

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

**United States. Congress. Senate.
Special Committee on Aging**



Rehab Nursing Documentation Samples:

Restorative Care Nursing for Older Adults Barbara Resnick, 2004-07-28 The purpose of restorative care nursing is to take an active role in helping older adults maintain their highest level of function thus preventing excess disability This book was written to help formal and informal caregivers and administrators at all levels to understand the basic philosophy of restorative care and be able to develop and implement successful restorative care programs The book provides a complete 6 week education program in restorative care for caregivers many suggestions for suitable activities and practical strategies for motivating both older adults and caregivers to engage in restorative care In addition the book provides an overview of the requirements for restorative care across all settings the necessary documentation and ways in which to complete that documentation

Documentation Basics Mia Erickson, Mia L. Erickson, 2012 Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively The new Second Edition of *Documentation Basics A Guide for the Physical Therapist Assistant* continues the path of teaching the student and clinician documentation from A to Z Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever evolving profession Updated inside *Documentation Basics A Guide for the Physical Therapist Assistant Second Edition* The discussion on integrating disablement into documentation The discussion on how a PTA can show medical necessity and need for skilled care The discussion on using documentation to communicate with other providers Writing the assessment and plan to coincide with the initial documentation Sample notes completed on forms More examples and practice including physical agents school based services paediatrics traumatic brain injury spinal cord injury and interventions consistent with the Guide to Physical Therapist Practice Medicare reimbursement in different settings The importance of consistent reliable and valid measurements How to improve communication and consistency between documentation by the PT the PTA The discussion on disablement has also been updated shifting away from the Nagi Model toward the International Classification of Functioning Disability and Health ICF In addition the PTA Normative Model has been integrated throughout to include more information on clinical decision making New inside *Documentation Basics A Guide for the Physical Therapist Assistant Second Edition* Navigating the PT plan of care A step by step model for PTAs to use as they navigate the initial PT documentation and plan of care How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem oriented medical record into electronic documentation Sample notes and discussion of documentation in school based settings early intervention skilled nursing settings in patient rehabilitation and direct access Medicare Parts C and D Cash based services and pro bono services Instructors in educational settings can visit www.efacultyounge.com for additional material to be used for teaching in the classroom *Documentation Basics A Guide for the Physical Therapist Assistant Second Edition* is the perfect guide for all physical therapist assistant students and clinicians

who want to update and refine their knowledge and skills in documentation **Tabbner's Nursing Care** Gabby Koutoukidis, Jodie Hughson, 2012-10 This text covers a wide range of issues surrounding nursing midwifery and health visiting The topics it covers are the structure and functions of the human body nursing care and nursing needs care of the individual with a body system disorder and special aspects of nursing care This edition written for Australia and NZ students

Documentation for Rehabilitation Lori Quinn, James Gordon, 2015-12-11 Better patient management starts with better documentation Documentation for Rehabilitation A Guide to Clinical Decision Making in Physical Therapy 3rd Edition shows how to accurately document treatment progress and patient outcomes Designed for use by rehabilitation professionals documentation guidelines are easily adaptable to different practice settings and patient populations Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned Written by expert physical therapy educators Lori Quinn and James Gordon this book will improve your skills in both documentation and clinical reasoning A practical framework shows how to organize and structure PT records making it easier to document functional outcomes in many practice settings and is based on the International Classification for Functioning Disability and Health ICF model the one adopted by the APTA Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care and nursing homes as well as a separate chapter on documentation in pediatric settings Guidelines to systematic documentation describe how to identify record measure and evaluate treatment and therapies especially important when insurance companies require evidence of functional progress in order to provide reimbursement Workbook textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations re evaluations and discharge summaries UPDATED content is based on data from current research federal policies and APTA guidelines including incorporation of new terminology from the Guide to Physical Therapist 3 0 and ICD 10 coding EXPANDED number of case examples covers an even broader range of clinical practice areas

