

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.

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Table of Contents Narrative Nursing Documentation Examples

1. Understanding the eBook Narrative Nursing Documentation Examples
 - The Rise of Digital Reading Narrative Nursing Documentation Examples
 - Advantages of eBooks Over Traditional Books
2. Identifying Narrative Nursing Documentation Examples
 - 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 Narrative Nursing Documentation Examples
 - User-Friendly Interface
4. Exploring eBook Recommendations from Narrative Nursing Documentation Examples

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

- Fact-Checking eBook Content of Narrative Nursing Documentation Examples
- 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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