HOSPICE NURSING VISIT

DATE: ____________ TIME IN: _______ OUT: _______

TYPE OF VISIT: ☐ SN ☐ SN & Supervisory
☐ Supervisory only ☐ Other _______

PAIN (Cont’d.)

What makes pain worse? ☐ Movement ☐ Ambulation
☐ Other: ___________________________________________________________________

What makes pain better? ☐ Heat/Ice ☐ Massage ☐ Repositioning
☐ Rest/Relaxation ☐ Medication ☐ Diversion
☐ Other: ___________________________________________________________________

How often is breakthrough medication needed?
☐ Never ☐ Less than daily ☐ 2-3 times/day
☐ Greater than 3 times/day
☐ Other: ___________________________________________________________________

Current pain control medications adequate
☐ Interventions/Instructions:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

SLEEP/REST

☐ WNL ☐ Changed ☐ Unchanged

Patient usually sleeps:
☐ Less than 4 hours ☐ 4-6 hours ☐ 6-8 hours ☐ 8-12 hours

Quality of Sleep/Rest:
☐ Quiet/Restful ☐ Restless/Noisy
☐ Frequently interrupted ☐ Soundly
☐ Frequent dreams/nightmares

Use of Sleep Aids:
☐ Never ☐ 1-3 times/week ☐ 4-6 times/week
☐ Nightly ☐ Other: ___________________________________________________________________

Caregiver rest adequate:
☐ Yes ☐ No

MEDICATION

(New or changed since last visit) ☐ None ☐ Update Medication Profile

Drug _____________________________________________________
Dosage/frequency _______________________________________
Effective ☐ Yes ☐ No ☐ Other: ________________________________

Drug _____________________________________________________
Dosage/frequency _______________________________________
Effective ☐ Yes ☐ No ☐ Other: ________________________________

Drug _____________________________________________________
Dosage/frequency _______________________________________
Effective ☐ Yes ☐ No ☐ Other: ________________________________

Instructed on:
☐ Safe use and disposal of medications
☐ S/S allergic reaction ☐ S/E contraindications
☐ Drug/food interactions ☐ Ample supply
☐ Drug/drug interactions ☐ Hospice
☐ Expiration dates ☐ Family/caregiver
☐ Prescription refills ___ ☐ Proper disposal of sharps
☐ Missed dose/what to do ☐ Duration of therapy
☐ Pill count (if applicable) ___ ☐ Other: _______________________
☐ Administered by: ☐ Self ☐ RN ☐ Family/Caregiver
☐ Other: ___________________________________________________________________

VITAL SIGNS

Temperature: ________________________
☐ Oral ☐ Axillary ☐ Rectal ☐ Rectal Anus
☐ Rectal Anus Anus

Pulse: ____________________________
☐ Regular ☐ Regulated ☐ Apical ☐ Radial ☐ Brachial

Respirations: ______________________
☐ Regular ☐ Irregular ☐ Cheyne Stokes ☐ Apnea ___ seconds

Blood Pressure: Right ______/_____ Left ______/_____
☐ Lying ☐ Sitting ☐ Standing

Level of Consciousness: ☐ Alert ☐ Lethargic ☐ Unresponsive
☐ Reacts to painful stimuli ☐ Other: _______________________

Weight: Actual weight today: _______ kg/lbs.
Difference from last recorded weight _______ kg/lbs.
(Date _______)

PAIN

Is patient experiencing pain?
☐ Yes ☐ No ☐ Controlled with medication

Intractable Pain: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient’s sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?
☐ No ☐ Yes

Unable to communicate
☐ Non-verbs demonstrated:
☐ Diaphoresis ☐ Grimacing
☐ Moaning/Crying ☐ Guarding ☐ Irritability ☐ Anger ☐ Tense
☐ Restlessness ☐ Change in vital signs ☐ Other:

Pain Location (site(s) specify):
______________________________

Intensity: (using scales below)

Wong-Baker FACES Pain Rating Scale

0 No Pain
1 LITTLE BIT
2 LITTLE MORE
3 EVEN MORE
4 WHOLE LOT
5 EVEN MORE
6 WHOLE LOT
7 EVEN MORE
8 WHOLE LOT
9 EVEN MORE
10 WHOLE LOT


