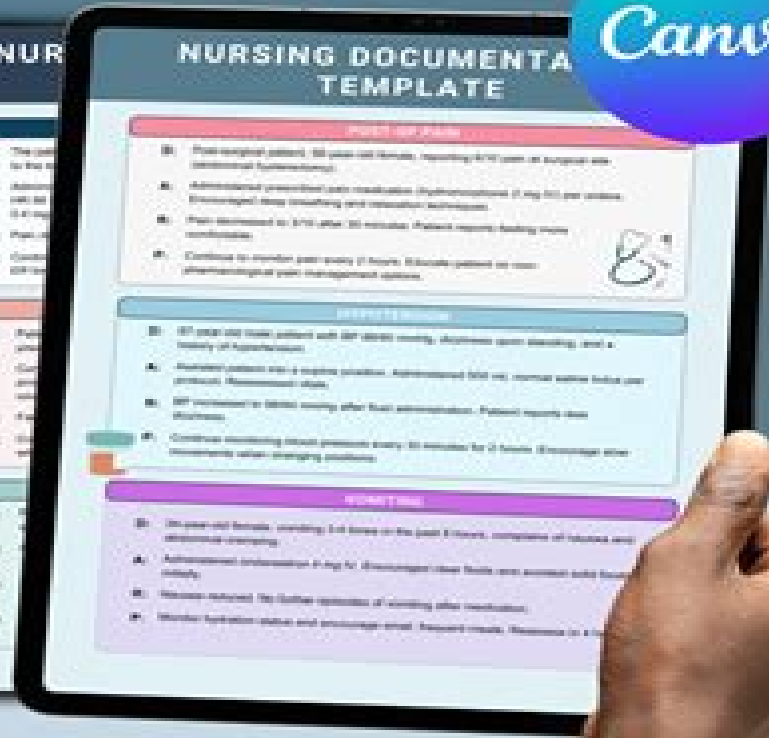


NURSING DOCUMENTATION CHARTING GUIDE



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 mcg tablet). 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 of pain management system.

VITALS/RESPONSE

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

WOUNDING

- 1. 68-year-old female, reporting 8/10 pain on the past 2 hours, complains of nausea and abdominal cramping.
- 2. Administered prescription 4 mg IV. Encourage client to take oral pain relief when able to tolerate.
- 3. Nausea resolved. The patient reports relief of cramping after medication.
- 4. Monitor vital signs and encourage oral. Reassess trends. Reassess on a 2-hour interval.

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Clemens Wendtner



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