VITAS **CONTINUOUS CARE SHIFT CARE NOTE-Nurse**

Plan of Care File

Patient Name:______________________________ **VITAS MR #**________________ **Date of Shift:** ___________

Start of shift: Present at bedside with patient at _____________ **(time)** ☐ **Reviewed POC and received report**

Reason(s) for Continuous Care:

VITAL SIGNS:

Time												
Temperature												
Blood Pressure												
Pulse												
Respiration												
Intake												
Output / Diaper Change												
Bowel Movement												

INITIAL EVALUATION at start of each shift:

PAIN: Pain Info obtained from: ☐ **Patient** ☐ **Caregiver/Family** ☐ **Nurse** ☐ **Non verbal cues** ☐ **Assessed, no problems identified**

Location:__________________	**Location:**__________________	**Location:**__________________
Palliation/Provocation__________	Palliation/Provocation__________	Palliation/Provocation__________
Quality ___________________	Quality ___________________	Quality ___________________
Radiation__________________	Radiation__________________	Radiation__________________
Scale (0-10) or statement _______	Scale (0-10) or statement _______	Scale (0-10) or statement _______
Temporal__________________	Temporal__________________	Temporal__________________

Comments:

NEUROSENSORY: Patient level of concern with neurosensory symptom(s) 0-10 ___ ☐ **Assessed, no problems identified**

☐ Headache ☐ Vision Changes ☐ Disoriented/Confused ☐ Non-responsive ☐ Sensory Changes ☐ Seizure ☐ Lethargic
☐ Tremors/Shakes ☐ Motor Changes ☐ Agitation/Restlessness ☐ Paresis/Paralysis ☐ Aphasia ☐ Vertigo/dizziness

Comments:

CARDIOVASCULAR: Patient level of concern with cardiovascular symptom(s) 0-10 ___ ☐ **Assessed, no problems identified**

☐ **SOB:** ☐ At rest ☐ With exertion ☐ **Chest Pain:** Describe:_________________ Relieved by:______________
Peripheral pulses: ☐ Irregular ☐ Absent **Edema:** ☐ Peripheral ☐ Abdominal Severity_______

Comments:

RESPIRATORY: Patient level of concern with respiratory symptom(s) 0-10 ___ ☐ **Assessed, no problems identified**

☐ SOB ☐ Congestion ☐ Oxygen ☐ Trach present ☐ Noisy respirations ☐ Cough: ☐ Dry ☐ Productive:
O2 @ ______ via ________ Describe:

Comments:

MUSCULOSKELETAL: Patient level of concern with musculoskeletal symptom(s) 0-10 ___ ☐ **Assessed, no problems identified**

☐ Poor balance ☐ Stiffness ☐ Muscle spasm ☐ Fracture ☐ Poor coordination ☐ Contractures ☐ Tremors/Shakes ☐ Amputations

Comments:

GASTROINTESTINAL: Patient level of concern with gastrointestinal symptom(s) 0-10 __ ☐ **Assessed, no problems identified**

☐ Constipation: ☐ Diarrhea ☐ Rectal bleeding ☐ Abdominal distention ☐ Incontinence Last BM____________
☐ Nause ☐ Vomiting ☐ Mouth sores ☐ Feeding tube present ☐ Lack of appetite ☐ Diff. Swallowing

Comments:

GENITOURINARY: Patient level of concern with genitourinary symptom(s) 0-10 ___ ☐ **Assessed, no problems identified**

☐ Painful urination ☐ Retention ☐ Urinary/vaginal bleeding ☐ Urine Output________ ☐ Incontinence ☐ Vaginal discharge
☐ Catheter Present ☐ Urine Appearance:

Comments:

SKIN: Patient level of concern with integumentary symptom(s) 0-10 ___ ☐ **Assessed, no problems identified**

☐ Jaundiced/yellowing ☐ Pruritis/itch ☐ Cyanosis/bluish ☐ Inflammation/swelling ☐ Erythema/Redness ☐ Diaphoresis/sweating
☐ Bruising ☐ Rash/lesions ☐ Skin tears ☐ Pressure sores:
Location: Stage: drainage: Color:

Comments:

Initials_____________

VITAS **CONTINUOUS CARE SHIFT CARE NOTE-Nurse**

Plan of Care File

Patient Name:_______________________________ **VITAS MR #**________________ **Date of Shift:** ___________

HYGIENE/SAFETY: ☐ **Assessed, no problems identified**

☐ Unstable mobility ☐ Vision Changes ☐ Weakness/fatigue ☐ Motor Changes ☐ Vertigo/dizziness ☐ Sensory Changes

Limitations: ☐ Dressing ☐ Bathing ☐ Positioning ☐ Grooming ☐ Toileting ☐ Transferring ☐ Eating ☐ Ambulation

Comments:

PERSONAL CARE provided during this shift:

☐ Bath Bed Shower Tub ☐ Peri Care ☐ Shampoo ☐ Skin Care ☐ Oral Hygiene ☐ Foley Care ☐ Foot Care ☐ Nail Care ☐ PPE Used ☐ Other:

NUTRITION / HYDRATION: ☐ **Assessed, no problems identified**

Route: ☐ Tube fed ☐ Tube fed Type:____________________ Amount____________ Site Appearance_____________

☐ PO Type: ☐ Liquid ☐ Puree ☐ Chopped ☐ Solid ☐ Soft Amount: Breakfast ___% Lunch ___% Dinner ___%

☐ Feed Patient ☐ Encourage Fluids ☐ IV ☐ SQ Site Appearance:

Comments:

PSYCHOSOCIAL/SPIRITUAL: Patient level of concern with psychosocial symptom(s) 0-10___ ☐ **Assessed, no problems identified**

Family: ☐ Present ☐ Not Present ☐ Phone contact made Visitors present during shift:

☐ Anxiety ☐ Family Conflict ☐ Mood:

Comments:

Controlled Substance Count ☐ **Not Applicable Facility Patient**

Drug	Count at Shift Start	Count at Shift End	Drug	Count at Shift Start	Count at Shift End

ONGOING DOCUMENTATION:

Describe Problem(s) / Symptom(s)	Time(s)	Medication Intervention(s)	Intervention(s)	Time(s)	Evaluation(s)

Shift End Time: Started new note or Left patient's residence at ____________ **(time)** ☐ **Report given** ☐ **See attached Addendum**

______________________ Print Name ______________________ Signature __________ Title __________ Date