ARBOR VITAE HOSPICE CARE, INC.

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NURSES NOTES

Problems/Needs

Alteration in Safety:
Weakness: ☐ Y ☐ N
Risk of falls: ☐ Y ☐ N
Sx Managed-Continue POC ☐ Y ☐ N
Describe:_____

Alteration in Neuro Status:
A/O x:_____Anxiety ☐ Y ☐N
Agitated: ☐Y ☐ N Confused: ☐ Y ☐N
Increased sleep: ☐ Y _____hrs ☐ N
Insomnia: ☐ Y ☐ N

Speech:
Clear: ☐ Y ☐N Non verbal: ☐Y ☐N
Less than 6 words: ☐Y ☐N
Describe: _____
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Nutrition:
Diet:_____% intake: ☐P.O. ☐Tube
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Urinary Status:
Incontinent : ☐Y ☐N
Cath (describe): _____
Fr:_____ml:_____Changed:_____
Describe:_____
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Bowel Status:
Incontinent: ☐Y ☐N LBM:_____
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Circulatory Status:
Edema: _____ Ascites _____
Other:_____
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Respiratory Status:
O2 at L/min. via N/C Mask
PRN:_____Continuous:_____
Lung sounds clear ☐Y ☐N
Describe:_____
Sx Managed-Continue POC: ☐Y ☐N
O2 Sat on Room Air_____

Self Care Deficit:
Dependent in:_____/ 6 ADL's
☐Ambulation ☐Transfer ☐Feeding
☐Toileting ☐Dressing ☐Bathing
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Comfort:
Pain (0-10)_____Non-Verbal: ☐Y ☐N
>3/10 Document Intervention
Describe pain / location: _____
N/V:_____Other:_____
Document Intervention:_____
_____
Sx Managed-Continue POC: ☐Y ☐N

Alteration in Skin Integrity:
☐New ☐Existing Wound:
_____
Special Mattress:_____
Color:_____ Turgor:_____
Continue Treatment: ☐Y ☐N
Sx Managed-Continue POC: ☐Y ☐N

Level of Care: ☐Routine ☐GIP ☐Respite ☐Cont. Care ☐***On Call Visit***
Reason: Reason:

V/S Deferred:_____Temp:____ Pulse_____ Resp_____ B/P____ WT: _____ MAC:_____
HA Supv. Visit: ☐ Y ☐ N HA Present : ☐ Y ☐ N
Continued HA POC: ☐ Y ☐ N ☐ N/A
Communication w/: ☐Facility Staff ☐Family/CG ☐HA ☐Volunteer ☐SW ☐SC ☐Hospice Medical Director ☐Attending MD ☐Other
Regarding:_____

New MD Orders: ☐Yes (See POC Addendum) ☐Add to Med Sheet ☐No
Refills: ☐Yes (Specify) _____ ☐No

EDUCATION:
Medications:_____
Safety/Fall Prevention: _____
Infection Control: _____
Personal Care:_____
Nutrition:_____
Other:_____

Narrative

Patient Name: _____

SN Name / Signature:_____***Units***:_____

Date:_____ ***Time In:***_____***Time Out:***_____ ***MR#***_____

Time Reporting Units/Minutes: **1**: <23 mins; **2**: 23-37 mins; **3**: 38-52 mins; **4**: 53-67mins; **5**: 68-82 mins; **6**: 83-97 mins; **7**: 98-112 mins; **8**: 113-127 mins; **9**: 128-142 mins; **10**: 143-157 mins