecchymoses, and oozing wounds.
8. Monitor serum platelet counts before during and after chemotherapy as ordered and record. Report oral bleeding, hematuria, indications of blood in stool, signs of CNS bleeding: headache, dizziness or lightheadedness.
9. Assess daily for pain describe treatment and response.
10. Assess for deficits in neurologic functioning: Paresthesia, abnormal deep tendon reflexes, or foot drop.
11. Document protection of area of decreased sensory perception from injury.
12. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Assess and document bowel and bladder elimination pattern.
15. Incorporate teaching of body mechanics and conservation of energy in ADLs to promote comfort and decrease dyspnea.

Lung Cancer (Chemotherapy) (2 of 2)

16. Teaching and training activities: Prevention, detection and management of bleeding, effects of chemotherapy, breathing exercises, instruction regarding medications, use, purpose, adverse effects, pain relief measures, signs and methods to prevent infection, neurologic changes, measures to control nausea, vomiting, to decrease dyspnea, when and how to seek emergency help.
17. Describe current rehabilitation services and progress.
18. Discharge planning.

Management and Development of Care Plan (1 of 2)

Daily Nursing Skills

The patient has many services, which do not require the direct skills of a nurse. But the management of the care plan for this patient **requires the skills of a nurse. A person who is not a skilled nurse would not have the capability to understand the relationship among the services and their effect on each other.**

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Document all areas which require service.
3. Nutrition needs: Appetite, dietary pattern, describe specific feeding needs.
4. Elimination: Describe pattern, constipation preventative bowel and bladder routines, incontinence, retention, use of laxatives, enemas, specific need for assistance, and results.
5. Activity pattern describe any stiffness, and response to ROM, etc., falls prevention or safety strategies and effectiveness.
6. Sleep rest patterns: Describe cycles, techniques used to facilitate adequate patterns.
7. Cognitive perception: Visual sensory deficits and how these triggers need for intervention, describe how staff incorporates techniques in daily treatment of patient.
8. Describe each physical assessment finding which requires daily observation i.e. gastrointestinal, cardiovascular: Patient may have increased pulse rate, have Dx of CHF, have oral medications which control heart rate and blood pressure.
9. Document any potential complications secondary to the primary diagnosis or current physical condition: mental confusion, contractures, fecal impaction, falls and fractures, urine retention, cystitis, UTI, pulmonary emboli, depression, exacerbation of symptoms of secondary diagnosis.
10. Record any high risk for slowed or diminished responsiveness related to cerebral degeneration.
11. Document any high risk for altered thought process related to diminished perception of sensory data.
12. Record any high risk for renal impairment related to physiologic degeneration of nephrons and glomeruli.
13. Document evaluation for high risk for nutritional deficit which places patient at risk for infection. Skin breakdown.

Management and Development of Care Plan (2 of 2)

14. At least once a week list all the non-skilled services which require a skilled nurse to monitor.
15. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
16. Assessment for therapeutic response to medication or discontinuance of medication.
17. Teaching and training activities.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

Multiple Sclerosis (1 of 2)

Daily Nursing Skills

Multiple sclerosis or MS is a disease that affects the brain and spinal cord resulting in loss of muscle control, vision, balance, sensation (such as numbness) or thinking ability. With MS, the nerves of the brain and spinal cord are damaged by one's own immune system. Thus, the condition is called an autoimmune disease. Autoimmune diseases are those whereby the body's immune system, which normally targets and destroys substances foreign to the body such as bacteria, mistakenly attacks normal tissues. In MS, the immune system attacks the brain and spinal cord, the two components of the central nervous system. Other autoimmune diseases include lupus and rheumatoid arthritis. Assess and evaluate for Muscle weakness, Decreased coordination, Blurred or hazy vision, Eye pain and Double vision. As the disease progresses, symptoms may include muscle stiffness (spasticity), pain, difficulty controlling urination or difficulty thinking clearly. Late effects can be similar to patients who suffer brain injuries such as CVA's with loss of skeletal muscle control and loss of independence with their activities of daily living.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and prn. Be sure to include mental status and postural changes with VS.
2. Statements made directly by the patient (if possible) quoted. For instance: "I have been having some tremors in my arms today that caused me to spill my juice this morning."
3. Statements reported by caregivers, quoted: For instance: "Mrs. Smith seems somewhat more unsteady today, unable to participate in her morning bath, dressing, and toileting."
4. Intake and Output Monitoring. ** Extremely important to monitor for dehydration secondary to inability to perform eating tasks without assistance and the high risk for depression based on newly diagnoses MS.
5. Thorough neurological assessment including:
    a. Reported changes in eyesight.
    b. Examination of gait and station.
    c. Assessment of motor function including muscle strength in upper and lower extremities.
    d. Assessment of muscle tone in upper and lower extremities (i.e., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements (i.e., tardive dyskinesia).

Multiple Sclerosis (2 of 2)

e. Assessment of higher integrative functions, including
   i. Orientation to time, place and person
   ii. Recent and remote memory
   iii. Attention span and concentration
   iv. Language (i.e. naming objects, repeating phrases, spontaneous speech)
   v. Fund of knowledge (i.e., awareness of current events, past history, vocabulary)

6. Medication changes that my affect assessment findings or indicate improvements/advancement of disease process.
7. Moods and behaviors.
8. ADL participation and number of assistance needed to complete tasks safely (bed mobility, transfer, eating and toileting).
9. Skin assessment findings.
10. Participation in skilled or restorative therapy programs.
11. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

** As with any diagnosis, multi-system assessments are necessary to accurately encompass all aspects of the patient's condition and response to treatment.

Myocardial Infarction

Daily Nursing Skills

High risk for cariogenic shock related to arrhythmias, impaired contractility or thrombosis, chest pain due to myocardial ischemia, hypoxemia due to ventilation-perfusion imbalance-minimize the risk of further infarction, optimize myocardial oxygen demand-supply ratio, high risk for activity intolerance related to myocardial ischemia, decreased contractility, arrhythmias.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor for use of stimulants or beverages containing caffeine.
3. Encourage patient performance of ADL, assess and document response or intolerance to activity.
4. Monitor vital signs before during and after each exercise session.
5. Stress and monitor avoidance of Valsalva's maneuver and isometric exercises.
6. Administer vasodilator as ordered and monitor for adverse effects particularly hypotension.
7. Teach the patient to monitor pulse rate before and after exercise.
8. Stress and monitor the importance of complying with the activity or exercise program and with rest requirements.
9. Assess daily for chest pain, describe type, location, radiation, precipitating factors, duration, vital signs, discussion with MD and outcome, list treatment and patient's response.
10. Assess daily for anxiety, depression, denial.
11. Increase knowledge of the disease, promote compliance with dietary modifications, stress the importance of hypertension management, smoking cessation, stress reduction.
12. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Teaching and training activities: Disease and its implications, measuring radial pulse accurately, medications, purpose, dose, schedule, adverse reactions. Need for risk factor modification, diet, rest and exercise programs.
15. Describe current rehabilitation services and progress.
16. Discharge planning.

