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. This

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 purse in your documentation, include her to initial, last

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. O:@ 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, sideralls 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

Trischana Davies

Narrative Nursing 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 NEWdiscussion 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 Dosher Memorial Hospital in Southport North Carolina **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 Narrative Nursing - What Does it Mean to be a Professional Nurse Joyce J. Fitzpatrick, Peter Stoffan, 2025-12-01 A nursing narrative note is a type of nursing documentation used to provide clear detailed information about a patient A narrative note is written in paragraph form and tells a story if you will about the

patient the care being received response to treatment and any interventions or education provided Narrative notes allow for more detailed descriptions of health conditions and concerns which means you have greater freedom when it comes to painting a representative picture of a patient s health You can communicate their thoughts and feelings as well as your own professional judgments The format of the book will cover the Narrative Nursing workshop format that has been instituted over the years with nurses from a range of organizations Each nurse will follow an outline of storytelling and select one meaningful nurse patient nurse colleague or nurse leader encounter to present as a story to share with other nurses Each chapter contains stories from nurses at all levels of development from the novice student nurse to the expert nurse and nurse leader The overall purpose is to illustrate in a structured format the impact of nursing care provided to individuals families and communities The storytelling process that will be used includes the key techniques of storytelling namely engaging the audience describing the scene building tension focusing on what is important keeping the flow logical and making the story conclusive particularly in light of the lessons learned from the story Each story will be accompanied by analysis and commentary from the two primary authors remarking on the meaningfulness of the story lessons learned and lessons for other nurses Each story will be unique but there will be conclusions drawn at the end of each story and there will also be an introductory chapter and a final chapter written by the primary authors to introduce the value of story telling and in the final chapter to synthesize lessons learned A main feature of this book is that the stories will allow the reader to identify personal and professional moral and ethical principles confronted by clinical nurses and nurse leaders at all levels <u>Documentation</u> Ellen Thomas Eggland, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good 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 Narrative Nursing - What Does It Mean to Be a Professional Nurse Joyce Fitzpatrick, Peter Stoffan, 2025-12 A nursing narrative note is a type of nursing documentation used to provide clear detailed information about a patient A narrative note is written in paragraph form and tells a story if you will about the patient the care being received response to treatment and any interventions or education provided Narrative notes allow for more detailed descriptions of health conditions and concerns which means you have greater freedom when it comes to painting a representative picture of a patient's health You can communicate their thoughts and feelings as well as your own professional judgments The format of the book will cover the Narrative Nursing workshop format that has been instituted over the years with nurses from a range of organizations Each nurse will follow an outline of storytelling and select one meaningful nurse patient nurse colleague or nurse leader encounter to present as a story to share with other nurses Each chapter contains stories from nurses at all levels of development from the novice student nurse to the expert nurse and nurse leader The overall purpose is to illustrate in a structured format the impact of nursing care provided to individuals families and communities The storytelling process that will be used includes the key techniques of storytelling namely engaging the audience describing the scene building tension focusing on what is important keeping the flow logical and making the story conclusive particularly in light of the lessons learned from the story Each story will be accompanied by analysis and commentary from the two primary authors remarking on the meaningfulness of the story lessons learned and lessons for other nurses Each story will be unique but there will be conclusions drawn at the end of each story and there will also be an introductory chapter and a final chapter written by the primary authors to introduce the value of story telling and in the final chapter to synthesize lessons learned A main feature of this book is that the stories will allow the reader to identify personal and professional moral and ethical principles confronted by clinical nurses and nurse leaders at all levels **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 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 Nursing Documentation in Aged Care Christine Crofton, Gaye Witney, 2004 As another volume in Ausmed's Guide to Practice series of textbooks and audiobooks this is an essential text for all aged care nurses who wish to enhance their documentation skills and deliver higher quality care to the elderly AudioBooks are ideal teaching tools **Connecting Health and Humans** Kaija Saranto, 2009 The proceedings of the 10th International Nursing Informatics Congress NI2009 offers a wide range of scientific knowledge to be disseminated among nurses administrators physicians or informaticians irrespective of whether they are clinicians teachers researchers or students The variation of papers follow the advances in health information technology although certain important topics such as ethics education management and clinical practice applications remain The proceedings follows the ten themes of the conference programme clinical workflow and human interface consumer health informatics and personal health records health information

