

DOCUMENTATION

The following is a sample narrative documentation from assessment of the head and neck of a healthy adult.

Nurses Notes:

Subjective Data:

Denies problems with the head and neck, reports no current headache, no lesions, and no changes in skin or hair. Recalls no problem with swollen glands or breathing. No personal or family history of headache, allergy, or thyroid disease. Takes 2 Tylenol for occasional headache, that is once a week during busy season at work (1 month) and "maybe one a month." Headache is associated with lack of sleep or stress and relieved with single dose (2 tablets) of Tylenol. Weight has been constant for several years.



Objective Data:

Skull round with symmetrical protuberances. Skull nontender to palpation. Hair even distribution, scalp free of lesions, clean. Eyebrows symmetrical, equal distances of brow to pupil and outer canthus to pinna. Nose is midline with equal nasolabial folds. Lips symmetrical. Facial movement and expression symmetrical. Trachea mobile, midline with palpable C rings. TMJ movement smooth and symmetrical. Thyroid nonpalpable, rises with swallow. Lymph nodes of neck nonpalpable.

ASSESSMENT FORM

General Overview

Skull: round, symmetrical

Protuberances: symmetrical

Hair: even distribution

Scalp: clean, no lesions

Eyes

Brows: symmetrical

Distance Brow to Pupil: equal

Distance Outer Canthus to Pinna: equal

Nose

Position: midline

Deviation: none, straight

Nasolabial Folds: equal

Mouth

Lips: symmetrical

Neck

Trachea: midline, mobile, C rings palpable

Thyroid: nonpalpable, rises with swallow

Lymph Nodes

PALPABLE	NO	YES
Preauricular:	☒	☐
Postauricular:	☒	☐
Occipital:	☒	☐
Retropharyngeal:	☒	☐
Submaxillary:	☒	☐
Submental:	☒	☐
Superficial cervical:	☒	☐
Deep cervical:	☒	☐
Supraclavicular:	☒	☐

Sample Of Nursing Documentation

Jennifer Richmond



Sample Of Nursing Documentation:

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

Documentation Skills for Quality Patient Care Fay Yocum, 1999 *Patient Safety and Quality: section 6, Tools for improvement*, 2008 Nurses play a vital role in improving the safety and quality of patient care not only in the hospital or ambulatory treatment facility but also of community based care and the care performed by family members Nurses need know what proven techniques and interventions they can use to enhance patient outcomes To address this need the Agency for Healthcare Research and Quality AHRQ with additional funding from the Robert Wood Johnson Foundation has prepared this comprehensive 1 400 page handbook for nurses on patient safety and quality Patient Safety and Quality An Evidence Based Handbook for Nurses AHRQ Publication No 08 0043 Online AHRQ blurb <http://www.ahrq.gov/qual/nursesdbk>

Nursing Documentation Ellen Thomas Eggland, Denise Skelly Heinemann, 1994 Focuses on the communication skills that are the key to good documentation **Nursing Documentation** Jennifer Richmond, 1997-01-01 If these are your concerns I ll never get time to finish my nursing notes Is it legal Can I use white out Can t they make a better form than this How can I record this family set up quickly Weren t computers made for clerks not nurses There has to be something wrong with documenting for funding How do you record the pain level of someone who has a dementing illness Who walks down critical pathways What happens if a home health record gets lost How can I document my client s spiritual concerns realistically Will managed care affect what I write Is there a culturally appropriate way to document What is charting by exception How did nurses document before NANDA then this book is for you Back cover *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 *Medical Records for Attorneys* Laurence M. Deutsch, 2001 **ChartSmart** Lippincott Williams & Wilkins, 2007

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Experiment	[CH_3COBr] (mol l^{-1})	[OH^-] (mol l^{-1})	Initial Rate ($\text{mol l}^{-1} \text{s}^{-1}$)
1	0.10	0.10	0.010
2	0.20	0.10	0.020
3	0.10	0.20	0.020
4	0.20	0.20	0.040

a 3 10
b 6 10
c 18 10
d 9 10
e none of these

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