Collected using: ☐ FACES Scale ☐ 0-10 Scale (subjective reporting)

Present level of pain_____ Worst pain gets_____ Best pain gets_____

Acceptable level of pain_____

Type: ☐ Aching ☐ Nagging ☐ Dull ☐ Heavy ☐ Crushing
☐ Sharp ☐ Stabbing ☐ Throbbing ☐ Radiating ☐ Burning
☐ Tingling ☐ Cramping ☐ Other:

Frequency of Pain interfering with patient’s activity or movement:
☐ Patient has no pain or pain does not interfere with activity or movement
☐ Less often than daily
☐ Daily, but not constantly
☐ All of the time

Pill count (if applicable) _______

ID# ____________

HOSPICE NURSING VISIT

Page 1 of 6
PATIENT NAME – Last, First, Middle Initial

HOSPICE NURSING VISIT
BRiGGS.

Page 2 of 6

CARDOIPULMONARY (Cont’d.)

- When is the patient dyspneic or noticeably Short of Breath?
  - Never, patient is not short of breath
  - When walking more than 20 feet, climbing stairs
  - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
  - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
  - At rest (during day or night)

  - Assessed  □ Reported

  Additional comments:

  Respiratory Status: □ Accessory muscles used □ Death rattle
  □ Cheyne Stokes □ Orthopnea □ Stridor/retractions
  □ Dyspnea at rest □ With exertion/activity
  □ Periods of apnea ___ seconds □ O₂ saturation _____%
  □ Pitting +1/+2/+3/+4 □ PRN □ Continuous

  Cardiac Status:
  □ Normal □ Regular □ Irregular □ Murmur
  □ Fatigued □ Edema □ Distended □ Dependent □ Sacral
  □ Pitting +1/+2/+3/+4 □ Non-pitting site
  □ Cramps/claudication
  □ Capillary refill greater than 3 seconds / less than 3 seconds

  Intervention/Instructions:

  Intermittent treatments (C&DB, medicated inhalation treatments, etc.)
  □ No
  □ Yes, explain:

  Cough: □ No
  □ Yes: □ Productive □ Non-productive

  Able/Unable to cough up secretions

  Suction: □ Yes □ No

  Dyspnea:
  □ No
  □ Yes, describe:

  Positioning necessary for improved breathing:
  □ No
  □ Yes, describe:

MENTAL/NEUROLOGICAL

- Mental Status: □ WNL

  Alert/Oriented to:
  □ Person □ Place □ Time

  Not Tired 0 1 2 3 4 5 6 7 8 9 10

  Worst Possible Tiredness

  □ Comatose □ Forgetful □ Depressed □ Disoriented

  □ Lethargic □ Agitated □ Other

  Comments:

  Neuro Status: □ WNL

  □ Sedated □ Non-verbal

  □ Speech: clear/garbled □ Aphasia: receptive/expressive

  □ Nuchal rigidity

  □ Grips: □ Equal □ Strong □ Unequal □ Weak

  Pupils: □ PERRLA □ Sluggish □ Dilated

  □ Constricted/nonreactive

  Other neurological problems such as tremors, seizures, paralysis (explain):

  Comments:
**NUTRITION**

- Diet: ____________________________  
- Appetite:  
  - Good  
  - Fair  
  - Poor  
  - NPO

**Worst Possible Appetite**
0 1 2 3 4 5 6 7 8 9 10  

- Anorexia  
- Nausea/vomiting  
- Hematemesis  
- Dysphagia  
- Heartburn/Reflux

- Not Nauseated:  
  0 1 2 3 4 5 6 7 8 9 10  

- Patient/family/caregiver concerns about nutrition (explain):

**Fluid Restriction:**  
- Yes  
- No

**Amount in 24 hours:** ____________________________  

- Pureed foods  
- Enteral support/supplements  
- Intervention/Instructions:

**ENDOCRINE**

- WNL  
- Changed  
- Unchanged

- Diabetes Mellitus: Type I  
- Type II

- Blood sugar range:

- Hyperglycemia: Glicousuria/polyuria/polydipsia

- Hypoglycemia: Sweats/polyphagia/weak/faint/stupor

- Drug/Insulin changes (specify):______________________________

**Intervention/Instructions:**

**ELIMINATION**

**Urinary**

- WNL  
- Changed  
- Unchanged

- Urgency/frequency  
- Burning/pain  
- Hesitancy  
- Nocturia

- Oliguria/anuria  
- Retention

- Incontinence occurs ____________________  
- Diapers/Chux

- Color:  
  - Yellow/straw  
  - Amber  
  - Brown/gray  
  - Blood-tinged

- Other:

