

## NURSING NOTE EXAMPLE

| CATEGORY    | DESCRIPTION                                    | EXAMPLE DETAILS                                                                                                                |
|-------------|------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|
| Subjective: | Patient's reported symptoms and experiences    | [Patient states they are experiencing shortness of breath and rates pain as 6/10]                                              |
|             | Relevant medical, family, and social history   | [Patient has a history of asthma and a family history of hypertension]                                                         |
|             | Patient's concerns or questions                | [Patient expresses concerns about managing their asthma and asks about treatment options]                                      |
| Objective:  | Vital signs and physical assessment findings   | [BP: 135/85 mmHg, HR: 88 bpm, RR: 22 breaths/min, SpO2: 95%, Temp: 98.6°F (37°C)]                                              |
|             | Results of diagnostic tests or lab work        | [Chest X-ray: no infiltrates or consolidation; ABG: pH 7.42, PaCO2 37 mmHg, PaO2 88 mmHg]                                      |
|             | Observations of patient behavior or appearance | [Patient appears anxious, uses accessory muscles to breathe, and has audible wheezing]                                         |
| Assessment: | Analysis of patient's condition and needs      | [Patient experiencing an asthma exacerbation with moderate respiratory distress]                                               |
|             | Potential problems or complications            | [Potential risks include worsening respiratory distress and hypoxia]                                                           |
| Plan:       | Interventions to address patient's needs       | [Administer prescribed short-acting bronchodilator via nebulizer; monitor vital signs]                                         |
|             | Patient education or referrals                 | [Educate patient on proper inhaler technique and self-management of asthma symptoms]                                           |
|             | Evaluation and follow-up                       | [Reassess patient's respiratory status and vital signs after treatment; notify provider if no improvement or worsening occurs] |

# Sample Nursing Notes Documentation

**K Payea**



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**You CAN Teach Med-Surg Nursing!** Mary A. Miller, Deborah C. Wirwicz, 2014-07-29 Print CourseSmart

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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

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