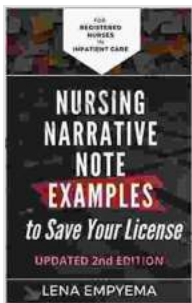


Charting and Documentation Suggestions for RNs and LPNs: A Comprehensive Guide to Describing The

As a nurse, you are responsible for providing safe and effective care to your patients. This includes accurately charting and documenting your observations, assessments, interventions, and patient responses. Your documentation is essential for communication among healthcare providers, and it can also be used to track patient progress and evaluate the effectiveness of care.

Charting and documentation can be a challenge, especially when you are new to the profession. However, by following some simple suggestions, you can improve the quality of your documentation and make it more useful for your patients.



Nursing Narrative Note Examples to Save Your License: Charting and Documentation Suggestions for RNs & LPNs Who Have to Describe the Indescribable in a Medical Record by Lena Empyema

★★★★☆ 4 out of 5

Language : English
File size : 5867 KB
Text-to-Speech : Enabled
Screen Reader : Supported
Enhanced typesetting : Enabled
Print length : 90 pages
Lending : Enabled



Here are some tips for charting and documentation:

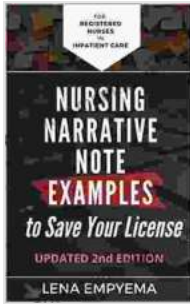
1. **Be objective.** Your documentation should be based on facts, not opinions. Use specific language and avoid using generalizations.
2. **Be accurate.** Make sure that your documentation is correct and complete. Double-check your entries before you sign them.
3. **Be timely.** Chart your observations and assessments as soon as possible after you make them. This will help you to remember the details and avoid errors.
4. **Use proper grammar and spelling.** Your documentation should be easy to read and understand. Use clear and concise language.
5. **Document all relevant information.** This includes the patient's vital signs, symptoms, medications, and treatments. You should also document any changes in the patient's condition.
6. **Be organized.** Your documentation should be organized in a way that makes it easy to find the information you need. Use headings and subheadings to divide your documentation into sections.
7. **Use abbreviations and acronyms correctly.** Abbreviations and acronyms can save time, but they can also be confusing if they are not used correctly. Make sure that you are using the correct abbreviations and acronyms and that you are consistent in your usage.
8. **Sign and date your documentation.** This will help to ensure that your documentation is authentic and that it can be traced back to you.

In addition to these general tips, there are some specific suggestions for charting and documenting the following:

- **Vital signs:** Vital signs should be charted every 4 hours for stable patients and more frequently for unstable patients. The vital signs that should be charted include blood pressure, pulse, respirations, and temperature.
- **Symptoms:** Symptoms should be charted as they are reported by the patient. The symptoms that should be charted include pain, nausea, vomiting, and diarrhea.
- **Medications:** Medications should be charted each time they are given. The information that should be charted includes the name of the medication, the dose, the route of administration, and the time of administration.
- **Treatments:** Treatments should be charted each time they are given. The information that should be charted includes the name of the treatment, the time of the treatment, and the person who performed the treatment.
- **Changes in the patient's condition:** Any changes in the patient's condition should be charted as soon as they are observed. The changes that should be charted include changes in vital signs, symptoms, or behavior.

Charting and documentation are essential components of nursing care. By following these suggestions, you can improve the quality of your documentation and make it more useful for your patients.

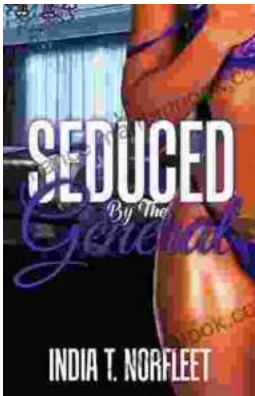
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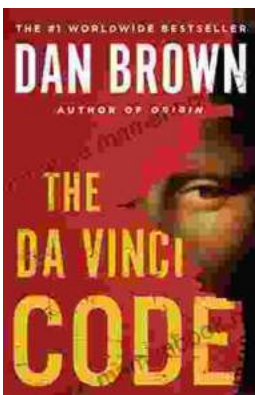
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