Med Surg Care Plan 1.docx

1600

Document Hygiene:

Time: <u>0730</u> Bath:

Complete/Partial/Self/Shower Shampoo Hair:

Yes/No

Heels Floated: Yes/No Turn & Reposition: Yes Q2h

Shave: Not applicable.

Nurse Narrative Note: The patient is a 76 year-old female, admitted on 5-25-19 with a postoperative wound infection of the right hip. She is alert and oriented to person, place, time and situation. She reports no pain and 0 on a 0-10 pain scale. She states, "it only hurts to move my right foot and leg it aches every time I move it or add pressure." Heels are elevated and achy pain noted on right foot around heel. No edema noted on right foot. Baseline vital signs are: respirations-16, blood pressure 179/77, pulse ox- 92% with a blood sugar reading of 121. She is on 2L of oxygen via nasal cannula and slowly weaning off. Ortho came in to change her right hip dressing at 0730. It is covered with an ABD. She had a picc line placed in the upper right brachium at 1630. She will be discharging to therapy with the antibiotics prescribed with her. She has her SCD's on and urine output total is 600mL from 0700-1600. She voids in a brief with purewick provided. No ambulation during shift. She is on a 1800 diabetic diet, she ate 100% of her breakfast and 25% of her lunch. She has been using the incentive spirometer Q2h. She is cooperative and very pleasant.

Nursing Narrative Notes

Dario Salvi, Pieter Van Gorp, Syed Ahmar Shah

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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 **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 **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 guick 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 nonreleasable information searching for

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Nursing Documentation Ellen Thomas Eggland, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good documentation

Narrative Nursing - What Does It Mean to Be a Professional Nurse Joyce Fitzpatrick, Peter Stoffan, 2025-12-09 A nursing narrative note is a type of nursing documentation used to provide clear detailed information about the patient A narrative note is written in paragraph form and tells a story if you will about the patient the care he is receiving 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 story telling 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 story telling 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 also there will be an introductory and 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 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

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Table of Contents Nursing Narrative Notes

- 1. Understanding the eBook Nursing Narrative Notes
 - The Rise of Digital Reading Nursing Narrative Notes
 - Advantages of eBooks Over Traditional Books
- 2. Identifying Nursing Narrative Notes
 - 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 Nursing Narrative Notes
 - User-Friendly Interface
- 4. Exploring eBook Recommendations from Nursing Narrative Notes
 - Personalized Recommendations
 - Nursing Narrative Notes User Reviews and Ratings
 - Nursing Narrative Notes and Bestseller Lists

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