

Continue



Nursing notes documentation examples

Charting is a nursing process that includes all the documentation required from nurses. This might include legal, professional, and institution-specific requirements. Some examples of charting include documenting medications administered, vital signs, physical assessments, and interventions provided. Nursing notes are a narrative written summary of a given nursing care encounter. This might include a description of a nursing visit, a specific care event, or a summary of care. A nurse's note is a form of charting that describes the nurse's decision-making process regarding the nursing care provided. Nursing notes are an important part of high-quality nursing documentation because they provide an opportunity for nurses to demonstrate their nursing knowledge and communicate the nursing process to other team members of the patient's interprofessional care team. A clear and comprehensive nursing note serves several purposes in nursing practice, both in patient care and to provide legal protection to the nurse writing the note. Reasons to write high-quality nursing notes include: Contributing to continuity of care for patients. Continuous care requires that the care provided to the patient is well-organized and that there is cooperative communication between nurses and other interdisciplinary team members. Continuous care contributes to patient-centered and safe care. Nursing notes allow all people on the care team to understand the patterns of patient care.1 Communicating care goals. Nursing notes are one place where the nurse can share the plan of care with team members. Nursing notes also allow others to see what interventions have been performed so far and what the outcome of those interventions were. Demonstrating the nurse's knowledge as required by professional regulators. Nursing notes are useful for demonstrating the knowledge, skill, and judgment required by the nurse's professional regulators, such as their college. In addition, if there is ever a concern about a nurse's license, nursing notes can be used as evidence of competent and safe practice in line with professional standards of practice. Contribute to quality improvement. Quality improvement projects across nursing settings may include a review of charts to understand the care process. Nursing notes that accurately and comprehensively reflect care delivered allow for more precise quality improvement initiatives. Contribute to nursing research. Nursing research projects may include a review of the chart. Similar to quality improvement initiatives, nursing notes that accurately reflect the care provided allow accurate research data to be collected. Legal protection. Nursing notes are included in the patient/client's permanent medical record. In the case of legal action related to care that a nurse provided or was involved in, nursing notes demonstrating that ethical and competent nursing care was delivered provide legal protection to the nurse. Reimbursing insurance claims. In some jurisdictions, insurance or other healthcare payers may directly reimburse nursing care. The nursing note may describe the rationale for reimbursable nursing activities in this case. These are just a few key reasons nurses should spend time and effort writing high-quality nursing notes. Different work settings may have an expected format or even templates for nursing notes. However, all nursing notes should include evidence of the nursing process. There are different templates for what should be included in a nursing note. Institutional or hospital policies may be in place on what should be included in the nursing note. However, it is the individual nurse's responsibility and a demonstration of nursing knowledge and judgment to decide what information is relevant or irrelevant for the nursing note. Nurses' notes usually include subjective (what the patient tells you) and objective (assessment/analysis) data. However, the nurse should be careful not to include judgments or their own opinion in nursing notes. It is important to include subjective data. However, subjective data should be written in quotation marks as statements made by the patient rather than objective facts. Two common templates for nursing notes use the mnemonics DAR and SOAPIE. Rather than absolute rules that describe how a nursing note should be structured, these two mnemonics are to be used as guidelines and to help the nurse remember what information should be included in their note. SOAPIE: subjective (what the patient tells you), objective (the nurse's assessment), analysis (interpretation of data), plan (what the nurse plans to do), implementation (what was done) and evaluation (how did the intervention work)? DAR: Data (both subjective and objective), action (what was done), response (how did the patient respond?) There are other acceptable templates for nursing notes. The nurse should check with their institution if there is a preferred or institution-specific policy regarding what should be included in the nursing note. Overall, what must be included in the nursing note is the nurse's own name, the name of the patient/client, the date and time of the note, and a demonstration of the appropriate nursing process. Nursing notes should also be made in chronological order. When writing a nursing note regarding a consultation with another healthcare provider, the nurse should include the name and designation of the other healthcare provider in addition to other components of the nursing note. In the following section you will find nursing note examples for the SOAPIE notes as for the DAR format. Patient Jane DoeDate: January 30, 2023 13:17: Patient reports pain to lower abdomen, rates pain at 7/10. She