

NURSING NOTE EXAMPLE

CATEGORY	DESCRIPTION	EXAMPLE DETAILS
Subjective:	Patient's reported symptoms and experiences	[Patient states they are experiencing shortness of breath and rates pain as 6/10]
	Relevant medical, family, and social history	[Patient has a history of asthma and a family history of hypertension]
	Patient's concerns or questions	[Patient expresses concerns about managing their asthma and asks about treatment options]
Objective:	Vital signs and physical assessment findings	[BP: 135/85 mmHg, HR: 88 bpm, RR: 22 breaths/min, SpO2: 95%, Temp: 98.6°F (37°C)]
	Results of diagnostic tests or lab work	[Chest X-ray: no infiltrates or consolidation; ABG: pH 7.42, PaCO2 37 mmHg, PaO2 88 mmHg]
	Observations of patient behavior or appearance	[Patient appears anxious, uses accessory muscles to breathe, and has audible wheezing]
Assessment:	Analysis of patient's condition and needs	[Patient experiencing an asthma exacerbation with moderate respiratory distress]
	Potential problems or complications	[Potential risks include worsening respiratory distress and hypoxia]
Plan:	Interventions to address patient's needs	[Administer prescribed short-acting bronchodilator via nebulizer; monitor vital signs]
	Patient education or referrals	[Educate patient on proper inhaler technique and self-management of asthma symptoms]
	Evaluation and follow-up	[Reassess patient's respiratory status and vital signs after treatment; notify provider if no improvement or worsening occurs]

Nursing Notes The Easy Way

Carol Ireton-Jones



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Table of Contents Nursing Notes The Easy Way

1. Understanding the eBook Nursing Notes The Easy Way
 - The Rise of Digital Reading Nursing Notes The Easy Way
 - Advantages of eBooks Over Traditional Books
2. Identifying Nursing Notes The Easy Way
 - Exploring Different Genres
 - Considering Fiction vs. Non-Fiction
 - Determining Your Reading Goals
3. Choosing the Right eBook Platform
 - Popular eBook Platforms
 - Features to Look for in an Nursing Notes The Easy Way
 - User-Friendly Interface
4. Exploring eBook Recommendations from Nursing Notes The Easy Way
 - Personalized Recommendations
 - Nursing Notes The Easy Way User Reviews and Ratings
 - Nursing Notes The Easy Way and Bestseller Lists
5. Accessing Nursing Notes The Easy Way Free and Paid eBooks

- Nursing Notes The Easy Way Public Domain eBooks
 - Nursing Notes The Easy Way eBook Subscription Services
 - Nursing Notes The Easy Way Budget-Friendly Options
6. Navigating Nursing Notes The Easy Way eBook Formats
- ePub, PDF, MOBI, and More
 - Nursing Notes The Easy Way Compatibility with Devices
 - Nursing Notes The Easy Way Enhanced eBook Features
7. Enhancing Your Reading Experience
- Adjustable Fonts and Text Sizes of Nursing Notes The Easy Way
 - Highlighting and Note-Taking Nursing Notes The Easy Way
 - Interactive Elements Nursing Notes The Easy Way
8. Staying Engaged with Nursing Notes The Easy Way
- Joining Online Reading Communities
 - Participating in Virtual Book Clubs
 - Following Authors and Publishers Nursing Notes The Easy Way
9. Balancing eBooks and Physical Books Nursing Notes The Easy Way
- Benefits of a Digital Library
 - Creating a Diverse Reading Collection Nursing Notes The Easy Way
10. Overcoming Reading Challenges
- Dealing with Digital Eye Strain
 - Minimizing Distractions
 - Managing Screen Time
11. Cultivating a Reading Routine Nursing Notes The Easy Way
- Setting Reading Goals Nursing Notes The Easy Way
 - Carving Out Dedicated Reading Time
12. Sourcing Reliable Information of Nursing Notes The Easy Way
- Fact-Checking eBook Content of Nursing Notes The Easy Way
 - Distinguishing Credible Sources
13. Promoting Lifelong Learning
- Utilizing eBooks for Skill Development

- Exploring Educational eBooks
- 14. Embracing eBook Trends
 - Integration of Multimedia Elements
 - Interactive and Gamified eBooks

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