

TIPS FOR WRITING A GREAT NURSING NOTE



Great nursing notes provide a detailed legal record of a patient's status, treatment, responses, and outcomes.

Characteristic	Incorrect	Correct
Factual	 Patient seems like they are in pain.	 Patient grimaced and moaned when their leg was touched.
Accurate	 There was a large amount of drainage.	 There was 150 mL of serosanguineous drainage.
Complete	 Patient was taught how to check their blood sugar.	 Patient was able to return-demonstrate how to check their blood sugar.
Current	 Patient had a temperature after breakfast.	 Patient had a temperature of 39.1°C (102.4°F) at 0900.
Organized	 Patient had altered mental status, stomach pain, and could not recall their name.	 Patient had altered mental status with inability to recall their name and complained of dull stomach pain.

Good Nursing Documentation Hints

SJ Ball



Good Nursing Documentation Hints:

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 Thoroughly updated for its Second Edition this comprehensive reference provides clear practical guidelines on documenting patient care in all nursing practice settings the leading clinical specialties and current documentation systems This edition features greatly expanded coverage of computerized charting and electronic medical records EMRs complete guidelines for documenting JCAHO safety goals and new information on charting pain management Hundreds of filled in sample forms show specific content and wording Icons highlight tips and timesavers critical case law and legal safeguards and advice for special situations Appendices include NANDA taxonomy JCAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

Managing Documentation Risk Patricia A. Duclos-Miller, 2004 Nurses are now commonly cited or implicated in medical malpractice cases

Nursing Documentation Made Incredibly Easy Kate Stout, 2018-06-05 Publisher's Note Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality authenticity or access to any online entitlements included with the product Feeling unsure about the ins and outs of charting Grasp the essential basics with the irreplaceable *Nursing Documentation Made Incredibly Easy* 5th Edition Packed with colorful images and clear as day guidance this friendly reference guides you through meeting documentation requirements working with electronic medical records systems complying with legal requirements following care planning guidelines and more Whether you are a nursing student or a new or experienced nurse this on the spot study and clinical guide is your ticket to ensuring your charting is timely accurate and watertight Let the experts walk you through up to date best practices for nursing documentation with NEW and updated fully illustrated content in quick read bulleted format NEW discussion of the necessary documentation process outside of charting informed consent advanced directives medication reconciliation Easy to retain guidance on using the electronic medical records electronic health records EMR EHR documentation systems and required charting and documentation practices Easy to read easy to remember content that provides helpful charting examples demonstrating what to document in different patient situations while addressing the different styles of charting Outlines the Do's and Don'ts of charting a common sense approach that addresses a wide range of topics including Documentation and the nursing process assessment nursing diagnosis planning care outcomes implementation evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings acute care home healthcare and long term care Documenting special situations release of patient information after death nonreleasable information searching for contraband documenting inappropriate behavior Special features include Just the facts a quick summary of each chapter's content Advice from the experts seasoned input on vital charting skills such as interviewing the patient writing outcome standards creating top notch care plans Nurse Joy and Jake

expert insights on the nursing process and problem solving That s a wrap a review of the topics covered in that chapter About the Clinical Editor Kate Stout RN MSN is a Post Anesthesia Care Staff Nurse at Doshier Memorial Hospital in Southport North Carolina *Tabbner's Nursing Care* Gabby Koutoukidis,Rita Funnell,Karen Lawrence,Jodie Hughson,Kate Stainton,2009 Tabbner s Nursing Care Theory and Practice is the only Australian and New Zealand textbook written specifically for the enrolled nurse student The new 5th edition of this best selling text has been fully revised and updated throughout to reflect the content of the new National Curriculum Unit 1 The evolution of nursing Unit 2 The health care environment Unit 3 Cultural diversity and nursing practice Unit 4 Promoting psychosocial health in nursing practice Unit 5 Nursing individuals throughout the lifespan Unit 6 The nursing process Unit 7 Assessing health Unit 8 Important component of nursing care Unit 9 Health promotion and nursing care of the individual Appendices Provided by publisher **Chart Smart** Lippincott Williams & Wilkins,2011 Chart Smart the A to Z Guide to Better Nursing Documentation tells nurses exactly what to document in virtually every type of situation they may encounter on the job no matter where they practice hospital medical office outpatient rehabilitation facility long term care facility or home This portable handbook has nearly 300 entries that cover documentation required for common diseases major emergencies complex procedures and difficult situations involving patients families other health care team members and supervisors In addition to patient care this book also covers documenta [Nursing Interventions & Clinical Skills - E-Book](#) Anne G. Perry,Patricia A. Potter,Wendy R. Ostendorf,2015-01-08 Master nursing skills with this guide from the respected Perry Potter Ostendorf author team The concise coverage in Nursing Interventions Clinical Skills 6th Edition makes it easy to master the clinical skills required in everyday nursing practice Clear guidelines address 159 basic intermediate and advanced skills from measuring body temperature to insertion of a peripheral intravenous device and step by step instructions emphasize the use of evidence based concepts to improve patient safety and outcomes Its friendly easy to read writing style includes a streamlined format and an Evolve companion website with review questions and handy checklists for each skill Coverage of 159 skills and interventions addresses basic intermediate and advanced skills you ll use every day in practice UNIQUE Using Evidence in Nursing Practice chapter provides the information needed to use evidence based practice to solve clinical problems Safe Patient Care Alerts highlight unusual risks in performing skills so you can plan ahead at each step of nursing care Delegation Collaboration guidelines help you make decisions in whether to delegate a skill to unlicensed assistive personnel and indicates what key information must be shared Special Considerations indicate additional risks or accommodations you may face when caring for pediatric or geriatric patients and patients in home care settings Documentation guidelines include samples of nurses notes showing what should be reported and recorded after performing skills A consistent format for nursing skills makes it easier to perform skills always including Assessment Planning Implementation and Evaluation A Glove icon identifies procedures in which clean gloves should be worn or gloves should be changed in order to minimize the risk of

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Canadian Clinical Nursing Skills and Techniques E-Book Shelley Cobbett, Anne G. Perry, Patricia A. Potter, Wendy R. Ostendorf, 2019-05-21 NEW Fully revised for a Canadian classroom includes Canadian statistics references and resources protocols documentation standards delegation rules Canadian nursing best practice guidelines metric measurements and more NEW All topics skills and sample documentation conform to Canadian provincial and territorial scopes of practice and Canadian standards in nursing practice NEW Inclusion of Canadian concepts Person Centred Care Evidence Informed Practice Interprofessional Collaboration and Delegation and Care in the Community NEW Greater emphasis on cultural assessment considerations and caring for Indigenous and vulnerable populations NEW Thoroughly revised chapters reflect Canadian practice and guidelines including Emergency Preparedness and Disaster Management Palliative Care Cardiac Care Vascular Access and Infusion Therapy Oral Nutrition and Prevention of Skin Breakdown and Wound Care NEW Enhanced and updated art program includes 70 new figures

Documentation in Action Lippincott Williams & Wilkins, 2006 Designed for rapid on the job reference Documentation in Action offers comprehensive authoritative practice oriented up to the minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties Need to know information is presented in bulleted lists charts flow sheets sidebars and boxes with icons and illustrative filled in samples Coverage includes documentation for care of patients with various diseases complications emergencies complex procedures and difficulties involving patients families and other health care professionals Suggestions are given for avoiding legal pitfalls involving telephone orders medication reactions patients who refuse care and much more A section addresses computerized documentation HIPAA confidentiality rules use of PDAs nursing informatics and electronic innovations that will soon be universal

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