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 tableto) 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 nasolablal folds. Lips symmetrical. Facial movement and expression symmetrical. Traches mobile, midline with palpable C rings. TMJ movement smooth and symmetrical. Thyroid nonpalpable, rises with swallow. Lymph nodes of neck nonpalpable.

ieneral Overview	Nock Traches: misting mobile, Cringe palpatrir		
Skull: round symmetrical			
Protuberances: symmetrical	Thyroid nonpalpatile, rises with swallow		
Hair: even allostribution	Lymph Nodes		
Scalp: clean, no lesions	PALPABLE	NO	YES
yes	Presuricular:		
Brows: symmetrical	Postauricular:		
Distance Brow to Pupil: equal	Occipital:	*	
Distance Outer Canthus to Pinna: equal	Retropharyngesit	100	-
lose	Submodillary:		
Position: midling	Submentalt		
Deviation: none, straight	Superficial cervical:	190	_
Nasolabial Folds: caust	Deep cervical:		_
louth	Supraclavicular:		_

Sample Of Nursing Documentation

Lippincott Williams & Wilkins

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

<u>Documentation Skills for Quality Patient Care</u> 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 car 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 nurseshdbk

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