

Nursing notes

Date / time	Notes
4/4 20 30	Admitted to ward via A and E at 1800 hours. Admission for investigation into confusion with a history of confusion 1-2 years. Usually mobile with a stick. Patient not for resuscitation – discussed with family and documented in notes. Lives in hostel normally independent but recently more confused and aggressive. Full assistance required with ADL's on admission. Requires incontinence aids. Catheter inserted in A and E – patient removed balloon intact. Some bleeding as a result. Patient given Haloperidol and Diazepam on admission to ward – reasonably settled at time of report. Charted for PRN meds for agitation overnight. For psych review in a.m. Encourage diet and fluid. Attended Head CT – NAD. Temp 37.2.
5/4/ 0510	Patient settled overnight. Incontinent. Special in place no episodes of aggression so far this shift. Small amount of bleeding from penis following self removal of catheter in A and E. Obs satisfactory continue special.
5/4 1255	Patient found of floor at commencement of shift. Had climbed out of bed and hit head. Assisted back to bed. Obs stable. Cut above right eye – steri strips in place. Dr attended and sutured x3 to laceration on scalp. Very drowsy, unable to take meds due to drowsiness. Very poor fluid intake. ?may require IV therapy? However, may not tolerate same.
6/4 1455	Requiring full assistance with ADL's. Incontinent of urine. Sat out of bed but complaining of being tired – returned to bed at 11a.m. Complaining of pain (? Lower leg?) Dr informed. Paracetamol given with good effect. Temp 38.
7/4 2130	Patient restless this shift obs stable, full assist with ADL's. Haloperidol given as charted.
8/4 0230	Woke up panicking temp 37. Unable to measure BP Patient looked confused. Paracetamol and Haloperidol given as charted.
8/4 0700	Patient very erratic. Trying to get out of bed. Medication given as per chart no effect. Dr informed and larger dose of haloperidol given. Settled for a while now getting agitated again. Temp 38 managed to take Paracetamol but refused antibiotic.
8/4 1900	Refusing most diet and fluid. Small sips of water only. Urine remains blood stained. Only passing small amounts. Refusing medication. Discussed antibiotics with team will require does this a.m. Very drowsy. Contact daughter if condition changes.
9/4 1450	Much improved this am. Alert and orientated at times. Taking good diet and fluid. Incontinent still. Small bowel action will require laxative tonight. Still sleepy. Daughter visited.

Sample Nursing Progress Notes

O García



Sample Nursing Progress Notes:

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

Modules for Basic Nursing Skills Janice Rider Ellis, Elizabeth Ann Nowlis, Patricia M. Bentz, 1992-01-01 **A Guide for International Nursing Students in Australia and New Zealand** M. Bernadette Hally, 2008 A Guide for International Nursing Students is an essential resource for overseas nurses and international students of nursing in Australia and New Zealand It assists the reader to develop essential communication skills for practice as a student and registered nurse in the region A companion CD allows the reader to become familiar with authentic nursing conversations and nursing handovers Provided by publisher

Textbook of Basic Nursing Caroline Bunker Rosdahl, Mary T. Kowalski, 2008 Now in its Ninth Edition this comprehensive all in one textbook covers the basic LPN LVN curriculum and all content areas of the NCLEX PN Coverage includes anatomy and physiology nursing process growth and development nursing skills and pharmacology as well as medical surgical maternal neonatal pediatric and psychiatric mental health nursing The book is written in a student friendly style and has an attractive full color design with numerous illustrations tables and boxes Bound in multimedia CD ROMs include audio pronunciations clinical simulations videos animations and a simulated NCLEX PN exam This edition's comprehensive ancillary package includes curriculum materials PowerPoint slides lesson plans and a test generator of NCLEX PN style questions Basic Concepts of Psychiatric-mental Health Nursing Louise Rebraca Shives, 2007 This

seventh edition includes new chapters and maintains popular features from previous editions such as self awareness prompts while adding research boxes and student worksheets at the end of each chapter Tabbner's Nursing Care Gabby

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A. Peterson, **McDonald's The Nurse Educator's Guide to Assessing Learning Outcomes** Tresa Kaur, 2024-11-25 McDonald s The Nurse Educator s Guide to Assessing Learning Outcomes Fifth Edition is a comprehensive guide for nurse educators that covers the assessment of critical thinking the development of learning objectives and the creation of tests including detailed tips for writing many kinds of individual test items This unique resource also covers the analysis of test reliability Examples of effective and ineffective test items are included throughout to help faculty and nurse educators deepen their understanding of how to create effective tests and assess student learning The updated Fifth Edition features two new chapters dedicated to the NextGen NCLEX to prepare faculty to develop questions for their students addressing the move from critical thinking to clinical judgment **Nursing Care Plans and Documentation** Lynda Juall Carpenito, 1991

Skillmasters , 2002-07-01 This portable reference is a timesaving guide on how to enhance charting skills avoid legal pitfalls and ensure that a complete and accurate record is created every time Reviews fundamental aspects of charting nursing process legal and professional requirements guidelines for developing a solid plan of care and the variety of charting forms currently in use including computerized charting Completed forms show exactly how to document assessment intervention and evaluation Also addresses the specific requirements for charting in acute care home care and long term care

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