

## Nursing Notes Example

0730 Introduced self to patient. VS obtained. Head to toe assessment performed. Patient denies needs at this time. (It's important to ask if they need anything. Some patients won't tell you anything until you ask. You will learn to get in the habit of asking this) Side rails x3 up. Bed in lowest position. Call light within reach and pt. verbalizes understanding of use. (Documentation of safety is a must. Also, it's not enough to say the call light is within reach...the patient must know how to use it as well ).

0800 Pt sitting up in bed eating regular diet. Tolerating diet well. (It is particularly important to chart if they are tolerating a diet change if we are advancing their diet...in other words, no nausea, no vomiting).

0845 Pt ambulating in hallway with assistance from PT. Pt is slightly winded but reports no difficulty in breathing. (Again, I'm including my observations on how well the patient is tolerating activity).

0900 Pt sitting in chair. Pt assisted with bath. (This tells the level of care the patient is able to do...the patient is partially dependent on us nurses for ADLS, such as baths)

1000 Pt remains in chair. Denies any needs. Educated patient regarding post operative instructions of stoma care. Patient eager to learn and verbalizes understanding. (Again, it's not enough that you have educated the patient. You must document whether or not they 1. are receptive to learning and 2. they understood what you are educating them on.

1030 Patient assisted back to bed without difficulty. No distress. Side rails x 3 up. Bed in lowest position. Call light within reach.

1115 Patient report "I'm aching in my belly". Patient rates pain 9 of out of 10. Patient is guarding abdomen. Heart rate= 110. Blood pressure= 170/89. Respiratory rate=24. Patient is sweating. (I'm painting a picture of the situation. Heart rate, respirations and blood pressure are all elevated which backs up the patient's report of pain)

# Notes On Patient With Behaviors

**J Spring**



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