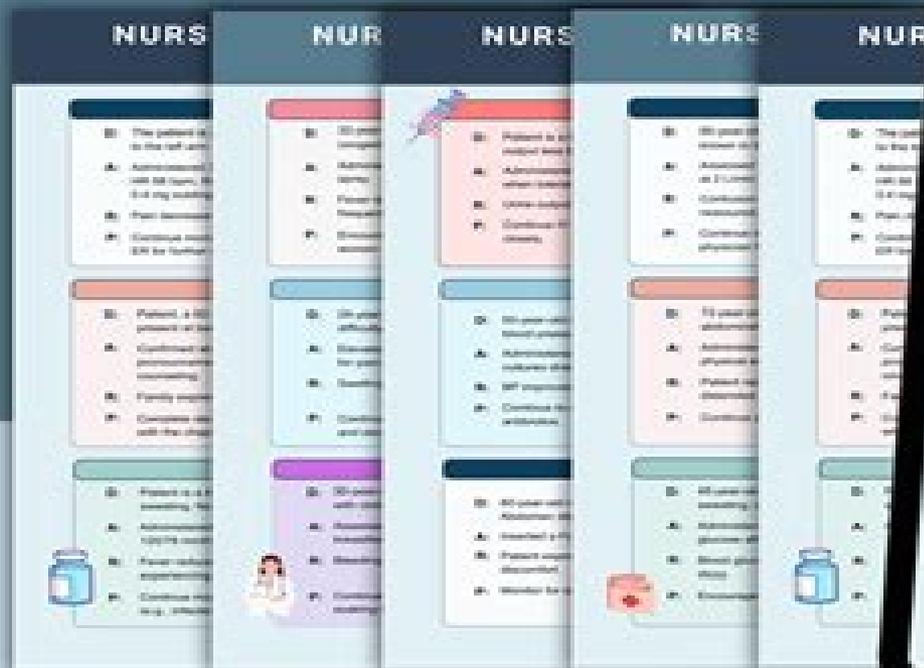


NURSING DOCUMENTATION CHARTING GUIDE



NURSING DOCUMENTATION TEMPLATE

POST-OP/PAIN

- 1. Post-operative patient, 68-year-old female, reporting 8/10 pain on supine and ambulation.
- 2. Administered prescription pain medication (morphine 2 mg IV per order). Encourage deep breathing and incentive spirometry.
- 3. Pain decreased to 4/10 after 30 minutes. Patient reports feeling more comfortable.
- 4. Continue to monitor pain every 2 hours. Reassess patient on next administration per management plan.

VITALS MONITORING

- 1. 68-year-old female patient with BP stable today. Assessments upon standing and a history of hypertension.
- 2. Monitor patient for a regular rhythm. Administered 500 mL normal saline bolus per protocol. Reassess vital signs.
- 3. BP increased to 160/90 mmHg after fluid administration. Patient reports dizziness.
- 4. Continue monitoring blood pressure every 30 minutes for 2 hours. Encourage slow movements when changing positions.

WOUND CARE

- 1. 68-year-old female, standing 2-3 times in the past 24 hours, inspection of incision and abdominal dressing.
- 2. Administration 4 mg IV for 2. Encourage client to use incentive spirometry hourly.
- 3. Wound is intact. The suture separation of incision after inspection.
- 4. Monitor hydration status and encourage oral. Report trends. Response to a

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RS Peters



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