

# 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 (hydrocodone 2 mg/325 mc morphine) 30 minutes after surgery and analgesia.
- 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 of pain management system.

**VITALS/RESPONSE**

- 1. 68-year-old female patient with BP stable, oxygen saturation 98% on room air, stable vital signs.
- 2. Administered 100% oxygen via nasal cannula. Administered 500 mL normal saline bolus per protocol. Reassess vital signs.
- 3. BP increased to 120/80 mmHg after fluid administration. Patient reports less dizziness.
- 4. Continue monitoring blood pressure every 30 minutes for 2 hours. Encourage oral intake when tolerating solid foods.

**WOUNDING**

- 1. 68-year-old female, standing 24 hours on the post-operative course, inspection of incision and dressing complete.
- 2. Administered analgesic 4 mg for 2. Encourage patient to void when possible to reduce urinary retention.
- 3. Wound dressing intact. The patient reports no tenderness after manipulation.
- 4. Monitor vital signs and encourage oral. Reassess incision. Response to a

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