Documentation for Rehabilitation - E-Book Lori Quinn, James Gordon, 2024-04-12 Better patient management starts with better documentation Documentation for Rehabilitation 4th Edition demonstrates how to accurately document treatment progress and patient outcomes using a framework for clinical reasoning based on the International Classification for Functioning Disability and Health ICF model adopted by the American Physical Therapy Association APTA The documentation guidelines in this practical resource are easily adaptable to different practice settings and patient populations in physical therapy and physical therapy assisting Realistic examples and practice exercises reinforce the understanding and application of concepts improving skills in both documentation and clinical reasoning Workbook textbook format with examples and exercises in each chapter helps reinforce understanding of concepts Coverage of practice settings includes documentation examples in acute care rehabilitation outpatient home care nursing homes pediatrics school and community

settings Case examples for a multitude of documentation types include initial evaluations progress notes daily notes letters to insurance companies Medicare documentation and documentation in specialized settings NEW Movement Analysis Linking Activities and Impairments content addresses issues related to diagnosis NEW An eBook version included with print purchase provides access to all the text figures and references with the ability to search customize content make notes and highlights and have content read aloud Updated case examples provide clinical context for patient documentation Revised content including updated terminology from the latest updates to the Guide to Physical Therapist Practice provides the most current information needed to be an effective practitioner Updated references ensure content is current and applicable for today's practice

Rehabilitation Nursing Shirley P. Hoeman, 2008-01-01 Providing a solid foundation of concepts and principles this book maintains the fundamental focus of rehabilitation nursing holistic care of the rehabilitation client to achieve maximum potential outcomes in functional and lifestyle independence

Physical Therapy Documentation Mia Erickson, Mia L. Erickson, Rebecca McKnight, Ralph Utzman, 2008 Complete accurate documentation is one of the essential skills for a physical therapist This book covers all the fundamentals includes practice exercises case studies throughout

Nursing Home Care United States. Congress. Senate. Special Committee on Aging, 1987

Elder Care in Occupational Therapy Sandra Cutler Lewis, 2003 Elder Care in Occupational Therapy has been extensively revised into a new and completely updated second edition This pragmatic text presents up to date information in a user friendly format that seamlessly flows from one subject to the next From wellness to hospice Elder Care in Occupational Therapy Second Edition offers a broad yet detailed discussion of occupational therapy practice that is devoted to older adults A wide variety of topics are covered in a concise format such as historical perspectives theoretical insights the aging process and current interventional strategies to name a few Twenty informative appendices are also included that clarify issues such as Medicare coverage community and clinical living arrangements client centered practice exercise programs evidence based practice and a summary of the newly adopted Occupational Therapy Practice Framework Domain and Process Additional features Contains information about the most advanced scientific achievements that can ultimately affect occupational therapy Lists new and updated resource materials Presents case studies that provide theoretical considerations and Intervention methods Clearly discusses exciting and new venues for occupational therapy programming Explains fundamentals of documentation and current reimbursement issues Perfect for the student or clinician Elder Care in Occupational Therapy Second Edition provides classic professional information on theory disease entities and intervention in a comprehensive format

Documentation Manual for Occupational Therapy Crystal Gateley, 2024-06-01 The best selling newly updated occupational therapy textbook Documentation Manual for Occupational Therapy Fifth Edition is made for students and early career practitioners learning the critical skill of documentation The workbook format offers students ample opportunities to practice writing occupation based problem statements and goals intervention plans SOAP notes and other forms of

documentation The Fifth Edition has also been updated to reflect changes in the American Occupational Therapy Association's Occupational Therapy Practice Framework Domain and Process Fourth Edition What's included in Documentation Manual for Occupational Therapy Numerous worksheets for students to practice individual skills with suggested answers provided in the Appendix Updated information on coding billing and reimbursement to reflect recent Medicare changes particularly in post acute care settings Examples from a variety of contemporary occupational therapy practice settings Included with the text are online supplemental materials for faculty use in the classroom Instructors in educational settings can visit the site for an Instructor's Manual with resources to develop an entire course on professional documentation or to use the textbook across several courses One of the most critical skills that occupational therapy practitioners must learn is effective documentation to guide client care communicate with colleagues and maximize reimbursement The newly updated and expanded Documentation Manual for Occupational Therapy Fifth Edition will help students master their documentation skills before they ever step foot into practice BOOK ALONE: THE CASE MANAGER'S HANDBOOK 5E Catherine M.