states that the pain has been increasing over the past half hour after her return from PACU. Mrs. Doe describes the pain as a "dull ache." (Subjective) Abdominal dressing is dry and intact. Bowel sounds are hypoactive X4. Most recent vital signs BP 114/82, HR 88, respiration 18, SpO2 94% on room air. (Objective) Patient experiencing post-operative pain related to recent hernia operation. (Analysis) Writer will offer patient education regarding PCA usage. (Plan) 13:26: Writer reminded the patient about how to use the button on her PCA to control her pain. Writer educated patient on the importance of managing post-surgical pain early to maintain comfort. (Intervention) 13:57 Reassessed patient pain after PCA education. Patient now describes that her pain is "subsiding." When rating her pain on the pain scale, patient now describes her pain as 2/10 which is acceptable to her. (Evaluation) This note includes all elements of the SOAPIE note and also is written at the time in which the activity was performed so there is a clear sequence of events. Patient: Jill DoeDate: January 30, 2023 0927: On assessment patient described increased shortness of breath related to her chronic asthma. Patient stated that she "uses her inhaler at home when I get short of breath." Patient respiration rate 22, SaO2 92% on room air, wheeze audible on auscultation of lungs. (Data) Writer administered 2 puffs (34 mcg) of patient's Ipratropium PRN inhaler. (Action) Patient states that shortness of breath now resolved. (Response) Writing high-quality nursing notes is a skill like any other nursing skill that takes time and focused effort to improve. With practice, nursing notes will become second nature as one pillar of safe and effective clinical practice. Here are a few quick practice pointers to improve your nursing notes. If you are using paper charting, ensure that the writing is legible. Illegible charting does not accomplish the goal of communicating care to the team and will not legally protect the nurse. Include both subjective and objective data. Including both subjective and objective data in the nursing note creates a comprehensive clinical picture. Remember to document significant interactions with family members, significant others, or substitute decision-makers. This might include interactions such as a family member describing the patient's medical history when the patient is unable to do so themselves. Limit your use of abbreviations. If you do use abbreviations, ensure that they are allowed for your institution. Document as soon as possible after the care interaction. It is preferable to document the care interaction as soon as possible, if the nurse waits to document, they may forget important details. If an error is made in documentation, do not delete, white-out, or attempt to erase the error. Instead, document that the first entry was made in error by drawing a line through and initialing for paper charting or following the correct procedure for the electronic medical record. For paper charting, use only black or blue ink, which is accepted in legal proceedings and is the easiest to read. Read other documentation on the patient! This could include other members of the interprofessional team or nurses' notes on the patient. These notes may include helpful information that may inform your care of the patient. However, a word of caution is that the nurse should never rely on another's assessment. Always double check the details of the patient's history and make your own assessment. To ensure high-quality nursing notes, the nurse might ask themselves if their note adequately answers the following question: "If another nurse were to take over this assignment, without a verbal handover, is there enough information here that they could provide safe and continuous care for this patient?"2 If the answer is no, the nurse might consider that more detail ought to be provided. College of Nurses of Ontario. Documentation, Revised 2008. Published online 2008. Accessed January 28, 2023. College of Registered Nurses of Manitoba. Documentation Guidelines for Registered Nurses. Accessed January 28, 2023. Published on February 4, 2023 As the primary point of contact for patients, nurses have a great deal of responsibility when it comes to documenting patient care. Nursing documentation is important for both practical and legal reasons. Improper documentation can ripen up an employer to liability and malpractice lawsuits, while proper nursing documentation helps prevent medical errors and promotes the delivery of high-quality patient care. Nursing Documentation Tips The following tips, recommendations, and best practices can ensure your documentation is as precise and useful as possible. Be Accurate. Write down information accurately in real-time. Inaccurate or misleading documentation is unethical and can harm patients. Avoid Late Entries. Late entries can introduce inaccuracies. If you have to document something after the fact, follow your employer's late entry policy and clearly mark late entry notations. Prioritize Legibility. Others must be able to read your documentation without difficulty. In addition, legible writing improves your credibility and authority. Use the Right Tools. Nursing documents can be used in legal proceedings. For that reason, use only blue or black ink and never erase information from a nursing document; make a correction and initial it instead. Follow Policy on Abbreviations. When you use abbreviations, be sure they're standard for your employer. Don't use obscure or colloquial abbreviations, which can be confusing to other people reading your documentation. Document Physician Consultations. Document all parties consulted during patient care, including