

HOME HEALTH SN VISIT DOCUMENTATION

MINI CHECKLIST

A quick review before completing your skilled nursing visit note

Use this checklist to help confirm that your documentation reflects the patient's condition, the skilled nursing services provided, the patient/PCG response, and any follow-up needed.

1. Reason for Skilled Visit

- ☐ Does the note make clear **why skilled nursing services were needed today?**
- ☐ Is the visit connected to the patient's current condition, ordered services, plan of care, recent changes, or identified nursing needs?

2. Relevant Skilled Assessment

- ☐ Did I document the **assessment findings that were relevant to today's skilled need?**
- ☐ Are important changes, symptoms, risks, or abnormal findings clearly documented when present?
- ☐ Did I avoid relying only on general statements such as "stable" or "no complaints" when more specific findings were assessed?

3. Skilled Nursing Intervention

- ☐ Does the note show **what skilled nursing care or intervention was actually provided?**
- ☐ Is the intervention connected to the patient's assessment findings, current needs, or plan of care?
- ☐ If monitoring, treatment, medication-related care, wound care, or another skilled service was performed, is the relevant care documented?

4. Patient/PCG Teaching

- ☐ Does the note identify the **specific topic or issue taught or reinforced?**
- ☐ Was the teaching relevant to the patient's condition, medications, safety risks, treatment, symptom monitoring, or care plan?
- ☐ If teaching was continued from a prior visit, does the note show what was reviewed or reinforced today?

5. Patient/PCG Response

- ☐ Did I document **how the patient or PCG responded** to the teaching, intervention, or instructions?
- ☐ When relevant, does the note show understanding, questions, difficulty, need for reinforcement, participation, or another observable response?

6. Abnormal Findings and Provider Communication

- ☐ Are abnormal or concerning findings clearly documented?
- ☐ If PCP/provider or another appropriate care team member was notified, does the note show what was reported and the resulting instructions or follow-up, when applicable? the nurse's clinical judgment
- ☐ If no provider notification was needed, does the documentation support the nursing assessment and follow-up plan when relevant?

7. Progress and Continued Skilled Need

- ☐ When applicable, does the note show the patient's **progress, lack of progress, change in condition, or continuing need for skilled nursing**?
- ☐ Does the documentation support why continued assessment, teaching, monitoring, treatment, or follow-up remains necessary?

8. Follow-Up and Next-Visit Plan

- ☐ Does the note identify important follow-up needs?
- ☐ Are unresolved concerns, continued teaching needs, monitoring needs, provider instructions, or planned skilled care reflected when applicable?
- ☐ Is it clear what should be reassessed, reinforced, or followed up on at the next visit?

9. Final Note Check

Before signing the note, ask:

- ☐ Is the documentation specific to **this patient and this visit**?
- ☐ Does it accurately reflect the services actually provided?
- ☐ Are the findings, interventions, teaching, patient/PCG response, and follow-up consistent with one another?
- ☐ Are required fields completed and obvious errors, conflicting information, or incomplete sections corrected?

Quick Final Review

Could another qualified clinician reviewing this note understand:

Why skilled nursing was needed → What was assessed → What the nurse did → How the patient/PCG responded → What needs follow-up?

If not, review the note before completing it.

Important Use Note

This checklist is provided for general educational and documentation-review purposes. Skilled nursing documentation must be individualized to the patient's condition, assessment findings, services actually provided, provider orders, plan of care, patient/PCG response, agency policies and procedures, payer requirements, applicable laws and regulations, and skilled nursing judgment.

This resource does not replace agency-specific documentation requirements, professional nursing judgment, provider instructions, or applicable regulatory and payer guidance.