Neurogenic Bladder/Catheter in Place

Daily Nursing Skills

The muscles and nerves of the urinary system work together to hold urine in the bladder and then release it at the appropriate time. Nerves carry messages from the bladder to the brain and from the brain to the muscles of the bladder telling them either to tighten or release. In a neurogenic bladder, the nerves that are supposed to carry these messages do not work properly. The following are possible causes of neurogenic bladder: diabetes, acute infections, accidents that cause trauma to the brain or spinal cord, genetic nerve problems, heavy metal poisoning. Assess and evaluate for urinary tract infection, kidney stones, chills, shivering, fever, urinary incontinence, small urine volume during voiding, urinary frequency and urgency, dribbling urine, loss of sensation of bladder fullness. The symptoms of neurogenic bladder may resemble other conditions and medical problems.

An indwelling urethral (Foley) catheter is a closed sterile system that is inserted through the urethra to allow for bladder drainage.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - I&O
2. Urinary Reproductive Condition:
   - Urine color, odor and sediment
   - Foley change (size, frequency and reason for change)
   - Foley irrigation (solution used, frequency and reason for irrigation)
3. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
4. Mood:
   - Mood pattern
5. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

Observation, Assessment and Development of a Care Plan (1 of 2)

Daily Nursing Skills

Observation and assessment are skilled services when the likelihood of change in a patient's condition requires skilled nursing or skilled rehabilitation per personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's treatment regimen is essentially stabilized.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. System assessments:
   Neurological/Cognitive: Pupils, hand grips, cognitive function, orientation, attention, memory, vocabulary, abstract reasoning, judgment, sensory/perception/coordination, thought process, sensation of extremities.
   Cardiovascular: Quality, rate, rhythm, regularity, consistence with respiration, radial pulse, apical pulse, check jugular for distention.
   Respiratory: Lung inspection for color, retraction, bilging, impairment in movement, rate and rhythm of breathing, SOB, dyspnea, sputum production color consistency, amount. Palpation: Areas of tenderness, abnormalities such as masses, presence of fremitus crepitus, symmetrical comparison. Percussion: Determine whether the underlying tissues are air filled, fluid filled or solid. Determine flatness, dullness, resonance, hyperresonance or tympany. Auscultation: Air flow, presence of fluid, mucus or obstruction, compare symmetrical breath sounds for quality, intensity, and location. Note pitch, duration of inspiration/expiration and intensity. Describe any abnormality, any rales, wheezes, rhonchi or pleural friction rubs.
   GI: Abdomen, inspection, auscultation, percussion pulsations.
3. **Pain assessment:** Location, type, severity on 1-10 scale. Exacerbated and relieved by. Change in mentation, objective signs of pain, grimacing, body positioning, altered breathing patterns, moaning.
4. **Skin assessment:** Variation in color, pigmentation, texture, thickness, lesions, pressure sores, puritis, incisions.

Observation, Assessment and Development of a Care Plan (2 of 2)

5. **Physical and functional status:** Document assistance required for bed mobility, positioning, transfers, ambulation, endurance level with activity and ADLs.
6. **Nutritional and hydration status:** List any eating or swallowing impairment, skin turgor, special dietary needs, percent of meals eaten daily.
7. Response to treatment: Document the patient's response to any change in medication, or treatment.
8. Record all nursing observations, which identify and evaluate that there may be a need to change or modify a patient's treatment; this includes any positive findings in daily assessments, lab results, vital signs.
9. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
10. Assessment for therapeutic response to medication or discontinuance of medication.
11. Teaching and training activities.
12. Describe current rehabilitation services and progress.
13. Discharge planning.

Pacemaker
(In addition to the listed topics for MI)

Daily Nursing Skills

A pacemaker (or artificial pacemaker, so as not to be confused with the heart's natural pacemaker) is a medical device designed to regulate the beating of the heart. The purpose of an artificial pacemaker is to stimulate the heart when either the heart's native pacemaker is not fast enough or if there are blocks in the heart's electrical conduction system preventing the propagation of electrical impulses from the native pacemaker to the lower chambers of the heart, known as the ventricles. Assess and evaluate surgical wound, vitals are within parameters, activity tolerance, mobility, postural stability, cognitive changes, signs and symptoms of depression.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Skin Condition:
   - Status of surgical incision (redness, warmth, edema, tenderness, drainage, staples or sutures)
   - Site care
2. Follow Up:
   - Next physician follow-up visit
   - Monthly pacemaker checks, include date, time and facility to call including phone number
3. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
4. Mood:
   - Mood pattern
5. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

Pain Management

Daily Nursing Skills

Skilled assessment of pain symptoms including duration, frequency, intensity, factors that exacerbate complaints of pain and factors that relieve pain symptoms. Impact pain has on mobility, mood, sleep, relationships with others. Response to pharmacology and non-pharmacological interventions. Inadequate pain control can contribute to insomnia, anxiety, depression and hostility.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Type of pain (sharp, pressing).
2. Location.
3. Pain level.
4. Medication (P.O./I.M./S.C. or topical) administration.
5. Is medication effective?
6. How long does it take to relieve pain?
7. Is pain completely relieved?
8. Scheduled pain regimen with complaints or signs of break through pain and need for supplemental medications.
9. Any communication with physician regarding pain management plan and outcome.
10. Monitor mental status for changes related to narcotics.
11. Assessment and implementation of an effective bowel regimen to prevent complications related to narcotic use.
12. Patient education regarding relaxational, diversional exercises, energy conservation and work simplifications strategies.
13. Identify how pain impacts other areas such as immobility, nutrition, insomnia, signs of impaired coping and mood indicators.

Other comfort measures:

1. Position change
2. Back rub
3. Emotional support
4. Relaxational or diversional exercises
5. Observation for respiratory depression

Parkinson's Disease (1 of 2)

Daily Nursing Skills

Parkinson's disease (also known as Parkinson disease or PD) is a degenerative disorder of the central nervous system that often impairs the sufferer's motor skills and speech. Parkinson's disease belongs to a group of conditions called movement disorders. The primary symptoms are the results of decreased stimulation of the motor cortex by the basal ganglia, normally caused by the insufficient formation and action of dopamine, which is produced in the dopaminergic neurons of the brain. PD is both chronic and progressive. PD is the most common cause of parkinsonism, a group of similar symptoms. PD is also called "primary parkinsonism" or "idiopathic PD" ("idiopathic" meaning of no known cause). While most forms of parkinsonism are idiopathic, there are some cases where the symptoms may result from toxicity, drugs, genetic mutation, head trauma, or other medical disorders. Assess for complications related to for muscle rigidity, dysphagia, drooling, sign and symptoms of aspiration, fatigue, tremor, postural instability, a slowing of physical movement (bradykinesia) and, in extreme cases, a loss of physical movement (akinesia). Assess and evaluate secondary symptoms including high level cognitive dysfunction and subtle language problems, disorders of mood, behavior, thinking, and sensation (non-motor symptoms).

