

NR304 Head-to-Toe Final Documentation

Your Name: Samantha Maxey Gender: F

Client Initials: T.B. Date of Birth: 02/20/95 Allergies: None

Review of Systems	Assessment Findings
General Survey:	Alert & oriented x4. Appears stated age and gender, skin color appropriate to ethnicity, symmetrical facial features. No signs of distress. Body posture is upright and erect, with no obvious signs of deformities. Straight upright position. Arms move in opposition. Balance is even, not in need of any assistive devices. Well nourished. Weight is appropriate for height and stature. Facial expression is appropriate for the situation, mood is pleasant and cooperative.
Hair:	Healthy and evenly distributed. No lesions or hair loss noted. No infestations.
Head:	Head is normocephalic w/o deformities and midline. TMJ has full ROM, with no pain, crepitus, clicks or pops on palpation. Facial structures are symmetrical without any drooping. No masses or lesions present. No infestations.
Eyes:	Sclera white, conjunctiva is pink and moist. Pupils are round and equal in size; both are reactive to light and accommodate bilaterally. Cornea intact. No discharge, redness or lesions.
Ears:	No piercings. No redness, discharge, or swelling. No signs of hearing loss.
Nose:	Septum is intact, no deformities, lesions, or inflammation. Both nares are patent bilaterally with no unusual drainage.
Mouth:	Lips are pink and moist. Tongue, gums, and mucus membranes are pink, moist, and intact. All teeth present w/o decay.
Throat:	Buccal pink and moist, w/o lesions. Uvula midline and pink, tonsils are not enlarged. Soft palate and uvula contract at the same time. No signs of redness or drainage present.
Lymphatics:	Full ROM with cervical spine.

How To Document Nursing Assessment

Theresa Capriotti



How To Document Nursing Assessment:

Documentation Skills for Quality Patient Care Fay Yocum, 1993 DOCUMENTATION SKILLS FOR QUALITY PATIENT CARE is written for students professional nurses who want to develop or strengthen existing documentation skills Documentation meets many needs requirements This book reviews those needs outlines the regulations that nurses must adhere to JCAHO ANA standards of nursing practice that relate to documentation are featured Nursing process writing NANDA nursing diagnoses are reviewed The book describes what needs to be documented as well as techniques pitfalls of documentation Numerous examples of nursing notes based on the author s long varied clinical experiences are included to guide the reader Written in a clear accessible style the book is intended for use as a primer refresher guide A busy teacher or hospital educator could use the book as a guideline for instruction Order from Awareness Productions P O Box 85 Tipp City OH 45371 0085 513 845 3617 *Nursing Documentation* Ellen Thomas Eggland, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good documentation **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 **Document Smart** Theresa Capriotti,2019-06-26 Feeling unsure about documenting patient care Learn to document with skill and ease with the freshly updated Document Smart 4th Edition This unique easy to use resource is a must have for every student and new nurse offering more than 300 alpha organized topics that demonstrate the latest nursing medical and government best practices for documenting a wide variety of patient conditions and scenarios Whether you are assessing data creating effective patient goals choosing optimal interventions or evaluating treatment this is your road map to documentation confidence and clarity

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

Legal and Ethical Issues Susan Westrick Killion,Susan J. Westrick,2006 Applying the Roper-Logan-Tierney Model in Practice Jane Jenkins, BA MSc SRN RNT,Jackie Solomon, MA, PGDip, SRN,Sue Whittam,Karen Holland,2008-06-03 This title is directed primarily towards health care professionals outside of the United States Applying the RLT Model in Practice has been written to enable students and their teachers in both Higher Education and clinical practice to explore the different dimensions of the model through a variety of case studies and exercises The case studies can be viewed as triggers for student problem solving skills in using the Model Many of the exercises are aimed at enabling readers to find evidence to support nursing activities The authors have incorporated an international perspective throughout the text Based on the most popular model used in general nursing care throughout the world Explicitly demonstrates how the RLT model can be used to assess plan deliver and evaluate individualised nursing care Applies the RLT model in the context of today s health services and links it to clinical governance and the multi disciplinary context of care Uses a problem solving approach with extensive use of exercises and case studies Attractive two colour design using boxes tables and summaries Fully updated throughout in line with changes in practice developments in the evidence base changes in the NHS e g modern matrons Modernisation Agency etc More material on how to apply the model in an inter disciplinary context Updated infection control section More on discharge planning More material relating to primary care **Nurses' Handbook of Health Assessment** Janet R.

Weber,2021-11-01 The perfect on the go companion to Health Assessment for Nursing 7th Edition this compact handbook gives students quick convenient access to the latest nursing assessment guidelines and findings in a see and do format ideal for today s fast paced nursing practice Streamlined step by step guidelines and full color illustrations detail everything students need to interview clients and conduct thorough physical assessments with ease **Documentation** ,2007 This full color handbook is a quick reference guide to all aspects of documentation for every nursing care situation It covers current documentation systems and formats including computerized documentation and features scores of sample filled in forms and in text narrative notes illustrating everything from everyday occurrences to emergency situations Coverage includes timesaving strategies for admission to discharge documentation in acute outpatient rehabilitation long term and home care environments and special documentation practices for selected clinical specialties critical care emergency perioperative maternal neonatal and psychiatric The book includes advice on legal safeguards dangerous abbreviations and compliance with HIPAA guidelines and JCAHO requirements *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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