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| MEDICAL RECORDS – NURSING | | | | NO. 172G | |
| The nurses’ notes must contain observations made by nursing personnel.  Upon admission, detailed notes will be recorded by the nurse on duty to include the following:   1. Date, hour, how transported, and who accompanied 2. Age, general description, height and weight, skin condition 3. Ambulation status 4. Mental status 5. Continent status 6. Ability to communicate 7. Assistance needed in activities of daily living 8. General description of physical condition or handicaps 9. Other items or importance - i.e. breaks in skin or discolored areas, hygiene 10. Known allergies, adverse drug reactions and idiosyncrasies 11. Prosthetic devices   Exact time and date are used, and entries are signed by the nurse making the entries.  If unusual changes or incidents occur, a detailed explanation should be made using the exact date and time of entry. Incidents on which reports are completed are to be charted in detail in the nurses’ notes. | | | | | |
| Approved: | Effective  Date: | Revision Date:  3/17 | Change No.: | | Page:  1 of 1 |