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms Q
2. Circulatory Condition Q
3. Muscular Skeletal Condition:
   - Contractures
   - Therapy attendance and response
4. Nervous Condition:
   - Reflex response
   - Tremors
   - Pill rolling
   - Facial mask
   - Teaching done and response
5. Bed Mobility:
   - Amount of assist needed
6. Transfer:
   - Amount of assist needed

Parkinson's Disease (2 of 2)

7. Locomotion:
    - Amount of assist needed
    - Gait (shuffling, forward leaning, weakness)
    - Falls (summarize)
8. Toilet Use:
    - Amount of assist needed.
9. Personal Hygiene:
    - Amount of assist needed
10. Bathing:
    - Amount of assist needed
11. Eating:
    - Signs and symptoms of swallowing problems
12. Cognitive:
    - Level of orientation
    - Cognitive
13. Emotional:
    - Emotional status
    - Acceptance of disease
14. Elimination:
    - Continence level of bowel and bladder
15. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
16. Mood:
    - Mood pattern

Pelvic or Lumbar Fracture (1 of 2)

Daily Nursing Skills

A pelvic fracture is when one or more of the pelvic (hip) bones are broken. Your pelvis is made up of 5 bones, shaped in a circle. The 5 bones are the sacrum, coccyx (COX-iks), ilium, pubis, and ischium (ISH-e-um). Your pelvis protects and supports organs inside your body. Fracture of one or more parts of the spinal column (vertebrae) of the middle (thoracic) or lower (lumbar) back is a serious injury usually caused by high-energy trauma. People with osteoporosis, tumors or other underlying conditions that weaken bone can get a spinal fracture with minimal trauma or normal activities of daily living. The lumbar spine provides for both stability and support when humans ambulate. Assess and evaluate for signs and symptoms of DVT, immobility, instability, loss of balance, pain, posture, skin integrity, vitals, dizziness, dehydration, sensation, numbness, tingling.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Peripheral pulses
   - CMTS
3. Skin Condition:
   - Skin integrity
   - Status of open areas
   - Potential related concerns
4. Urinary Condition:
   - Presence of urine retention
5. Muscular Skeletal Condition:
   - Pain
   - Attendance at therapy and progress
   - ROM given
6. Digestive Condition:
   - Bowel sounds
   - Constipation
7. Bed Mobility:
   - Amount of assist needed

Pelvic or Lumber Fracture (2 of 2)

8. Transfer:
    - Amount of assist needed
9. Locomotion:
    - Amount of assist needed
10. Dressing:
    - Amount of assist needed
11. Eating:
    - Amount of assist needed
12. Toilet Use:
    - Amount of assist needed
13. Personal Hygiene:
    - Amount of assist needed
14. Bathing:
    - Amount of assist needed
15. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
16. Mood:
    - Mood pattern

Permanent Pacemaker Insertion

Daily Nursing Skills

High risk for arrhythmias related to pacemaker malfunctions or catheter displacement. High risk for infection related to surgical disruption of skin barrier. High risk for bleeding, infection (elevated WBC), drainage at insertion site. High risk for vagal-medicate arrhythmias. Observations and assessment for deviation from baseline vital signs which may indicate pacemaker failure of complications.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs, apical pulse.
2. Record pacemaker type, and rate.
3. Administer cardiac medications and effectiveness, and adverse effects.
4. Observe insertion site for redness, swelling, drainage, warmth and local pain.
5. Monitor response to increased activity.
6. Monitor use ROM and restrictions to use of arm, (decrease change of lead displacement).
7. Monitor for S&S of decreased cardiac output, shortness of breath, low or erratic pulse, lightheadedness, chest pain decreased exercise tolerance, prolonged fatigue or weakness, or recurrence of pre-implant symptoms.
8. Assess for vagal-mediated arrhythmias, encourage non-laxative stool softeners.
9. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
10. Assessment for therapeutic response to medication or discontinuance of medication.
11. Teaching and training activities: symptoms of pacemaker failure, complications, limitations and precautions, pulse rate measurement, medications, purpose, dose administration schedule, adverse reactions requiring medical attention. Follow-up pacemaker monitoring with cardiologist.
12. Describe current rehabilitation services and progress.
13. Discharge planning.

Pneumonia (1 of 2)

Daily Nursing Skills

High risk for hypoxemia related to inflammatory response to pathogen and inadequate airway and alveolar clearance, symptoms related to pain fever and pleuritic irritation, activity tolerance from increased oxygen demands and a compromised respiratory system.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Document daily pulmonary assessment.
3. Monitor for need of oxygen or patient's response to medical gases.
4. Record maintenance of oxygen during activity.
5. Observe tolerance of activity. Pulmonary response to physical activity and needs for increased liter flow of oxygen to compensate.
6. Assess for signs of increased fatigue, tachypnea, cyanosis, tachycardia, and other signs of impaired oxygenation.
7. Administer antibiotic therapy as ordered, and results of blood level studies.
8. Monitor and report any adverse effect.
9. Document: LOC, sputum character and color, presence or absence of cough, temperature, pulse, respiratory rate, skin color, breath sounds, and activity level.
10. Document non-invasive measures to promote airway clearance: Deep breathing, coughing, incentive spirometer.
11. Document any postural drainage, percussion or vibration, and the patient's response to the treatment.
12. Assess for need by pulmonary assessment, record gurgling, heard over major airways and any nasotracheal suctioning performed. Record any increase in supplemental oxygen used before and during airway clearance procedures. Describe results and patient's response.
13. Maintain adequate hydration, record I&O.
14. Document patient's progress with mobility, and compliance with recommended rest periods.
15. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
16. Assessment for therapeutic response to medication or discontinuance of medication.

Pneumonia (2 of 2)

17. Teaching and training activities: Pulmonary hygiene, avoidance of infection and irritants, importance of rest, importance of prompt reporting of signs of recurrence of pneumonia and medication regimen.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

Psychiatric Disorders

Daily Nursing Skills

High risk for exacerbation of symptoms in mood or behaviors that may negatively impact self or others. Medication management and skilled monitoring of effects. Management in care plan to promote stability of condition. Behavior plans, interventions and need for modification. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This should address one or more of these areas of skilled nursing.

1. Complete vital signs.
2. Mental status, level of orientation and decision-making.
3. Behaviors, verbal complaints of physical or emotional distress.
4. Presence of auditory or visual hallucinations and delusional thought process.
5. Sleep pattern signs insomnia and lethargy.
6. Nutritional and fluid intake, signs of inadequate hydration or unplanned weight loss.
7. Affect/insight into condition or limitations.
8. Signs of medical instability related to secondary diagnosis or conditions.
9. Medication compliance, side effects, therapeutic effects, therapeutic drug levels. Change in meds or dosage and patient's response – negative or positive.
10. Interventions with response – negative or positive.
11. Physician visits, medical or psychiatric.
12. Motivation to participate in ADLs, training in skills to return to the community.
13. Social interaction, activity level.
14. Discharge planning, medication teaching, community referrals, caregiver education.

