

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

Ensheng Dong



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

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