technology terminology standards and NMDS s patient preferences and quality of care patient safety evidence based practice and decision support consumer and professional education strategies and methods for HIT training and national eHealth initiatives across the globe The OASIS Nursing Narrative Note Reference Blueprint Trischana Davies, 2021-05-18 This is a book that specifies the aspects required of Medicare to be included within an OASIS nursing narrative note in order for a skilled nursing visit to be deemed as approved by and reimbursable by Medicare 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 Informatics for Nurses with Navigate Advantage Access Susan Alexander, Heather Carter-Templeton, Karen Frith, 2024-12-23 Nurses need to be aware of the latest information technologies and research available to provide safe patient centered evidence based care Applied Clinical Informatics for Nurses continues its student centered approach to nursing informatics in a modern new edition full of illustrations tables figures and boxes that enhance the readers experience and assists in comprehension In the updated Third Edition the authors emphasize the importance of understanding principles and applications of informatics and apply a context based teaching approach to enhance clinical decision making promote ethical conduct and improve problem solving skills The Third Edition features extensive updates on telehealth mobile health and clinical decision support It also includes expanded information related to software used for data mining and additional case studies to help illustrate creative informatics projects developed by nurses With Applied Clinical Informatics for Nurses Third Edition students will develop a deeper understanding of how clinical data can be made useful in healthcare and nursing **Connecting Medical Informatics and Bio-informatics** Rolf Engelbrecht, 2005 A variety of topics of bio practice informatics including both medical and bio medical informatics are addressed by MIE The main theme in this publication is the development of connections between bio informatics and medical informatics Tools and concepts from both disciplines can complement each other **Documentation Skills for Quality Patient Care** Fay Yocum, 1999 **Fundamentals of** Nursing Carol R. Taylor, Carol Lillis, Priscilla LeMone, 2001 comprehensive introductory textbook Fundamentals of Nursing presents basic professional concepts clinical concepts and clinical skills with step by step illustrated procedures The text s striking full color visual material holds students interest and the clear readable writing style enhances understanding

Throughout it takes a holistic approach toward nursing care by consistently emphasizing four types of blended skills of nursing that students must master technical cognitive ethical legal and interpersonal Special features include Promoting Health displays Applying Learning to Practice exercises Through the Eyes of a Student Patient Family Caregiver and Thinking Critically displays New to the Fourth Edition are the chapters Wound Care and Blended Skills and Critical Thinking Throughout the Nursing Process and updated content on timely topics such as latex allergies needleless systems conscious sedation pain and more Detailed procedure guidelines now include home care and lifespan considerations Computing Technologies for Healthcare Dario Salvi, Pieter Van Gorp, Syed Ahmar Shah, 2024-06-03 This book constitutes the refereed proceedings of the 17th EAI International Conference on Pervasive Computing Technologies for Healthcare PervasiveHealth 2023 held in Malm Sweden during November 27 29 2023 The 29 full papers and 6 short papers were selected from 90 submissions and are organized in thematic sessions as follows Pervasive Mental Health Privacy Ethics and Regulations Datasets and Big data Processing Pervasive health for Carers Pervasive Health in Clinical Practice Remote Monitoring Patient and User Aspects Motion and rehabilitation Workshop on the Internet of Things in Health Research Posters and demos non indexed annex Consumer-Centered Computer-Supported Care for Healthy People H.-A. Park, P.J. Murray, C. Delaney, 2006-06 Intended for nurses and informatics experts working with informatics applications in nursing care administration research and education This book s theme Consumer Centered Computer Supported Care for Healthy People emphasizes the central role of the consumer and the function of information technology in health care **Informatics Odyssey** Suzanne Bakken, 2001 AMIA 2001 Medical Informatics Odyssey provides a venue to learn the past and to envision the future role of medical informatics innovations in the discovery creation and application of biomedical knowledge the delivery of health care in a wide variety of settings and the health of the public In addition a panel examines the 20 year history of nursing at the Symposium A second special track on Patient Safety partially supported by funding from the Agency for Healthcare Research and Quality is specifically designed to highlight the Symposium content focused on system strategies to reduce medical errors and improve patient safety Illustrated Manual of Nursing Practice, 1994 Clinical material is organized by body system with each chapter providing fully illustrated anatomy and physiology assessment techniques diagnostic test data nursing diagnoses with sample plans of care information on major disorders patient teaching guidelines treatments and related patient care This edition provides updates on more than 1 500 disorders tests procedures and treatments including information on cardiovascular drugs AIDS and hypertension classifications peptic ulcers and CPR guidelines Nurses find more detailed information on drugs and professional issues an added chapter on documentation and an expanded chapter on the nursing process Contributors include renowned nurse educators researchers and practitioners

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