Pulmonary Disease

Daily Nursing Skills

High risk for hypoxemia related to inadequate gas exchange. High risk for respiratory infection secondary to limited ability to expand lungs secondary to disease effects. High risk for anxiety and depression.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assessment of lungs:
    a. Auscultation q shift x _____ days.
        1. Presence and location of rales/wheeze/rhonchi.
        2. Congestion.
    b. Presence of sternal or intercostal retraction.
    c. Unequal chest expansion.
    d. Distention of next veins.
    e. Ability to cough and deep breathe (sputum, color, consistency, amount).
    f. Response to antibiotic therapy/respiratory treatments and or use of a metered dose inhaler.
3. O2 requirements (liters/minute per delivery device used).
4. Nutritional/hydration status.
5. Activity level and amount of assistance needed. Pulmonary response to physical activity.
6. Endurance – cyanosis/SOB/need for O2, use of accessory muscles.
7. Saturation Rates.
8. Symptoms related to chronic disease effects of air hunger and limitations imposed by disease effects.

Radiation Therapy or Chemotherapy (1 of 3)

Daily Nursing Skills

Chemotherapy refers to drugs that are used to kill microorganisms (bacteria, viruses, fungi) and cancer cells. Most commonly, the term is used to refer to cancer-fighting drugs. Cancer chemotherapy kills or arrests the growth of cancer cells by targeting specific parts of the cell growth cycle. However, normal healthy cells share some of these pathways, and thus are also injured or killed by chemotherapy. This is what causes most side effects from chemotherapy. A patient becomes less resistant to any type of virus of infection putting them at risk for more acute complications.

Radiation therapy is a treatment approach that uses radiation to destroy cancer cells. Radiation therapy is used to fight many types of cancer. Often it is used to shrink the tumor as much as possible before surgery to remove the cancer. Radiation can also be given after surgery to prevent the cancer from coming back. For certain types of cancer, radiation may be the only treatment needed. Radiation treatment may also be used to provide temporary relief of symptoms, or to treat malignancies (cancers) that cannot be removed with surgery.

Radiation therapy can have many side effects. These side effects depend on the part of the body being irradiated and the dose and schedule of the radiation:

- Fatigue and malaise
- Low blood counts
- Difficulty or pain swallowing
- Erythema
- Edema
- The shedding or sloughing-off of the outer layer of skin (desquamation)
- Increased skin pigment (hyperpigmentation)
- Atrophy
- Pruritis
- Skin pain
- Changes in taste
- Anorexia
- Nausea
- Vomiting
- Hair loss
- Increased susceptibility to infection

Radiation Therapy or Chemotherapy (2 of 3)

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Edema
   - CMTS
3. Vital statistics/symptoms:
   - Vitals
4. Hydration Condition:
   - Dehydration
5. Circulatory Condition:
   - Edema
   - Ascites
6. Skin Condition:
   - Skin integrity (sloughing, redness, edema, tenderness)
   - Status of open areas
   - Potential related concerns
   - Jaundice
7. Digestive Condition:
   - Pain
   - Nausea/vomiting
   - Nausea medication ordered
8. Eating:
   - Nutritional status
   - Percent of food taken
   - Supplements taken
9. Emotional:
   - Adaptation to changes in body image.

Radiation Therapy or Chemotherapy (3 of 3)

10. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices.
    - Days per week received for more than or equal to 15 minutes
    - Attendance at therapy and progress
    - ROM given
11. Mood:
    - Mood pattern.

Rehab for Strengthening Due to Functional Loss (1 of 2)

Daily Nursing Skills

There are multiple health benefits that are derived from endurance training and/or strengthening in the elderly. For example, bone density, insulin sensitivity, and co-morbidities associated with obesity can be effectively managed with resistance exercise when it is conducted on a regular basis. Assess and evaluate signs and symptoms of exacerbation of primary and secondary medical diagnosis related to complications of functional loss and post therapy intervention. Often patients participate with 100% effort in the therapy appointment as they view this as the portal to returning home. Following return to the nursing unit a patient can experience a decline in medical status due to the efforts exerted during a rehabilitation session.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Bed Mobility:
   - Amount of assist needed
3. Transfers:
   - Amount of assist needed
4. Locomotion:
   - Amount of assist needed
   - Endurance
5. Dressing:
   - Amount of assist needed
6. Eating:
   - Amount of assist needed
7. Toilet use:
   - Amount of assist needed
8. Personal Hygiene:
   - Amount of assist needed
9. Bathing:
   - Amount of assist needed

Rehab for Strengthening Due to Functional Loss (1 of 2)

10. Cognitive:
    - Ability to follow directions
11. Muscular Skeletal Condition:
    - Attendance and response to therapy (PT or OT)
12. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
13. Mood:
    - Mood pattern

Renal Failure with Dialysis (1 of 2)

Daily Nursing Skills

High risk for hyperkalemia, related to decreases renal excretion, metabolic acidosis, excessive dietary intake, blood transfusion, catabolism, and noncompliance with therapeutic regimen. High risk for pericarditis, pericardial effusion, and pericardial tamponade related to uremia or inadequate dialysis. High risk for hypertension related to sodium and water retention and malfunction of the renin-angiotensin-aldosterone system. High risk for anemia related to decreased life span of RBC's and blood loss during hemodialysis. High risk for osteodystrophy and metastatic calcification related to hyperphosphatemia, hypocalcemia, abnormal vitamin D metabolism, hyperparathyroidism, and elevated aluminum levels. High risk for nutritional deficit related to anorexia, nausea, vomiting, diarrhea, restricted dietary intake, GL inflammation with poor absorption, and altered metabolism of proteins, lipids and carbohydrates. High risk for altered oral mucous membrane and unpleasant taste related to accumulation of urea and ammonia. High risk for impaired skin integrity related to decreased activity of oil and sweat glands, scratching, capillary fragility, abnormal blood clotting, anemia, retention of pigments, and calcium deposits on the skin.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Monitor and record serum potassium, and report S&S's of hyperkalemia (slow irregular pulse, muscular weakness and flaccidity, diarrhea and ECG changes.)
3. Assess measures for prevention of metabolic acidosis assess prevention measures to avoid catabolism, ensure prescribed amounts of dietary protein and carbohydrates, treatment of infections, prevention of fever.
4. Assess daily for pericarditis (fever, chest pain, friction rub).
5. Assess for paradoxical pulse greater than 10mm Hg., peripheral edema, decrease in sensorium, hypotension, narrow pulse pressure, weak or absent peripheral pulses, cold and poorly perfused extremities, rapid decrease in sensorium, and bulging neck veins (signs of rapidly occurring large tamponade).
6. Dialysis removes sodium and water and controls vascular volume, monitor and record compliance with restrictions to prevent excessive sodium and fluid intake.
7. Assess daily for orthostatic hypotension; teach and record patient compliance with techniques to avoid this.