- Clarity:  
  - Clear  
  - Cloudy  
  - Sediment/mucus

- Odor:  
  - Yes  
  - No

- **Urinary Catheter:**  
  - Type (specify): ____________________  
  - French_________

- Balloon inflated _______mL sterile water  
- Date inserted ________________

- Date changed:  
  - No problem  
  - Other:

- Foley/Irrigation type (specify):  
- Frequency of stools

- Amt _______mL Frequency __________________

- Returns______________________  
- Patient tolerated procedure well

- Intervention/Instructions:

**Bowel**

- WNL  
- Changed  
- Unchanged

- Flatulence  
- Constipation/Impaction  
- Diarrhea

- Hemorrhoids

- Frequency of stools ____________________  
- Last B.M._________

- Bowel regimen/program:

- Laxative/Enema use:  
  - Daily  
  - Weekly  
  - Monthly

- Other:

- Incontinence occurs ____________________  
- Diapers/Chux

- Ileostomy/Colostomy site (describe skin around stoma):

- Other______________________  
- site (describe skin around stoma):

**Abdomen:**

- WNL  
- Changed  
- Unchanged

- Check for impaction  
- Administer enema results  
- Patient tolerated procedure well

- Tenderness  
- Pain  
- Distention  
- Hard/soft  
- Ascites

- Other:

- NG/Enteral tube (type/size):

- Bowel Sounds:  
  - Active/absent/hypoactive/hyperactive

  - x____ quadrants

- Intervention/Instructions:

**HOSPICE NURSING VISIT**

**PATIENT NAME – Last, First, Middle Initial**

**ID#**
### SELF CARE DEFICIT/MOBILITY

- WNL  [  ] Changed  [  ] Unchanged
- Gait:  [  ] Steady  [  ] Unsteady  [  ] Weakness  [  ] Limited mobility/ROM
  - Contractures/paralysis  [  ] Assistive devices needed:
    - Walker/cane/crutches/wheelchair  [  ] Other:
- ADL's:  [  ] Independent  [  ] Needs minimal assistance
  - Needs maximum assistance  [  ] Dependent
- Comments:

### Activity Level:
- [  ] Up as tolerated  [  ] Transfer bed/chair  [  ] Bedbound
- Comments:

### Recent Fall:
- [  ] Yes  [  ] No  # ______
- Describe:

### COPING/COMMUNICATION

- Coping  [  ] Effective  [  ] Ineffective
- Anxiety  Least 0 1 2 3 4 5 6 7 8 9 10  Most
- Agitated  Least 0 1 2 3 4 5 6 7 8 9 10 Most
- Depressed  Least 0 1 2 3 4 5 6 7 8 9 10 Most
- Forgetful/Confused  Least 0 1 2 3 4 5 6 7 8 9 10 Most
- Affect  [  ] Appropriate  [  ] Flat  [  ] Distressed  [  ] Other:
  - Abnormal behavior (explain):

### Communication:
- [  ] Effective  [  ] Non-effective  [  ] Same
- Changed (explain):

### Patient/family/caregiver adjusting:
- [  ] Yes  [  ] No
- Explain:

### Hospice/Community Resources utilizes or knowledgeable about the following resources:

### Patient/family/caregiver stressed/overloaded:
- [  ] Yes  [  ] No
- Explain:

### Intervention/Instructions:

### INTEGUMENTARY STATUS

Denote location of specific skin conditions/wounds by numbering appropriately on illustrations below. Proceed by completing applicable information for each numbered site on chart.