names, times, responses, and any resulting actions. This is critical in case a need or emergency arises. Chart the Symptom and the Treatment. Make sure you document both the symptom and the treatment you administered to address it. Avoid Opinions and Hearsay. Don't write down opinions as facts. Use quotation marks to indicate an opinion and attribute the remarks to the correct person. Common Nursing Documentation Errors Common errors to avoid in nursing documentation include the following. Medication or Allergy Omission. Knowing what medications patients are taking and what they're allergic to is critical to a doctor's ability to administer the right treatment.. If a patient complains of a symptom, and that symptom is a side effect of a medication interaction introduced because the patient's medications weren't documented properly, it's that much harder to narrow down what's causing the symptom. Specify each medication administered, any permissions required, dosages, and patient reactions. Similarly, knowing that a patient is allergic to penicillin can be the difference between a real simple reaction with the right drug and creating more medical issues for the patient. Blank Spaces on a Chart. Blank space on a chart does more than fail to provide necessary information; it also creates ambiguity. Was a space left blank because treatment wasn't administered or because the nurses forgot to document the treatment that was administered? Blank spaces on charts can have legal ramifications, too. A patient who sues has a much stronger case if treatment wasn't documented, even if it was provided, than if there's no way to prove the treatment occurred. Unclear Orders. Just as you should never write unclear documentation, you should never accept orders you have questions about. If you disagree with or don't understand an order, seek clarification. It's better to take the extra time to understand what a patient's treatment should be. When documenting orders, leave out the guesswork; ensure that you are conveying information as clearly and precisely as possible. Improving Your Nursing Skills Nursing documentation is critical to effective communication within a patient care team. Rivier's Department of Nursing and Health Professions prepares students to become licensed registered nurses, nurse practitioners, nurse educators, and nurse leaders throughout the United States. For more than 30 years, Rivier University's Department of Nursing and Health Professions has prepared students to meet the rapidly changing demands of the healthcare environment. Rivier continually builds on its strengths, offering programs that provide students with individual attention, quality education, and numerous opportunities for practical experience. Rivier offers nursing degrees at the associate, bachelor's, master's, and doctoral levels. Students develop the skills and work ethic that prepare them to excel in today's rapidly changing healthcare environment. Request more information today to learn how Rivier can help you achieve your career goals. Written By: Darby Faubion RN, BSN, MBA If you are a nurse, you know one of the most important parts of our jobs is to document about our patient's status, the care they receive, and their response to any treatments. There are many types of documentation nurses and other healthcare professionals use. One type of documentation is a nursing progress note. If you are new to nursing or unsure about the different types of documentation, you may wonder, "When is a nursing progress note?" In this article, I will tell you what nursing progress notes, what they are, their purposes and disadvantages of using them. I will also share 5 perfect nursing progress note examples and how to write them. At the end of this article, I will answer some frequently asked questions about nursing progress notes to give you more insight into these important documents. Nursing progress notes are the records used by nurses to document patient changes and progress during hospitalization or while under medical care. A nursing progress note is a crucial record of events that occur in the time during which the patient is under a nurse's care. The notes are used to compare the patient's past and current status, communicate with members of the interdisciplinary team, and plan patient care based on the patient's current needs. The purpose of a nursing progress note is to relay information between nurses and other healthcare providers about events that occur during patient encounters. Nursing progress notes convey details about the chain of events in patient care directed at achieving anticipated goals and outcomes. Nursing progress notes are a narrative summary of the care provided by the nurse during a patient encounter. Nursing progress charts include nursing progress notes and other vital information relevant to the patient's status from admission until discharge. The nursing progress chart may have copies of laboratory and other diagnostic testing, medication records, and copies of the nursing care plan. Documentation is one of the most important jobs we have as nurses. When we document patient care thoroughly, we create a story that any healthcare professional should be able to follow. The following are three main advantages of using nursing progress notes as a form of documentation. Well-written nursing progress notes provide detailed information about a patient's progress for nurses and other healthcare team members to track changes in the patient's status. When we create progress notes that follow appropriate guidelines and include essential information, any member of our team should be able to read through past notes and determine if the patient is improving with the current plan of care or