Mullahy,2013-06-20 **Quality Assurance in Rehabilitation Nursing** Adrienne E. Avillion,Barbara B. Mirgon,1989 Now you can save months of time developing a quality assurance program on your own With Quality Assurance in Rehabilitation Nursing you'll find it easy to set up implement monitor and evaluate a QA program specific to rehabilitation All stages of the process are covered with sample forms questionnaires and charts you can photocopy and use or adapt to your facility

The Case Manager's Handbook Catherine M. Mullahy,2010-10-25 Written by renowned author Catherine Mullahy The Case Manager's Handbook Fourth Edition is the ultimate how to guide for Case Managers It is designed to define good case management examine the case management process and present practical procedural information The Fourth Edition has been completely revised and updated with new references and pertinent information This book is an excellent daily reference or can be used as a training guide for new case managers or a teaching tool for client groups Accompanied by a CD ROM and a FREE Student Study Guide is available online The OTA's Guide to Documentation Marie Morreale,2024-06-01 The bestselling newly updated occupational therapy assistant OTA textbook The OTA's Guide to Documentation Writing SOAP Notes Fifth Edition explains the critical skill of documentation while offering multiple opportunities for OTA students to practice documentation through learning activities worksheets and bonus videos The Fifth Edition contains step by step instruction on occupational therapy documentation and the legal ethical and professional documentation standards required for clinical practice and reimbursement of services Students and professors alike can expect the same easy to read format from previous editions to aid OTAs in learning the purpose and standards of documentation throughout all stages of the occupational therapy process and different areas of clinical practice Essentials of documentation reimbursement and best practice are reflected in the many examples presented throughout the text Worksheets and learning activities provide the reader with multiple opportunities to practice observation skills and clinical reasoning learn documentation methods create

occupation based goals and develop a repertoire of professional language Templates are provided to assist beginning OTA students in formatting occupation based SOAP notes and the task of documentation is broken down into smaller units to make learning easier Other formats and methods of recording client care are also explained such as the use of electronic health records and narrative notes This text also presents an overview of the initial evaluation process delineating the roles of the OT and OTA and guidelines for implementing appropriate interventions New in the Fifth Edition Incorporation of the Occupational Therapy Practice Framework Domain and Process Fourth Edition and other updated American Occupational Therapy Association documents Updated information to meet Medicare Part B and other third party payer requirements Revised clinical terminology on par with current trends Added examples from emerging practice areas Expanded tables along with new worksheets and learning activities Included with the text are online supplemental materials for faculty use in the classroom this includes access to supplemental website worksheets learning activities and scenario based videos to practice the documentation process

Documentation and Reimbursement for Speech-Language Pathologists Nancy Swigert, 2024-06-01 Although it is the least noticed by patients effective documentation is one of the most critical skills that speech language pathologists must learn With that in mind *Documentation and Reimbursement for Speech Language Pathologists Principles and Practice* provides a comprehensive guide to documentation coding and reimbursement across all work settings The text begins with section 1 covering the importance of documentation and the basic rules both ethical and legal followed by an exploration of the various documentation forms and formats Also included are tips on how to use electronic health records as well as different coding systems for diagnosis and for procedures with an emphasis on the link between coding reimbursement and the documentation to support reimbursement Section 2 explains the importance of focusing on function in patient centered care with the ICF as the conceptual model then goes on to cover each of the types of services speech language pathologists provide evaluation treatment planning therapy and discharge planning Multiple examples of forms and formats are given for each In section 3 Nancy Swigert and her expert team of contributors dedicate each chapter to a work setting in which speech language pathologists might work whether adult or pediatric because each setting has its own set of documentation and reimbursement challenges And since client documentation is not the only kind of writing done by speech language pathologists a separate chapter on other professional writing includes information on how to write correspondence avoid common mistakes and even prepare effective PowerPoint presentations Each chapter in *Documentation and Reimbursement for Speech Language Pathologists Principles and Practice* contains activities to apply information learned in that chapter as well as review questions for students to test their knowledge Customizable samples of many types of forms and reports are also available Included with the text are online supplemental materials for faculty use in the classroom *Documentation and Reimbursement for Speech Language Pathologists Principles and Practice* is the perfect text for speech language pathology students to learn these vital skills but it will also provide clinical supervisors new clinicians and speech

