
DOCUMENTATION

The following is sample documentation from health assessment of the respiratory system of a healthy adult.

Nurses Notes:

Subjective Data:

No problems with breathing. Has had no change in breathing in last 6 months or 2 years. Complete all activities without change in breathing. Sleeps with one pillow. No history of problems that affect breathing. No family history of respiratory disease. Has had occasional cold or throat infection. A cold almost every year treated with OTC medication and subsides. Sore throat in high school, treated with antibiotics, no ongoing problems. No cough, no wheezing, no chest pain. No history of allergies. Has never smoked. Works and lives in smoke-free environments. No anxiety. Uses OTC medication for headache, rarely. No change in weight for 5 years. No exposure to fumes or irritants.



Objective Data:

Height 5'8", weight 154 lb. Skin of face pink. No nasal flaring, nares patent. Lips pink, moist. Alert and oriented. BP 118/66—P 76—RR 16. Respirations regular, deep, no use of accessory muscles. Chest movement and excursion symmetrical. Transverse to AP diameter 2:1. Scapulae on plane perpendicular to vertebral line. Muscles mass firm. Chest color pink, warm. No masses, lesions, pain, or crepitus. Spine vertically aligned, ribs intact.

Symmetrical respiratory expansion. Tactile fremitus strong over trachea, weakening over bronchi, and absent over alveoli. Resonance throughout lung fields to percussion. Diaphragmatic excursion 5 cm bilaterally and parallel. Anterior and posterior breath sounds vesicular over periphery, bronchovesicular between scapulae and lateral to sternum, bronchial sounds next to trachea, tracheal sounds over the trachea. No adventitious sounds.

Sample Nursing Notes Documentation

Katrin Zwirglmaier



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Table of Contents Sample Nursing Notes Documentation

1. Understanding the eBook Sample Nursing Notes Documentation
 - The Rise of Digital Reading Sample Nursing Notes Documentation
 - Advantages of eBooks Over Traditional Books
2. Identifying Sample Nursing Notes Documentation
 - 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 Sample Nursing Notes Documentation
 - User-Friendly Interface
4. Exploring eBook Recommendations from Sample Nursing Notes Documentation
 - Personalized Recommendations
 - Sample Nursing Notes Documentation User Reviews and Ratings
 - Sample Nursing Notes Documentation and Bestseller Lists
5. Accessing Sample Nursing Notes Documentation Free and Paid eBooks
 - Sample Nursing Notes Documentation Public Domain eBooks
 - Sample Nursing Notes Documentation eBook Subscription Services
 - Sample Nursing Notes Documentation Budget-Friendly Options
6. Navigating Sample Nursing Notes Documentation eBook Formats
 - ePub, PDF, MOBI, and More
 - Sample Nursing Notes Documentation Compatibility with Devices
 - Sample Nursing Notes Documentation Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Sample Nursing Notes Documentation
 - Highlighting and Note-Taking Sample Nursing Notes Documentation
 - Interactive Elements Sample Nursing Notes Documentation
8. Staying Engaged with Sample Nursing Notes Documentation

- Joining Online Reading Communities
- Participating in Virtual Book Clubs
- Following Authors and Publishers Sample Nursing Notes Documentation
- 9. Balancing eBooks and Physical Books Sample Nursing Notes Documentation
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Sample Nursing Notes Documentation
- 10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
- 11. Cultivating a Reading Routine Sample Nursing Notes Documentation
 - Setting Reading Goals Sample Nursing Notes Documentation
 - Carving Out Dedicated Reading Time
- 12. Sourcing Reliable Information of Sample Nursing Notes Documentation
 - Fact-Checking eBook Content of Sample Nursing Notes Documentation
 - 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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