

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 orders. 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 orders.

[Signature]

VITALS MONITORING

- 1. 67-year-old male patient with BP stable today. Discuss with teaching and a history of hypertension.
- 2. Monitor patient for a regular rhythm. Administered 60 mg oral warfarin before last protocol. Reassess vital signs.
- 3. BP increased to 160/90 mmHg after last administration. Patient reports dizziness.
- 4. Continue monitoring blood pressure every 30 minutes for 2 hours. Encourage slow movements when changing position.

WOUND CARE

- 1. 58-year-old female, standing 24 hours on the post-operative, inspection of incision and abdominal girdling.
- 2. Administered analgesic 4 mg IV. Encourage client to use incentive spirometry hourly.
- 3. Wound is intact. The suture separation of 1 centimeter after manipulation.
- 4. Monitor hydration status and encourage oral. Record intake. Response to a

Examples Of Nursing Documentation Charting

R Bogdan



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