whether the care plan should be changed to meet their current needs. Nursing progress notes, when written correctly and in a timely manner, tell a story about your patient that includes vital information. As nurses, we can use the information from progress notes to determine which interventions are effective and whether new or modified interventions will be more effective. By reviewing previous entries from nurses and comparing the findings from your patient and your own, you can implement measures that promote better patient outcomes. One thing I always stress to nursing students is something one of my former nursing instructors told me, "If you did not chart it, you did not do it." Even if you remember providing care to a patient, if you do not document the care, in the eyes of the law, you did not do it. We use nursing progress notes to document changes in our patients from the time they are admitted to our service until they are discharged. Everything we do for them must be carefully documented. Although you may never experience having one of your patients being involved in a medical malpractice or negligence case, there is no way to know for sure. 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nurses use in nursing is known as SOAPI, which stands for Subjective, Objective, Assessment, Plan, and Interventions. The nursing narrative note should identify the patient's primary complaint or problem first then any secondary issues. Information such as vital signs or things you can visualize. After you note objective information, add subjective data you hear, see, feel, and do. While you want to be thorough, don't embellish. Keep it simple by stating the facts. The nursing narrative note should identify the patient's primary complaint or problem first then any secondary issues. Information such as vital signs or things you can visualize. After you note objective information, add subjective data you gather from the patient. Assessment notes should begin with objective assessment such as finger stick blood sugar results. The patient's loved one may have reported concern about the patient's altered mental status, which is subjective assessment information. Document how the patient handled any procedure. If you report the patient's status or other information to another team member, supervisor, or physician, document who you reported to. If that person has not yet responded, be sure to document "awaiting response." A nursing narrative note that does not have the nurse's signature is not complete. (Below are 5 excellent nursing narrative note examples.) 02/17/22, 1845. 79 y/o white female admitted to Med-Surg bed 4, DX recent Rt CVA. Vital Signs upon admission: BP 150/84, Pulse 78, Resp 20, Temp. 98.8 (oral). Patient is alert and oriented X3, responds appropriately to verbal commands and stimuli. Speech is clear with no signs of slurring. Patient's spouse reports some episodes of dysphagia. Soft mechanical diet ordered r/t increased risk for injury r/t dysphagia; typically feeds self with little to no assistance. PERRLA, 3 mm bilaterally. Unequal grips noted with obvious right-sided deficiency. Notable weakness in right leg and foot. Patient is at risk for falls due to limited mobility; side rails up X 4. Negative Homan's sign; at risk for DVT due to immobility, TEDS applied bilaterally, active ROM right leg, passive ROM left leg q4 hrs. Pedal pulses present, palpable, and strong bilaterally. Capillary refill Example #2: Assessment of Nursing Home Resident 2/14/22, 0730. Resident K.B. is an 80 yr. old black male, alert and oriented to person and place, but not oriented to date or time. Oriented patient to date and time verbally and wrote the date on a notepad by his chair. Calm, pleasant affect; denies complaints of pain, discomfort, or any new concerns. Skin is warm and dry to touch; no pallor or cyanosis noted; turgor fair. Bilateral upper extremities have some purpura, but the skin is intact. No edema noted in bilateral lower extremities. Peripheral pulses present x2 in upper and lower extremities. Patient is on O2 @ 2L per NC with no signs of skin breakdown near the nose or ears from the NC; lungs sound clear bilaterally, chest symmetrical. Approx. 300 cc clear, amber urine in urinal, urinal emptied and cleaned; Abdomen is slightly firm and tender to touch. Bowel sounds present in upper quadrants, but hypoactive in lower. Resident reports last BM "may have been a few days ago." Per CNA flowchart, no BM noted since 02/10/22. VS stable; BP 130/72, P 70, R16, T 98.6. Notified Ms. Head, Assistant Director of Nursing of abdominal tenderness and no BM, administered Fleet's enema x1 per standing order. -----M. Boles, RN@0830. CNA assisted resident to BSC; resident passed a large amount of hard, dark brown stool. Instructed resident about the importance of having regular bowel movements and measures to help promote healthy bowel habits, including increasing water and fiber in the diet and avoiding too much junk food. Resident voiced understanding and jokingly stated, "I guess I have to tell my grandkids to take it easy on bringing the sweets." Denies any complaints, pain, or discomfort at this time. -----M. Boles, RN Example #3: Nursing Narrative Note Example for Patient Recently Admitted and Found on Hospital Floor1/29/22, 1625. 69 y/o white female admitted this morning for observation following a fall at home. Pt. Found on floor in her room at beginning of this shift after attempting to go to restroom unassisted. Pt states she "wasn't sure if that light thing worked," referring to the call light. Assisted back to bed and assessed for injuries, none apparent. VS stable: BP 120/72, P 68, R 18, T 98.1. Alert and oriented x3. Instructed patient on the use of call light and demonstrated it works. Pt. Verbalizes understanding of the importance of calling for assistance before getting out of bed to prevent falls or injuries. CNA assisted pt. to restroom while nurse present and assisted back to bed. Side rails up x2, bed in the lowest position, call light within reach. -----M. Gray, RN Example #4: Patient with Complaints of Left Knee Pain02/12/22, 0930. 