### WOUND CARE PROVIDED:
- Soiled dressing removed/disposed of properly
- Wound cleansed (specify)
- Wound irrigated (specify)
- Wound debridement (specify)
- Drainage collection container emptied: Volume

### CONDITION

<table>
<thead>
<tr>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
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<tbody>
<tr>
<td>Type of Wound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Size (cm) (LxWxD)</td>
<td></td>
<td></td>
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<tr>
<td>Stage</td>
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<tr>
<td>Tunneling/Undermining</td>
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<td>Odor</td>
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<td>Surrounding Skin</td>
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<td>Edema</td>
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<tr>
<td>Stoma</td>
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<tr>
<td>Appearance of the Wound Bed</td>
<td></td>
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<tr>
<td>Drainage/Amount</td>
<td>None</td>
<td>Small</td>
<td>Moderate</td>
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<tr>
<td>Color</td>
<td>Clear</td>
<td>Tan</td>
<td>Serosanginous</td>
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<tr>
<td>Consistency</td>
<td>Thin</td>
<td>Thick</td>
<td>Thin</td>
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</tbody>
</table>

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**PATIENT NAME** – Last, First, Middle Initial  
**ID#**
### Integumentary Status (Cont'd.)

- Patient tolerated procedure well: **Yes** **No**
- Medication prior to wound care: **Yes** **No**
- Wound care/dressing change performed by:
  - Self
  - RN
  - Family/caregiver
  - Other: ______________________________________
- Patient/family/caregiver instructed on wound care/disposal of soiled dressing: **Yes** **No**
- Patient/family/caregiver to perform wound care/dressing change: **Yes** **No**
- Other: ______________________________________

### Infusion

- N/A
- Type of line: **Peripheral** **PICC** **Central (type)***
  - Implanted port
  - Subcutaneous
  - Location (specify)_____________________________________
  - Size (if appropriate) cm
  - Site (describe)_____________________________________
  - Catheter length cm
  - Arm circumference cm
  - No evidence of infection
  - Dressing changed performed by:
    - Self
    - RN
    - Family/caregiver
    - Other: ______________________________________
  - Cap change performed by:
    - Self
    - RN
    - Family/caregiver
    - Other: ______________________________________
  - Extension/Tubing changed by:
    - Self
    - RN
    - Family/caregiver
    - Other: ______________________________________
  - Line flushed ______mL saline/sterile water
  - Heparin _____unit/mL _____mL
  - Instructed patient/family/caregiver on infusion therapy
  - Patient/family/caregiver demonstrates/verbalizes proper management of infusion(s)

### Comments: ______________________________________

### Lab

- None
- Blood drawn from ________ for ________
- Other: ______________________________________
  - Delivered to ______________________________________

### Aide Supervisory Visit (Complete if applicable)

- AIDE: **Present** **Not present**
- SUPERVISORY VISIT: **Scheduled** **Unscheduled**
- AIDE CARE PLAN UPDATED? **Yes** **No**
- CARE PROVIDED APPROPRIATE? **Yes** **No**

### Observation of:

- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________

### Teaching/Training of:

- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________
- ________________

### Need for Additional Equipment/Supplies

- Yes **No**
  - Walker
  - Wheelchair
  - Cane/crutches
  - Hospital bed
  - Overbed table
  - Bedside commode
  - Lift chair
  - Bath/shower bench
  - Suction machine
  - Nebulizer
  - Oxygen
  - Other supplies needed: ______________________________________

### Education provided: ______________________________________

### Spiritual/Cultural

- Using resources appropriately
- Declines hospice assistance at this time
- Chaplain/Clergy contacted: **Yes** **No**
- Intervention/Instructions: ______________________________________

### Summary Checklist

- CARE PLAN: **Reviewed/Revised with patient/family/caregiver**
- **Reviewed with facility staff**
- **Outcome achieved**
- **PRN order obtained**

### Plan for Next Visit

- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________
- ______________________________________

### Approximate Next Visit Date ______/_____/_____

### Care Coordination

- Attending physician
- Medical Director
- RN
- MSW
- Chaplain/Clergy
- Aide
- Dietitian
- Therapy services
- Volunteer
- Other: ______________________________________

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## INSTRUCTION

**INSTRUCTION PROVIDED ON:**  
- Symptom management  
- Disease progression  
- Dying process  
- Other: _____________________________________________________
  
**Comments:**

________________________________________________________________________________
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## PATIENT/FAMILY/CAREGIVER RESPONSE:

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## SUMMARY

**CONCLUSION/SUMMARY OF VISIT (Include caregiver/facility participation in Plan of Care):**

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Clinician: ____________________________________________  Date: __________

Signature/Title

**PATIENT NAME – Last, First, Middle Initial**  

**ID#**