Renal Failure with Dialysis (2 of 2)

8. Assess daily for S&Ss of fluid overload: Hypertensive encephalopathy, vision changes, periorbital, sacral or peripheral edema, headaches blurred vision seizures and blurred vision.
9. Assess the degree of anemia (Hgb. level, RBC) and its physiologic effects: fatigue, pallor, dyspnea, palpitations, ecchymoses, and tachycardia.
10. Assess every shift: Dialysis catheter, AV shunt, bruit and thrill, IV dressing integrity, IV site presence of drainage and redness or warmth.
11. Assess with development of activity and exercise program with regular rest periods to avoid fatigue due to decreased Hgb., decreased tissue oxygenation. Assess the patient's ability to perform ADLs.
12. Describe current rehabilitation services and progress.
13. Intake and output, fluid restrictions, compliance to restriction.

Rheumatoid Arthritis

Daily Nursing Skills

High risk for joint deformity, pain and muscle atrophy. Risk to other body systems as rheumatoid nodules may for in the heart, lungs, and spleen. Manifestations of the multi-system involvement include: Pleuritis, Pulmonary Fibrosis, Pericarditis, Aortic Valve Disease, Lymphadenopathy, Glaucoma, and Splenomegaly. The acute narcotizing vacillates that is common in the autoimmune disorders may result in myocardial infarction, cerebrovascular accident, Kidney damage, and Raynaud's disease. High risk for ineffective pain control, fatigue, negative self-concept, decreased mobility and injuries with the risk for development of skin ulcers and contractures.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified nursing skills**, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Inspection and palpation of the same joints on both sides of the body for symmetry, skin color, size and shape.
3. Inspection of tenderness, heat, and swelling of joints
4. Assess and document limitations of active joint ROM
5. Assess and document pain with ROM
6. Evaluate and document effectiveness of pain relief measures, evaluate type intensity and duration of pain. Teach relaxation techniques and alternate methods of pain control.
7. Assess measures utilized to promote independence. Assist with supportive, assistive measures. Promote frequent position changes and adequate rest periods.
8. Work simplification strategies and assist with ADLs.
9. Comprehensive skin assessments for signs of ulcers related to decreased mobility and contractures.
10. Assess psychological effects imposed by disease with limitations and coping abilities.
11. Assess response to medications, anti-inflammatory medications and side effects.
12. Review and report laboratory results including ESR.
13. Document communication with physician, consults with Rheumatologist, and orthopedic physicians.
14. Discuss current rehabilitation services and response to therapy.
15. Discharge teaching and training, caregiver education.
16. Discharge planning.

Seizure Disorder

Daily Nursing Skills

High risk for trauma related to seizure activity. High risk for aspiration secondary to decreased consciousness following a seizure. High risk for impaired adjustment related to disability requiring change in lifestyle and possible change in independence. High risk for adverse effects of non-therapeutic drug levels.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. Observation of any seizure activity – petit mal or grand mal seizure. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Time began.
2. Symptoms at beginning.
3. Pattern of seizures.
4. Type (grand mal, petit).
5. Type of movements.
6. Unconsciousness (check airway).
7. Incontinence of urine/feces.
8. Size of pupils/fixed in one position.
9. Vital signs post seizure.
10. Duration.
11. Injuries sustained during seizure.
12. PRN post-conclusive medication given.
13. Physician notified.
14. Sleeping afterwards/exhausted. Postictal phase. Level of assist with ADLs required post-seizure.
15. Laboratory results of seizure drug levels.
16. Adverse side effects of seizure drugs.
17. Potential interactions with seizure drugs.
18. Signs of ineffective coping and altered mood secondary to seizure activities.

Skeletal Traction

Daily Nursing Skills

Patient is at high risk for skin breakdown or dermatitis under skin traction, complications of immobilization; stasis pneumonia, thrombophlebitis, pressure ulcers, urinary tract infection, calculi, constipation. Altered tissue perfusion, deformity related to traction therapy and underlying pathology.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Assessment frequently for pain, deformity, swelling.
3. Neurovascular assessment frequently for motor and sensory function and circulatory status of the affected extremity; color, temperature, motion, capillary refill of peripheral circulation. Assess specific nerves which may be compromised: peroneal, radial, median.
4. Assessment daily of skin condition of the affected extremity, both under skin traction, and around skeletal traction, as well as over bony prominence throughout the body.
5. Pulmonary assessment for signs of complications auscultate the lung fields at least twice daily, document frequency of deep breathing exercises.
6. Assess traction equipment for safety and effectiveness, deformity. Check ropes and pulleys for alignment. Assure that the pulleys are in line with the long axis of the bone, weights are hanging freely, ropes are unobstructed, and not in contact with the bed or equipment.
7. Inspect skin around pin sites frequently for signs of infection or points of contact with external traction devices.
8. Document fluid I&O, and development of an effective bowel program, high fiber diet, avoid high calcium intake.
9. Assess frequently for signs of thrombophlebitis. Color, sensation and movement of affected extremity absence or presence of Homan's sign. Presence of increased edema and tenderness.
10. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
11. Assessment for therapeutic response to medication or discontinuance of medication.
12. Teaching and training activities.
13. Describe current rehabilitation services and progress.
14. Discharge planning.

Specialty Bed

Daily Nursing Skills

High risk for complications related to the reason the specialty bed is necessary. Local and systemic infection including high risk for osteomyelitis.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs include fever, chills or rigors without elevated temperature.
2. Document at the initiation of use of specialty bed, all other treatments that were unsuccessful, and response.
3. Specify the diagnosis for which use of the bed is indicated, usually stage 3 or 4 decubitus ulcers of the trunk.
4. Describe immobility, and the amount of time the patient is in the bed for each shift. Generally full bed rest with short periods out of bed only for specific periods of essential rehabilitation. Describe psychosocial impact of bed rest status and measures to increase social stimuli.
5. Document skin condition. Identify any new areas of concern.
6. Record nutritional status, appetite, diet, intake.
7. Document elimination patterns, bowel and bladder programs, incontinence, use of laxatives, etc.
8. Document specific ulcer data: Location(s), stage, diameter, depth, size, drainage, color, odor, and any observed changes to the ulcer. Document pain related to ulcer, treatment and response.
9. Document treatment to the ulcer, describe exact treatment, medication, irrigations, dressings, frequency, response to treatment. Document measures to control odors and drainage.
10. Document any changes to the treatment plan as well as the patient's response.
11. Record any discussion with the physician regarding treatment plan or change of plan.
12. Document any consults: Wound care specialist, surgical, dietitian, social worker, wound clinical visits and primary care physician. Reason for consult and outcome.
13. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
14. Assessment for therapeutic response to medication/treatments or discontinuance of medication/treatments.
15. Teaching and training activities.
16. Describe current rehabilitation services and progress.