language pathologists starting a private practice or managing a department with essential information about documentation coding and reimbursement Physical Medicine & Rehabilitation Pocket Companion Marlis Gonzalez-Fernandez, Jarrod David Friedman, MD, 2011-01-28 This book is designed to meet the day to day needs of PM R residents practicing physiatrists and physicians in other specialties treating rehabilitation patients Focused solely on clinical care delivery this reference provides the tools necessary to navigate everything from PM R team coordination to the tailoring of medical management to achieve functional goals *Essentials for Nursing Practice - E-Book* Patricia A. Potter, Anne G. Perry, Patricia A. Stockert, Amy Hall, 2014-02-28 Approx 1218 pages Approx 1218 pages NEW QSEN scenarios present a clinical situation followed by an open ended question designed to help you understand and apply these core competencies NEW Chapter on professional nursing includes information on QSEN prioritization delegation and professional levels NEW Completely revised review questions contain a strong mix of clinical thinking and application level questions NEW Content on the impact of exercise covers its influence on disease reduction compassion fatigue lateral violence cyber bullying social media implications caregiver strain and safe patient handling NEW Expanded use of Evidence Based Practice boxes include a PICO question summary of the results of a research study and a description of how the study has affected nursing practice in every chapter NEW Patient Centered Care boxes address racial and ethnic diversity along with the cultural differences that impact socioeconomic status values geography and religion These will related to the chapter case studies when possible **Home Health Nursing Manual** Sunny Sutton, 1988 The whys and hows of charting for home health care *Potter and Perry's Canadian Fundamentals of Nursing - E-Book* Barbara J. Astle, Wendy Duggleby, Patricia A. Potter, Anne G. Perry, Patricia A. Stockert, Amy Hall, 2023-02-15 Get the solid foundation you need to practise nursing in Canada Potter Perry s Canadian Fundamentals of Nursing 7th Edition covers the nursing concepts knowledge research and skills that are essential to professional nursing practice in Canada The text s full colour easy to use approach addresses the entire scope of nursing care reflecting Canadian standards culture and the latest in evidence informed care New to this edition are real life case studies and a new chapter on practical nursing in Canada Based on Potter Perry s respected Fundamentals text and adapted and edited by a team of Canadian nursing experts led by Barbara J Astle and Wendy Duggleby this book ensures that you understand Canada s health care system and health care issues as well as national nursing practice guidelines More than 50 nursing skills are presented in a clear two column format that includes steps and rationales to help you learn how and why each skill is performed The five step nursing process provides a consistent framework for care and is demonstrated in more than 20 care plans Nursing care plans help you understand the relationship between assessment findings and nursing diagnoses the identification of goals and outcomes the selection of interventions and the process for evaluating care Planning sections help nurses plan and prioritize care by emphasizing Goals and Outcomes Setting Priorities and Teamwork and Collaboration More than 20 concept maps show care planning for clients with multiple nursing diagnoses UNIQUE Critical

Thinking Model in each clinical chapter shows you how to apply the nursing process and critical thinking to provide the best care for patients UNIQUE Critical Thinking Exercises help you to apply essential content Coverage of interprofessional collaboration includes a focus on patient centered care Indigenous peoples health referencing the Truth and Reconciliation Commission TRC Report the CNA Code of Ethics and Medical Assistance in Dying MAID legislation Evidence Informed Practice boxes provide examples of recent state of the science guidelines for nursing practice Research Highlight boxes provide abstracts of current nursing research studies and explain the implications for daily practice Patient Teaching boxes highlight what and how to teach patients and how to evaluate learning Learning objectives key concepts and key terms in each chapter summarize important content for more efficient review and study Online glossary provides quick access to definitions for all key terms

The OTA's Guide to Writing SOAP Notes Sherry Borcharding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA's Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcharding and Marie J Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice

New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA's role in all stages of treatment including referral evaluation intervention plan and discharge Documentation of physical agent modalities With reorganized and shorter chapters The OTA's Guide to Writing SOAP Notes Second Edition is the essential text to providing instruction in writing SOAP notes specifically aimed at the OTA practitioner and student This exceptional edition offers both the necessary instruction and multiple opportunities to practice as skills are built on each other in a logical manner Templates are provided for beginning students to use in formatting SOAP notes and the task of documentation is broken down into small units to make learning easier A detachable summary sheet is included that can be pulled out and carried to clinical sites as a reminder of the necessary contents for a SOAP note Updated information expanded discussions and reorganized learning tools make The OTA's Guide to Writing SOAP Notes Second Edition a must have for all occupational therapy assistant students This text is the essential resource needed to master professional documentation skills in today's healthcare environment

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