

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: 1" 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 1" 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.

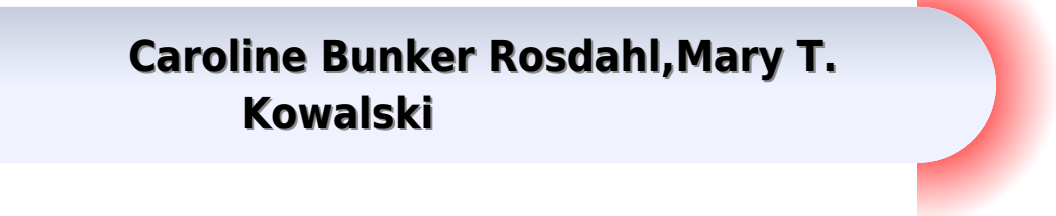
The amount of fluid in CCs is recorded in the I&O sheet. In the narrative note document the type of diet, percentage consumed, and any pertinent information :

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

Documentation of complete physical assessment.

Narrative Nursing Documentation

**Caroline Bunker Rosdahl, Mary T.
Kowalski**



Narrative 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

Illustrated Manual of Nursing Practice, 2002 Completely revised and updated this broad yet comprehensive edition contains twenty nine chapters on nursing issues and clinical practice Topics cover practice and process documentation legal issues health promotion physical assessment I V therapy surgical care and more Disorders are organized by body system and feature an overview of anatomy and physiology assessment diagnostic tests medication treatment and home care with coverage of care for maternal neonatal pediatric geriatric emergency and psychiatric patients Added features include grabbing nursing procedure graphics complementary therapies clinical pathways and cultural information Over 1 000 illustrations charts and graphs enhance the text with a new appendix relating Internet sites for nurses

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 Textbook of Basic Nursing Caroline Bunker Rosdahl, Mary T. Kowalski, 2008 Now in its Ninth Edition this comprehensive all in one textbook covers the basic LPN LVN curriculum and all content areas of the NCLEX PN Coverage includes anatomy and physiology nursing process growth and development nursing skills and pharmacology as well as medical surgical maternal neonatal pediatric and psychiatric mental health nursing The book is written in a student friendly style and has an attractive full color design with numerous illustrations tables and boxes Bound in multimedia CD ROMs include audio pronunciations clinical simulations videos animations and a simulated NCLEX PN exam This edition s comprehensive ancillary package includes curriculum materials PowerPoint slides lesson plans and a test generator of NCLEX PN style questions **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 **Nursing Documentation** Ellen Thomas Eggland, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good documentation **Nursing Narrative Note Examples to Save Your License** Lena Empyema, 2020-01-06 Nursing can be nuts On a twelve hour shift the last thing most nurses want to do is sit down and draft a lengthy note describing the craziness that occurred Written by a nurse for nurses this book is chock full of narrative note examples describing hypothetical situations to help you describe the well the indescribable Some shifts are just like that **Avoiding Common Nursing Errors** Jeannie Scruggs Garber, Monty Gross, Anthony D. Slonim, 2010 This handbook succinctly describes over 500 common errors made by nurses and offers practical easy to remember tips for avoiding these errors Coverage includes the entire scope of nursing practice administration medications process of care behavioral and psychiatric cardiology critical care endocrine gastroenterology

and nutrition hematology oncology infectious diseases nephrology neurology pulmonary preoperative operative and postoperative care emergency nursing obstetrics and gynecology and pediatric nursing The book can easily be read immediately before the start of a rotation or used for quick reference Each error is described in a quick reading one page entry that includes a brief clinical scenario and tips on how to avoid or resolve the problem Illustrations are included where appropriate Fundamentals of Nursing - E-Book Patricia A. Potter, Anne G. Perry, Patricia A. Stockert, Amy Hall, Wendy R. Ostendorf, 2025-01-15 Selected for 2025 Doody's Core Titles with Essential Purchase designation in Fundamentals Learn the concepts and skills and develop the clinical judgment you need to provide excellent nursing care Fundamentals of Nursing 12th Edition prepares you to succeed as a nurse by providing a solid foundation in critical thinking clinical judgment nursing theory evidence based practice and person centered care in all settings With illustrated step by step guidelines this book makes it easy to learn important skills and procedures Care plans are presented within a nursing process framework that is coordinated with clinical judgement and case studies show how to apply concepts to nursing practice From an expert author team led by Patricia Potter and Anne Perry this bestselling nursing textbook helps you develop the understanding and clinical judgment you need to succeed in the classroom and in your career *Nursing Documentation* Sue Meiner, 1999-05-06 Focusing on the legal implications in the US this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice

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