Speech and Language Problems (Aphasia)

Daily Nursing Skills

Aphasia usually results from damage to the left side of the brain, which is the area responsible for language. Some people who have aphasia may not be able to understand written or spoken language, read or write, or express their own thoughts. Recovering from significant injury to the brain may take from days to years. Much of your improvement in motor functioning-walking, using your arms and legs-comes in the early phase of stroke recovery. Provide detailed assessment documentation to support the patient's functional improvements and deteriorations on a daily basis. Assess and evaluate vitals, oral communication, safety, ability to make daily needs known, signs and symptoms of distress, and signs and symptoms of neurovascular episodes.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs every shift and prn. Be sure to include mental status and postural changes with VS.
2 Statements made directly by the patient (if possible) quoted. For instance: "I have been having some tremors in my arms today that caused me to spill my juice this morning."
3. Statements reported by caregivers, quoted: For instance: "Mrs. Smith seems somewhat more unsteady today, unable to participate in her morning bath, dressing, and toileting."
4. Intake and Output Monitoring.
5. It is not unusual that with new CVAs, aphasia is accompanied by dysphagia, thus putting the patient at risk for dehydration, aspiration, and depression. Monitor for all.
6. Detail any communication techniques used by caregivers and patient to assist with making the patient's need known. (i.e., communication boards, sign language).
7. Medication changes that my affect assessment findings.
8. Moods and behaviors.
9. ADL participation and number of assistance needed to complete tasks safely (bed mobility, transfer, eating and toileting).
10. Skin assessment findings.
11. Participation in skilled or restorative therapy programs.
12. Always include detailed information shared with physicians, plans based on reported findings, and care plan adjustments being made based on assessments.

**As with any diagnosis, multi-system assessments are necessary to accurately encompass all aspects of the patient's condition and response to treatment.

Suctioning (1 of 2)

Daily Nursing Skills

There are many clinical reasons when suctioning (the removal of unwanted secretions from the respiratory tract) is necessary. For instance, patients with chronic lung diseases, respiratory infections (pneumonia, bronchitis) and paralysis require the skills of a clinical professional to at times assist the patient with the removal of such secretions. Suctioning can be performed through the oral route, nasopharyngeal route, or by tracheal aspiration. Medicare recognizes the latter two routes as requiring the skills of a licensed professional to be considered a covered service. Many facilities have policies surrounding the performance of suctioning at the bedside and should include strategies to move secretions through peripheral airways. These measures include: appropriate hydration and adequate humidification of inspired gases (to keep secretions thin); coughing and deep breathing; frequent position changes (may need rotation bed); chest physiotherapy; and bronchodilating agents as ordered. Above all, the ongoing skilled observation and assessment are vital to the task of effective suctioning.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
2. Circulatory Condition:
   - Skin color and temperature
3. Respiratory Condition:
   - Breath sounds
   - Sputum color
   - Head of bed elevated
   - Reason for suctioning
   - Frequency of suctioning
   - Location of suctioning (via nose, oral cavity, tracheostomy, etc.)
   - Characteristic of substance suctioned (color, amount, odor, consistency)
   - Date suction equipment changed
4. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes

Suctioning (2 of 2)

5. Mood:
   - Mood pattern
6. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

Teaching and Training

Daily Nursing Skills

High risk for complications related to knowledge deficit for self-care and management of disease process, treatment or conditions. Patient requires teaching and training in the specified area to promote medical recovery, stability and prevention of exacerbation of symptoms and or conditions. Patient requires daily skilled nursing for evaluation of outcomes of teaching and training interventions. There is a high likelihood for the need to modify the teaching and training program to attain the desired outcome. The daily skills of a nurse are required to assess the effectiveness of the teaching and training program.
Examples of Skilled Teaching Activities include:

1. Self-administration of injectable medications
2. A newly diagnosed diabetic with insulin, diet, and foot care
3. Self-administration of medical gases
4. Gait training or prosthetic care
5. Care of a recent ostomy
6. Care of braces, splints or orthotics.
7. Bowel and bladder training
8. Straight catheterizations
9. Tube feeding administration and care

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing Notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Area of teaching or training
2. Current teaching methods
3. Response to current teaching methods
4. Progress with teaching or training methods, or lack of progress
5. Modification to teaching/training interventions and outcomes
6. Caregiver training and progress
7. Discharge plan and progress towards goals.
8. Continued skilled assessment of conditions/ diagnosis that prompted initial admission.
9. Vital signs

Terminal Care

Daily Nursing Skills

At risk for powerlessness related to the inevitability of death. Lack of control over bodily functions, dependence on others for care. At risk for spiritual distress, identity disturbance. High risk for pain related to underlying disease or injury (see specific disease related Guideline). High risk for fluid, volume deficit related to anorexia and dehydration related to imminent death. High risk related to multi-organ failure with end of life disease processes.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly Note should include all of the identified nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Pain assessment frequently, record response to pain relief techniques non-pharmacologic and pharmacologic. Urge calling for medication before pain becomes severe.
3. Document what measures were taken to support or improve the patient's physical or emotional condition.
4. Describe any dysphagia, nausea, anorexia.
5. Document the elimination pattern, and bladder/bowel regimen.
6. Observe and record activity, positioning, its effect on pain.
7. Document the skin condition, measures for comfort and relief of pain.
8. Document the coordination of family involvement.
9. Avoid vigorous fluid replacement record frequent mouth care.
10. Include family in care planning. Ensure unrestricted family involvement and visits.
11. Plan care treatments according to pain, and family involvement.
12. Review of laboratory studies for abnormal values (review is skilled, even for negative results).
13. Assessment for therapeutic response to medication or discontinuance of medication.
14. Document communications with the physician.
15. Describe current rehabilitation services and progress.
16. Discharge plan – terminal care at SNF level vs. home care with necessary referrals.
17. Document systems assessment with changes and interventions to minimize discomfort, pain and distress.

Total Hip Replacement

Daily Nursing Skills

Patient is at high risk of complications related to surgical procedure, infection. thrombophlebitis, pulmonary embolism, compartment syndrome, unusual bleeding related to anticoagulation therapy, neurovascular complications. Patient is at risk for complications related to decreased physical mobility including pressure ulcers, constipation, and urinary tract infection. Patient is at risk for surgical wound infection and delayed healing of wound. Patient is at risk for dislocation of prosthesis secondary to knowledge deficit or cognitive deficits with total hip precautions.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. Condition of surgical site:
   a. Redness, warmth, edema, tenderness, drainage.
   b. Staples/Sutures in place.
3. Amount of assistance required for transfer, ambulation, ADLs, weight bearing limitations and compliance.
4. Total hip precautions:
   a. By staff.
   b. Patient compliance.
5. Anticoagulation signs of bleeding, adjustments in dose, abnormal lab results. Signs of anemia.
6. Pain management and response to pharmacological and non-pharmacological interventions.
7. Skilled assessment for circulatory/neurological complications, monitor/document C.S.M, Homan's Sign, edema and increased pain. Daily skin assessment and preventative measures secondary to reduced mobility.
8. Patient/resident/caregiver teaching of post discharge information on total hip.
9. Attendance of therapies, progress.

