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~~Nursing Notes the Easy Way~~

~~(January 1, 2004 edition ...~~

Keep Your Notes Simple: Don't  
write down irrelevant information  
that has nothing to do with the  
patient's health. Nursing notes  
are supposed to be designed to to  
be read quickly. That way the  
next shift will be caught up on the  
patient. Always Write Down All  
Communication: Write down  
everything important about the



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patient's health. Every single discussion you had with the families, doctors, and other medical professionals need to be documented in your nursing notes.

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You can also handwrite notes, and to do that I highly recommend the Cornell method. In the Cornell method, you draw a line down the left side of your page to create about a 2.5 inch margin on the left. You'll write your notes on the larger section along the right, and then use the area on the left for labeling the specific topics.

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school — Straight A Nursing~~  
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January 1, 2004 by Nursethings.  
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nurses notes, but pay little attention to why they need to write a note in the first place. Once you understand the reasoning behind why you need a note; the rest is easy because you are just filling the blanks and connecting the dots. To write or not to write are equally important. Nursing documentation cannot be erased;

~~HOW TO WRITE NURSING NOTES~~

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Interesting. We started Patho. Our instructor recommended that we study it by disease process.

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How to Write a Soap Note.  
Healthcare workers use  
Subjective, Objective,  
Assessment, and Plan (SOAP)  
notes to relay helpful and  
organized information about  
patients between professionals.  
SOAP notes get passed along to  
multiple people, so...

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Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal communication in nursing to help you.

Provides information on documentation issues, including electronic medical records, legal and ethical implications, and documentation in acute cases, along with a variety of charting examples.

This pocket-size guide saves nurses precious time while ensuring that a complete patient



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record is created and that legal, quality assurance, and reimbursement requirements are met. This handbook provides specific verbiage for charting patient progress, change or tasks accomplished for approximately 50 common problems. The new third edition has been completely updated to include Critical Assessment Findings, Subjective Findings for Documentation, Resources for Care and Practice, Legal Considerations, Time Saving Tips, and new Managed Care information. Plus, roughly 15 additional common problems and diagnoses have been added making this practical resource more valuable than ever. Diagnoses are in alphabetical order allowing for fast and easy

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access. Each patient problem or diagnosis found in this handbook includes specific documentation

guidelines for the following aspects of nursing care:

- \*Assessment of patient problem
- \*Associated nursing diagnosis
- \*Examples of objective findings for documentation
- \*Examples of subjective findings for documentation
- \*Examples of assessment of the data
- \*Examples of potential medical problems for this patient
- \*Examples of the documentation of potential nursing interventions/actions
- \*Examples of the evaluations of the interventions/actions
- \*Other services that may be indicated and their associated interventions and goals/outcomes
- \*Nursing

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goals and outcomes \*Potential discharge plans for this patient \*Patient, family, caregiver educational needs \*Resources for care and practice \*Legal considerations for documentation, as appropriate Introductory chapters describe documentation, the medical record systems of nursing documentation, and current JCAHO and ANA standards related to documentation. Specialty sections provide important and specific guidelines for hospice care and maternal-child care. Appendices provide the latest NANDA-approved nursing diagnoses, descriptions of services provided by other disciplines, abbreviations, and a listing of resources (i.e., directory of resources, clinical newsletters

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and journals. Internet resources, further reading). Includes Time Saving Tips boxes to help minimize the time needed for documentation responsibilities. Each diagnosis includes a Critical Assessment Components/Findings section to help nurses with their critical decision making and determine whether an assessment finding indicates immediate attention or patient follow up. The Goals/Outcomes section of each diagnosis now appears at the beginning so that nurses know the intended goals and outcomes up front before beginning the assessment. All documentation guidelines now include sections on Examples of Subjective Findings for Documentation and Resources for

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Care and Practice Includes Legal Considerations for Documentation as appropriate to highlight important legal issues. Part One has been updated to reflect the current managed care environment, including new information required by the National Community of Quality Assurance [NCQA], so that nurses can incorporate and focus on these changes as they document

Focuses on the communication skills that are the key to good documentation.

This unique, spiral-bound handbook is compact, portable, and written with busy home health nurses in mind! Organized by body system, it offers instant

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advice on assessment and care planning for the disorders home health nurses are likely to encounter. Providing assessment guides for all body systems, the home environment, and the client's psychological status, it includes full care plans for over 50 illnesses and conditions most commonly encountered in the home. Each plan lists nursing diagnoses, short- and long-term expected outcomes, nursing interventions, and client caregiver interventions. Care plans are organized by body systems to allow for quick retrieval of information. Both short-term and long-term outcomes are included in the care plans to aid evaluation of the care provided. Detailed assessment guidelines are

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provided for all body systems to facilitate complete and comprehensive client examinations. Guidelines for environmental and safety assessments aid in the appraisal and improvement of clients' living conditions. Client and caregiver interventions are outlined in the care plans to promote active client participation in self-care. The convenient pocket size makes transportation and use convenient to home health nurses. Appendices on documentation guidelines, laboratory values, medication administration, home care resources, and standard precautions provide quick access to useful home care information. Related OASIS items are

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Identified in the assessment section, and ICD-9 diagnostic codes in the care plans section assist with proper home care documentation. Visit frequency and duration schedules are suggested within each care plan to assist nurses in evaluating and planning care. NANDA nursing diagnoses are consistent with the latest 2001-2002 nomenclature. An increase in suggested therapy referrals within the care plans and in a new appendix helps nurses identify indicators for specialized services. A fully updated Resources Appendix includes websites for easy access to home health service information.

Chart Smart: the A-to-Z Guide to  
Better Nursing Documentation



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tells nurses exactly what to document in virtually every type of situation they may encounter on the job, no matter where they practice--hospital, medical office, outpatient, rehabilitation facility, long-term care facility, or home. This portable handbook has nearly 300 entries that cover documentation required for common diseases, major emergencies, complex procedures, and difficult situations involving patients, families, other health care team members, and supervisors. In addition to patient care, this book also covers documenta

With all the training and

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education nurses receive, there is little true explanation about the importance of documentation.

Even in today's litigious culture and the backlash of services no longer reimbursable -- it is crucial we as nurses understand the rationale for our documentation practices. By creating specific systems to ensure license protection, we in turn provide more effective hand-off communication. Every nurse knows it's the law and that you don't want to lose your license, but do we really know why the methods of documentation are so vital to our livelihood? Has the electronic medical record made this approach additionally arduous? Do the questions on the EMR provide an accurate picture

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of the actual care provided? Often times, these reports are not clear or complete. Through fictional and non-fictional stories, Rosale Lobo reveals proper nursing documentation techniques providing clarity and important best practice concepts that can be applied immediately.

Extraneous situations will arise in nursing, making it imperative to develop intentional methods of documentation. By putting together an effective system you will decrease your chances of being sued. For the future of nursing documentation, the EMR is not the answer, a personal system of accountability is.

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