

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: 1st 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 1st 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:

Nursing Narrative Notes

Lena Empyema

Nursing Narrative Notes:

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

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

The OASIS Nursing Narrative Note RefeRNce 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 *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. NEW discussion 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, Non-releasable 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 Documentation* Ellen Thomas, Eggland, Denise Skelly, Heinemann, 1994 Focuses on the communication skills that are the key to good documentation. **Documentation Skills for Quality Patient Care** Fay Yocom, 1993 DOCUMENTATION SKILLS FOR QUALITY PATIENT CARE is written for students and 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 **Mosby's Pocket Guide to Fetal Monitoring** Lisa A. Miller,David Miller,Susan Martin Tucker,2012-02-23 Rev ed of Mosby s pocket guide to fetal monitoring Susan Martin Tucker Lisa A Miller David A Miller

Skills for Professional Nursing Practice Barbara A. Norton,Anna Miller,1986 **Nursing Narrative Note Examples to Save Your License**

Lena Empyema,2021 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

Medical Records for Attorneys Laurence M. Deutsch,2001 **Wound Care Essentials** Sharon Baranoski,Elizabeth A. Ayello,2008 Written by two well known wound care specialists and an interdisciplinary team of experts this handbook is essential for all professionals involved in wound care including nurses physical therapists physicians podiatrists and long term care professionals The book provides practical comprehensive guidelines for assessment and management of both common and atypical wound problems and covers many topics not sufficiently addressed in other texts such as sickle cell wounds amputation gene therapy and the specific wound care needs of special populations Features include more than 100 photographs and illustrations recurring icons such as Evidence Based Practice and Practice Points case studies and review questions

Documentation Skills for Quality Patient Care Fay Yocom,1999 **Comprehensive Gynecology** David M. Gershenson,Gretchen M Lentz,Rogerio A. Lobo,2021-05-08 With its trademark clear concise writing style and evidence based focus Comprehensive Gynecology 8th Edition remains your 1 choice for practical in depth coverage of any women s health issue you re likely to encounter It covers all key issues in gynecology now fully updated to include new information on topics such as laparoscopy and innovations in robotic surgery reversible contraception and advancements in treating endometriosis For residents specialists primary care doctors and other healthcare providers Comprehensive Gynecology is an easy to access source of trusted information for everyday practice Includes helpful features such as key references and terms key points at the end of each chapter summary boxes for quick reference and new bolded text to highlight the most important concepts Features newly improved artwork a more cohesive easy to navigate design throughout and more clinical algorithms Contains hundreds of illustrations and tables anatomical figures radiographs and photographs as well as 20 videos that address topics such as Pap smear techniques hysteroscopic metroplasty and endometriosis of the bladder Brings you up to date with the latest applications in diagnostic and interventional ultrasound issues in infertility the latest research in

menopause and other essential aspects of today's practice *Nursing 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 [A Medical Informatics Odyssey](#) Suzanne Bakken, 2001 AMIA 2001 Medical 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. *Fundamental Skills and Concepts in Patient Care* Barbara Kuhn Timby, 1996 *Chart to Save Your RN License* Lena Empyema, 2021-08-11 You can be an excellent nurse in the clinical setting and still fail to prove that you are an excellent nurse if your documentation is inadequate. Having worked in a variety of inpatient and outpatient settings, I understand the obstacles nurses face. There's just not time nor do nurses have the mental energy to meticulously document every little thing on top of the rest of their to-do list. That's part of why I became passionate about documentation education. It doesn't have to be an overwhelming, endless challenge to chart exhaustively in hopes that you enter enough data into the chart to defend yourself one day. Rather, leveraging the most critical data, knowing how to format notes and exactly what to say and when to spend five minutes dumping information into the chart can be learned skills that make documentation faster, easier, and less stressful while doing a better job of defending your actions.

The Importance of Documentation
Overcoming Obstacles
Purpose's of Documentation
Defensive Charting
Obstacles Impacting Quality of Medical Record
Overcoming Obstacles
Legal Responsibilities of the Nurse
Duties of the Nurse
Nurse Practice Acts
Duties of the Hospital
Hospital Policy vs State Board of Nursing Regulations
Reasonable Prudence
Failure to Fulfill Document Responsibilities
Fulfilling Responsibilities vs Documenting Responsibilities
What if Responsibilities Aren't Fulfilled
Mistakes Happen
Professional Liability Insurance
Malpractice
Medical Negligence
Acting with Malice
Fraud
What Happens When a Nurse is Charged with Malpractice
What to Do if You Receive Notification of a Claim
Common Charting Mistakes
How to Avoid Them
The Most Common Errors
Charting By Exception
Charting to Capture Minimal Data
But I've Always Charted This Way and Nothing Bad Has Happened Yet
What You Should Be Charting
How and What to Chart
Quick Glance Charting Checklists
What is a Timely Manner
Documenting Assessments Sample

Focused Assessment Criteria Sharing the Responsibility Modifying Electronic Data Abbreviations Standing Orders Early Warning Systems Scores Scales Informed Consent Special Circumstances Paper Charting Writing an Incident Report Patient Leaving AMA Patient Threatening to Sue You Identifying Patient Belongings Another Member of the Team is Not Documenting Correctly Restraints Defective Equipment Suspected Abuse Patient Requesting to View Their EMR on Hospital Computer Narrative Notes When How to Write Notes One Note or Several Notes Daily Narrative Notes Examples of Common Notes Written As Needed How to Title Narrative Notes How to Format Notes Using Patient Names in Notes Length of Notes Create a Template Tips for Less Stress When Charting BONUS How I Chart on a Typical Shift ABOUT THE AUTHOR I m Andrea RN MSN Perfecting my own documentation and working to find concrete guidelines to share with my fellow nurses has become my passion As I gained more knowledge and researched the dusty forgotten corners of the internet for obscure evidence based practice and case studies becoming a subject matter expert on nursing documentation lit a spark because sharing this information helps empower nurses to understand exactly what should appear in their patient charts where when it should entered and how it should be phrased **Patient Education** Sally H. Rankin,Karen Duffy Stallings,1996 This practical reference provides theory based approaches to patient teaching in a clear and concise format Guidance is presented for teaching patients of all ages and their families and the book covers a variety of health care settings **Mastering Documentation** Springhouse Corporation,1995 The complete guide for streamlining and improving nursing documentation for virtually every system Nurses will find instructions for virtually every common and not so common charting method From progress notes to protocols there is a wealth of easy to follow examples throughout the book Includes JCAHO approved nursing abbreviations ANA standards of practice and JCAHO and Medicare guidelines for nursing documentation

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