Total Parenteral Nutrition (TPN) (1 of 2)

Daily Nursing Skills

High risk for sepsis, mechanical injury from catheter, pneumothorax, hemothorax, arterial puncture, air emboli, catheter emboli, catheter and venous thrombosis. Metabolic disorders, hypoglycemia, fluid and electrolyte abnormalities, hyperglycemia, essential fatty deficiency. Neurological abnormalities. High risk for fluid volume excess, or deficit. High risk for nutrition deficit. High risk for infection related to invasive CVC, leukopenia, or damp dressing.

Following nursing admission assessment, identify **which of the list areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these areas of skilled nursing. A comprehensive Weekly Note should include **all of the identified** nursing skills, plus any periodic episodes which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs daily assessment for complications.
2. Record observation for signs of air emboli: Extreme anxiousness, sharp chest pain, cyanosis or churning precordial murmur.
3. Document dressing changes, presence of suture at the site of the CVC, and external catheter length. Signs and symptoms of infection.
4. Record inability to draw blood, complaints of chest pain or burning, leaking fluid, swelling around the catheter, shoulder clavicle and upper extremity.
5. Document visible signs of circulation on the chest wall.
6. Record administration of TPN solution, rate and patient tolerance.
7. Document fluid intake and output accurately.
8. Observe for: hypoglycemia, weakness, agitation, tremors, cold clammy skin, serum glucose levels less than 60 mg/dl and urine tests negative for sugar and acetone.
9. Observe for signs of: hyperglycemia: thirst, acetone breath, diuresis, dehydration, serum glucose level above 200 mg/dl: Urine positive for glucose and varying from negative to large amounts of acetone.
10. Assess for hyper osmolar overload: thirst, headache, lethargy, seizures, and urine positive for glucose and negative for acetone.
11. Document observation for electrolyte imbalance: Hypocalcemia (numbness and tingling), hypokalemia (lethargy and confusion), hypokalemia (muscle weakness, cramps, paresthesia, lethargy, confusion, ileus, and arrhythmias), hypomagnesemia (confusion, positive Chvostek's sign and tetany), hyponatremia (lethargy and confusion). Record serum electrolytes as ordered.
12. Record daily weights and exercise.
13. Daily pulmonary assessment.
14. Observe for edema, signs of excess fluid volume.

Total Parenteral Nutrition (TPN) (2 of 2)

15. Observe for thirst and signs of dehydration.
16. Labs as ordered, review with physician and pharmacist, changes to TPN formulator in assessment/tolerance of change in formula.
17. Assessment for therapeutic response to medication or discontinuance of medication.
18. Teaching and training activities.
19. Describe current rehabilitation services and progress.
20. Discharge planning.

Tracheostomy (1 of 2)

Daily Nursing Skills

A tracheostomy is an opening surgically created through the neck into the trachea (windpipe). A tube is usually placed through this opening to provide an airway, and to remove secretions from the lungs. This tube is called a tracheostomy tube or trach tube.

Rubbing of the trach tube and secretions can irritate the skin around the stoma. Daily care of the trach site is needed to prevent infection and skin breakdown under the tracheostomy tube and ties. Care should be done at least once a day; more often if needed. People with new trachs or who are on ventilators may need trach care more often. Tracheostomy dressings are used if there is drainage from the tracheostomy site or irritation from the tube rubbing on the skin.

Some older children and teens have trach tubes with an inner cannula. Some inner cannulas are disposable (DIC: Disposable Inner Cannula). These should be changed daily, discarding the old cannula. Check with your equipment vendor regarding disposable cannulas. For the reusable cannulas, the cannula should be cleaned 1 to 3 times a day and more often if needed. Do not leave the inner cannula out for more than 15 minutes.

Following nursing admission assessment, identify which of the listed areas are pertinent for each patient. Daily Nursing notes should address one or more of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
2. Respiratory Condition:
   - Type and size of trach and frequency of change
   - Ability to handle secretions
   - Sputum
   - Lung sounds upon auscultation
   - Antibiotic use
   - Frequency and response to suctioning
   - Oxygen therapy (flow, rate, method of delivery)
   - Weaning from trach
   - Time and frequency of plugging trach
   - Response to weaning
   - Teaching done and response

Tracheostomy (2 of 2)

3. Skin Condition:
   - Condition of skin at trach opening
   - Wound precautions maintained
4. Eating:
   - Nutritional status
   - Percent of food eaten
   - Supplements taken
5. Lab Results:
   - Lab results
6. Rehab/Restorative:
   - Rehabilitation or restorative techniques or practices
   - Days per week received for more than or equal to 15 minutes
7. Mood:
   - Mood pattern
8. Muscular Skeletal Condition:
   - Attendance at therapy and progress
   - ROM given

Traction (1 of 3)

Daily Nursing Skills

Traction uses weights and pulleys to put tension on a displaced bone or joint, such as a dislocated hip, to realign the bone and immobilize it. Traction is also used to keep a group of muscles stretched (such as the lower spinal muscles) to reduce muscle spasm. As a treatment, traction will involve a certain amount of tension to pull the body part into another position, a length of time to use the tension, and a way to maintain the tension. Traction is most often used as a temporary measure when operative fixation is not available for a period of time.

Traction can either be applied through the skin (skin traction) or through pins inserted into bones (skeletal traction). Skin traction is generally less desirable due to the fact that skin can be injured when pressure is applied for extend periods of time. Skin traction called Buck's traction is commonly used in patients who have a hip fracture. Skeletal traction does have the disadvantage of complications associated with pin insertion, and infections can come from the sites of pin insertion.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
   - I&O
2. Circulatory Condition:
   - Distal pulses
   - CMTS
3. Skin Condition:
   - Skin integrity
   - Status of open areas
   - Potential related concerns

Traction (2 of 3)

4. Muscular Skeletal Condition:
   - Pain
   - Type of traction
   - Special equipment used (special bed, etc.)
   - Amount of weights applied
   - Therapy attendance and progress
   - Teaching done and response
5. Urinary Condition:
   - Presence of urine retention
6. Bed Mobility:
   - If on bed rest, tolerance of same
   - Amount of assist needed
   - Frequency of repositioning
7. Transfer:
   - Amount of assist needed
8. Locomotion:
   - If out of bed, activity level and tolerance of same
9. Eating:
   - Nutritional status
   - Percent of food eaten
   - Amount of assist needed
10. Personal Hygiene:
    - Amount of assist needed
11. Toilet Use:
    - Amount of assist needed
12. Bathing:
    - Amount of assist needed
13. Cognitive:
    - Cognitive
14. Emotional:
    - Emotional status
15. Elimination:
    - Constipation
    - Diarrhea
    - Incontinence

Traction (3 of 3)

16. Rehab/Restorative:
    - Rehabilitation or restorative techniques and practices
    - Days per week received for more than or equal to 15 minutes
17. Mood:
    - Mood pattern

Urinary Retention

Daily Nursing Skills

High risk for kidney damage and electrolyte imbalance related to inability to empty bladder. High risk for infection secondary to invasive procedures, catheters- indwelling or intermittent, and stasis of urine in the bladder promoting growth of microbes. Skilled assessments and evaluation of signs of bladder distention and evaluation of intake and output measurements. Skilled assessment of symptoms and conditions precipitating urinary retention. Evaluation of laboratory data, neurological assessment and medication effects with voiding pattern.

