

Nursing notes

Date / time	Notes
4/4 20 30	Admitted to ward via A and E at 1800 hours. Admission for investigation into confusion with a history of confusion 1-2 years. Usually mobile with a stick. Patient not for resuscitation – discussed with family and documented in notes. Lives in hostel normally independent but recently more confused and aggressive. Full assistance required with ADL's on admission. Requires incontinence aids. Catheter inserted in A and E – patient removed balloon intact. Some bleeding as a result. Patient given Haloperidol and Diazepam on admission to ward – reasonably settled at time of report. Charted for PRN meds for agitation overnight. For psych review in a.m. Encourage diet and fluid. Attended Head CT – NAD. Temp 37.2.
5/4/ 0510	Patient settled overnight. Incontinent. Special in place no episodes of aggression so far this shift. Small amount of bleeding from penis following self removal of catheter in A and E. Obs satisfactory continue special.
5/4 1255	Patient found of floor at commencement of shift. Had climbed out of bed and hit head. Assisted back to bed. Obs stable. Cut above right eye – steri strips in place. Dr attended and sutured x3 to laceration on scalp. Very drowsy, unable to take meds due to drowsiness. Very poor fluid intake. ?may require IV therapy? However, may not tolerate same.
6/4 1455	Requiring full assistance with ADL's. Incontinent of urine. Sat out of bed but complaining of being tired – returned to bed at 11a.m. Complaining of pain (? Lower leg?) Dr informed. Paracetamol given with good effect. Temp 38.
7/4 2130	Patient restless this shift obs stable, full assist with ADL's. Haloperidol given as charted.
8/4 0230	Woke up panicking temp 37. Unable to measure BP Patient looked confused. Paracetamol and Haloperidol given as charted.
8/4 0700	Patient very erratic. Trying to get out of bed. Medication given as per chart no effect. Dr informed and larger dose of haloperidol given. Settled for a while now getting agitated again. Temp 38 managed to take Paracetamol but refused antibiotic.
8/4 1900	Refusing most diet and fluid. Small sips of water only. Urine remains blood stained. Only passing small amounts. Refusing medication. Discussed antibiotics with team will require does this a.m. Very drowsy. Contact daughter if condition changes.
9/4 1450	Much improved this am. Alert and orientated at times. Taking good diet and fluid. Incontinent still. Small bowel action will require laxative tonight. Still sleepy. Daughter visited.

Examples Of Nursing Documentation Charting

Sue Meiner



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Unveiling the Magic of Words: A Review of "**Examples Of Nursing Documentation Charting**"

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Table of Contents Examples Of Nursing Documentation Charting

1. Understanding the eBook Examples Of Nursing Documentation Charting
 - The Rise of Digital Reading Examples Of Nursing Documentation Charting
 - Advantages of eBooks Over Traditional Books
2. Identifying Examples Of Nursing Documentation Charting
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Examples Of Nursing Documentation Charting
 - User-Friendly Interface
4. Exploring eBook Recommendations from Examples Of Nursing Documentation Charting
 - Personalized Recommendations
 - Examples Of Nursing Documentation Charting User Reviews and Ratings
 - Examples Of Nursing Documentation Charting and Bestseller Lists

5. Accessing Examples Of Nursing Documentation Charting Free and Paid eBooks
 - Examples Of Nursing Documentation Charting Public Domain eBooks
 - Examples Of Nursing Documentation Charting eBook Subscription Services
 - Examples Of Nursing Documentation Charting Budget-Friendly Options
6. Navigating Examples Of Nursing Documentation Charting eBook Formats
 - ePub, PDF, MOBI, and More
 - Examples Of Nursing Documentation Charting Compatibility with Devices
 - Examples Of Nursing Documentation Charting Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Examples Of Nursing Documentation Charting
 - Highlighting and Note-Taking Examples Of Nursing Documentation Charting
 - Interactive Elements Examples Of Nursing Documentation Charting
8. Staying Engaged with Examples Of Nursing Documentation Charting
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Examples Of Nursing Documentation Charting
9. Balancing eBooks and Physical Books Examples Of Nursing Documentation Charting
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Examples Of Nursing Documentation Charting
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Examples Of Nursing Documentation Charting
 - Setting Reading Goals Examples Of Nursing Documentation Charting
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Examples Of Nursing Documentation Charting
 - Fact-Checking eBook Content of Examples Of Nursing Documentation Charting
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning

- Utilizing eBooks for Skill Development
- Exploring Educational eBooks

14. Embracing eBook Trends

- Integration of Multimedia Elements
- Interactive and Gamified eBooks

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