

Nursing notes (NARRATIVE NOTE SAMPLE ENTRIES)

General concepts

Besides the initial entry and assessment, narrative notes include all patient care activities such as diet, hygiene, ambulation, elimination, visits from health care professionals (Dr, PT, etc) or family, tests, specific problems, how addressed and how resolved. *All entry are signed and dated. Every timed entry must have a legal signature: 1st initial, last name and legal status. "M. Nurse, RN"*

The last entry on a page **must have a legal signature**. Plan the last entry on a page so it has a logical statement and signature. You may have to have a partial blank line to do so and may have to continue the same timed entry on the next page. All blank lines have lines drawn to end of line or to signature

Each page of narrative notes is a legal document must be **dated-and signed**.

Safety checks: Most hospital protocols require you to document that your patient has been checked for safety at the initial entry, q 2 hours and the last entry. This must also be included in your narrative notes.

When referring to another nurse in your documentation, include her 1st initial, last name and legal title. "Pt c/o shortness of breath, P. Smith, RN notified".

Initial entry:

When you perform your initial assessment, you will take vital signs, briefly assess the patient's status in all systems, and check that all ordered modalities, equipment, and treatments are in place and properly functioning. Your initial entry will include: level of consciousness; ability to follow directions; general status of the skin, respiratory system, cardiac system, and bowel sounds; the status of systems related to current diagnosis or surgery; any untoward findings; the status IVs, drainage tubes, dressings, and any special equipment; and then end with a safety check.

07:30 Alert, awake, orientated to person place and time (or A & O x3). Follows commands. Skin warm and dry. Respirations unlabored @18. AP = 82, regular. Bowel Sounds absent. Hand grasps equal. O₂@ 4L via N/C. IV D5/1/2NS infusing @100 to R forearm via pump. Site clean and dry with no swelling or redness. Abdominal dressing dry and intact. Foley draining clear amber urine. Compression boots in place. TEDS in place. Bed in low position, call bell in reach, siderails up. M. Nurse, RN

Documenting diet.

The amount of fluid in CCs is recorded in the I&O sheet. In the narrative note document the type of diet, percentage consumed, and any pertinent information :

08:00 Took 100% of low sodium, soft diet. Had difficulty swallowing chopped meat._M. Nurse, RN

Documentation of complete physical assessment.

Example Nursing Documentation

E Durkheim



Example Nursing Documentation:

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

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 Documentation Skills for Quality Patient Care Fay Yocum,1999 **Nursing Documentation** Patricia W. Iyer,Nancy Hand Camp,1995

Clearly and concisely provides guidelines for appropriate and careful documentation of care Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources In addition it plays a large role in how third party payors make payment or denial decisions This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment Special attention focuses on the latest documentation issues specific to specialty settings such as acute care home care and long term care and a variety of clinical specialties such as obstetrics pediatrics and critical care Amazon com

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care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono services Instructors in educational settings can visit www.efacultyounge.com for additional material to be used for teaching in the classroom Documentation Basics A Guide for the Physical Therapist Assistant Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation *Cognitive Systems Engineering in Health Care* Ann M. Bisantz, Catherine M. Burns, Rollin J.

Fairbanks, 2014-12-02 Cognitive systems engineering has been widely and successfully applied in the design of safety critical systems such as nuclear power aviation and military command and control More recently these methods are being applied to the design of health and medical systems in order to improve health care quality reduce errors and adverse events and i

Strategic Information Management in Hospitals Reinhold Haux, Alfred Winter, Elske Ammenwerth, Birgit Brigl, 2013-03-09 Strategic Information Management In Hospitals An Introduction To Hospital Information Systems is a definitive volume written by four authoritative voices in medical informatics Illustrating the importance of hospital information management in delivering high quality health care at the lowest possible cost this book provides the essential resources needed by the medical informatics specialist to understand and successfully manage the complex nature of hospital information systems Author of the book s Foreword Reed M Gardner PhD Professor and Chair Department of Medical Informatics University of Utah and LDS Hospital Salt Lake City Utah applauds the text s focus on the underlying administrative systems that are in place in hospitals throughout the world He writes These administrative systems are fundamental to the development and implementation of the even more challenging systems that acquire process and manage the patient s clinical information Hospital information systems provide a major part of the information needed by those paying for health care Chapter highlights include significance of information processing in hospitals information systems and their components health information systems architectures of hospital information systems and organizational structures for information management Writing in the Workplace Rachel Spilka, 1993 An anthology containing 19 previously unpublished contributions some reporting on workplace writing studies completed since the mid 1980s and others introducing new arguments about research to date and future research directions Annotation copyright by Book News Inc Portland OR *Legal Issues in School Health Services* Nadine Schwab, 2005-07 Legal Issues in School Health Services offers a legal resource never before available for education and health professionals and their legal advisors All professionals involved in the development implementation and evaluation of school health services will find this an exceptional tool This book addresses the spirit and letter of the laws the related standards the conflict between them and how they affect the

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