Following nursing admission assessment, identify which of the list areas are pertinent for each patient. Daily Nursing notes should address one or more of these areas of skilled nursing. A comprehensive Weekly note should include all of the identified nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital signs.
2. The presence of fever, chills, or rigors in the absence of fever. Temp spikes.
3. Intake and output monitoring. Evaluation of relationship of I&O totals.
4. Presence of indwelling catheter or intermittent catheter placement to facilitate emptying of bladder.
5. Removal of catheter and voiding trials with outcome.
6. Effects of medications: Urecholine to initiate voiding by stimulation of the detrusor muscle of the bladder, Prophylactic antibiotic therapy.
7. Voiding patterns: Inability to void (retention), voiding in small frequent amounts (retention with overflow).
8. Pain with voiding for possible UTI or obstructive uropathy.
9. Document sense or need to void or bladder fullness immediately after voiding (retention with overflow).
10. Palpation of bladder for fullness or tenderness.
11. Positional changes to promote voiding and response.
12. Post void residuals and intermittent catheterization results.
13. Document communication with physician, consults- urology, and outcome or change in treatment plans.
14. Teaching and training: Bladder retraining, intermittent catheterizations, prevention of urinary tract infections, adequate fluid intake. Signs of infection and need for prompt medical attention. Caregiver education.
15. Discharge planning and teaching of medications, follow-up care. Home care referrals needed.

Urinary Tract Infection

Daily Nursing Skills

High risk for sepsis related exacerbation of symptoms. High risk for recurrent UTI, observation for S&S of recurrence, monitoring of labs, effectiveness of medication, effects of inactivity, decreased nutrition on mobility and endurance.

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1. Vital signs.
2. Temperature.
3. I&O.
4. Signs and symptoms of reaction to medication.
5. Mental status changes.
6. Presence of burning, frequency, urgency.
7. Presence of chills, nausea, vomiting.
8. Presence of visible signs of pyuria or hematuria.
9. Presence of pain, bladder region or back.
10. Signs of urinary retention.
11. Assess for incontinence. Assess need for bladder retraining.
12. Malaise or headache.
13. Collection of urine samples for lab study.
14. Review of laboratory studies for abnormal values (**review** is skilled, even for negative results).
15. Assessment for therapeutic response to medication or discontinuance of medication.
16. Signs of reoccurrence post treatment.
17. Teaching and training activities – hygiene and fluid intake.
18. Describe current rehabilitation services and progress.
19. Discharge planning.

Ventilator (1 of 2)

Daily Nursing Skills

A medical ventilator is a device designed to provide **mechanical ventilation** to a patient. In its simplest form, a ventilator consists of a compressible **air** reservoir, air and **oxygen** supplies, a set of valves and tubes, and a disposable or reusable "patient circuit". The air reservoir is pneumatically compressed several times a minute to deliver room-air, or in most cases, an air/oxygen mixture to the patient. When overpressure is released, the patient will exhale passively due to the **lungs'** elasticity, the exhaled air being released usually through a one-way valve within the patient circuit. The oxygen content of the inspired gas can be set from 21 percent (ambient air) to 100 percent (pure oxygen). Pressure and flow characteristics can be set mechanically or electronically.
Observe, assess and document signs and symptoms of hypotension, decreased cardiac output, pneumothorax, subcutaneous emphysema, interstitial pulmonary emphysema, and air embolus, localized pulmonary hyperinflation, nosocomial infections (pneumonia), and increased intracranial pressure (cerebral edema). In addition to these conditions assess and evaluate for skin breakdown and gastric distension. However, these do not occur often and, when they do, are generally not severe.

Following nursing admission assessment, identify **which of the listed areas are pertinent for each patient. Daily Nursing notes** should address **one or more** of these assessment results as evidence of ongoing skilled observation, assessment and ongoing care planning for the individual patient. A comprehensive Weekly note should include **all of the identified** nursing skills, plus any periodic episodes, which have occurred. This list should be kept updated, eliminate or add skills as appropriate for the patient's Plan of Care.

1. Vital Statistics/Symptoms:
   - Vitals
   - Weight
   - I&O
2. Hydration Condition:
   - Hydration
3. Circulatory Condition:
   - Head of bed elevated
   - Edema
   - Antibiotic therapy

Ventilator (2 of 2)

4. Respiratory Condition:
   - Breath sounds
   - Sputum characteristics
   - Ventilator setting
   - Oxygen therapy (frequency, reason, rate, effectiveness, method of delivery)
5. Skin Condition:
   - Skin status
6. Bed Mobility:
   - Amount of assist needed
   - Frequency of repositioning (if on bed rest)
7. Transfer:
   - Amount of assist needed
   - Bed rest maintained (if pertinent)
   - Endurance
8. Eating:
   - Amount of assist needed
   - Nutritional status
   - Percent eaten
   - Current diet
9. Toileting:
   - Amount of assist needed
10. Elimination:
    - Continence
11. Rehab/Restorative:
    - Rehabilitation or restorative techniques or practices
    - Days per week received for more than or equal to 15 minutes
12. Mood:
    - Mood pattern
13. Muscular Skeletal Condition:
    - Attendance at therapy and progress
    - ROM given

Wound/Dressing Changes

Daily Nursing Skills

High risk for infection or delayed healing related to impaired skin integrity. High risk for pain related to trauma procedure.

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Daily

1. Vital signs, presence of fever or chills, rigors without elevated temperature.
2. Site, presence of sutures, staples – integrity.
3. Odor present/absent.
4. Drainage (color, amount), warmth, edema.
5. Patient's complaints of pain, action taken, patient's response.
6. Communication with physician and change in treatment plan.
7. Change in status/progress.

Weekly

1. Wound site.
2. Type of wound (e.g., stasis ulcers, incision, pressure ulcer)
3. Size, including length, width, depth.
4. Description of surrounding tissue.
5. Frequency and type of treatment.
6. Progress of wound since previous assessment.
7. Use of special equipment.
8. Other factors:
    a. Nutritional status
    b. Positioning changes (frequency)
    c. Pain management