

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.

Rehab Nursing Documentation Samples

Rachel S Tattersall



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Table of Contents Rehab Nursing Documentation Samples

1. Understanding the eBook Rehab Nursing Documentation Samples
 - The Rise of Digital Reading Rehab Nursing Documentation Samples
 - Advantages of eBooks Over Traditional Books
2. Identifying Rehab Nursing Documentation Samples
 - 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 Rehab Nursing Documentation Samples
 - User-Friendly Interface
4. Exploring eBook Recommendations from Rehab Nursing Documentation Samples
 - Personalized Recommendations
 - Rehab Nursing Documentation Samples User Reviews and Ratings
 - Rehab Nursing Documentation Samples and Bestseller Lists
5. Accessing Rehab Nursing Documentation Samples Free and Paid eBooks
 - Rehab Nursing Documentation Samples Public Domain eBooks
 - Rehab Nursing Documentation Samples eBook Subscription Services
 - Rehab Nursing Documentation Samples Budget-Friendly Options

6. Navigating Rehab Nursing Documentation Samples eBook Formats
 - ePub, PDF, MOBI, and More
 - Rehab Nursing Documentation Samples Compatibility with Devices
 - Rehab Nursing Documentation Samples Enhanced eBook Features
7. Enhancing Your Reading Experience
 - Adjustable Fonts and Text Sizes of Rehab Nursing Documentation Samples
 - Highlighting and Note-Taking Rehab Nursing Documentation Samples
 - Interactive Elements Rehab Nursing Documentation Samples
8. Staying Engaged with Rehab Nursing Documentation Samples
 - Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Rehab Nursing Documentation Samples
9. Balancing eBooks and Physical Books Rehab Nursing Documentation Samples
 - Benefits of a Digital Library
 - Creating a Diverse Reading Collection Rehab Nursing Documentation Samples
10. Overcoming Reading Challenges
 - Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Rehab Nursing Documentation Samples
 - Setting Reading Goals Rehab Nursing Documentation Samples
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Rehab Nursing Documentation Samples
 - Fact-Checking eBook Content of Rehab Nursing Documentation Samples
 - 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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