28 y/o African American female presents with complaints of left knee pain x3 days. Pt. Reports she was jogging three days ago (02/09/22) and felt a slight "twinge" in her knee but was not overly concerned at the time. She reports pain worsened within the last 24 hours despite the alternating warm and cold compresses and taking ibuprofen for the discomfort. Pt. rates scale 5/10 on the pain scale presently, VS stable: BP 118/78, P 76, R 20, T 98.6. Redness, bruising, and minimal swelling were noted around the left knee. Pt. denies falling. PERRLA. Bilateral hand grips equal. Denies dizziness or headache. Skin W&D to touch, turgor good. Capillary refill Example #5: Patient Complaint of Nausea, PRN Medication Administered01/06/22, 1345. Pt. c/o nausea denies vomiting but states he feels like he may be sick, requests medication to ease stomach discomfort. VS: BP 100/64, P 70, R 18, T 98.4. O2 Sat 98% on room air. Abdomen is soft, BS active x4 quads. Pt reports some abdominal tenderness when palpated. Continent of bowel; reports last BM 01/05/22, normal consistency, and denies any history of diarrhea or constipation. Promethazine 25 mg. (one) given po, as per prn order for N&V. Continent of bladder with 18 Fr. indwelling foley catheter with leg band attached to right thigh, catheter is patent to gravity with approx. 200 cc pale yellow urine in foley bag. Skin is warm and dry to touch, turgor fair. Peripheral pulses present x2 upper and lower extremities with good capillary refill. Skin is warm and dry to touch, turgor fair, no edema noted. No skin tears or lacerations noted, no integumentary compromise noted on visual assessment. PERRLA. Lungs CTAB. Mucous membranes pink and moist. -----M. Sikes, RN@1430. Reassessed pt. for c/o nausea and vomiting. Pt. reports nausea has subsided since taking medication at 1345. Denies vomiting or other complaints currently. Bed in low position, SR up x2, call light within reach. -----M. Sikes, RN BONUS! 6 Expert Tips for Writing an Excellent Nursing Narrative Note If you are going to document about patient care, there is no reason you should not write an excellent nursing narrative note. The following are some tips to help you create great narrative nurse's notes. 1. Document nursing actions immediately. The longer you wait between nursing interventions, assessments, and documentation, the greater the chance of omitting important details. 2. Keep Documentation Descriptive. The nursing narrative note should clearly state everything that is observed by or reported to the nurse. Descriptive documentation reduces the risk of information being misinterpreted. 3. Be objective. When creating narrative nurses' notes, it is important to keep an objective view. Although you may report subjective information as well, the things you observe (objective data) are crucial for decision making. 4. Add new information anytime it is necessary. Unfortunately, writing a narrative note and signing off on it does not mean you will not see a change in your patient's status or that the doctor will not issue a new order. Anytime something new occurs, create a new entry with the date and time and any pertinent information. 5. Convey Enough Information to Get Your Point Across. At times it may be necessary to write longer narrative nursing notes. The idea is to give enough information to make the message clear and cover all important aspects of the patient's status, needs, treatment, and responses without writing a novel full of frivolous or unnecessary details. 6. Make sure your handwriting is legible. If your facility still uses paper notes, this tip is especially important. Always remember, the patient's chart can be used as a legal document. If anything about your patient's care were ever called into question, you want to be sure your entries are clearly legible to information is not misunderstood. My Final Thoughts One of the most important things you can do is learn how to create exceptional nursing narrative notes. That is why we chose to address the question of how to write a nursing narrative note? By using the 5 nursing narrative note examples + how to write them featured in this article, you can create high-quality, professional nurses' notes. Remember, it is always better to document more than enough than not enough. Frequently Asked Questions Answered by Our Expert 1. Who Can Write a Nursing Narrative Note?Any licensed nurse can write a narrative nursing note. Additionally, nursing students may write narrative notes if their school's clinical contract allows it. Some clinical sites require nursing instructors or a staff nurse to review the student nurse's notes and sign beside them. 2. When To Write a Nursing Narrative Note? It is best to write nursing narrative notes as soon as possible after performing an assessment, administering a medication or treatment, or when any other pertinent event occurs related to the patient's care. Failure to write notes in a timely manner increases the chance of forgetting important information or forgetting to document altogether. 3. Can I Use Abbreviations in a Nursing Narrative Note? You may use abbreviations for medical terms in narrative nursing notes. However, it is best to use whole words whenever possible instead of abbreviations. If you have questions or are unsure about a proper medical abbreviation, always err on the side of caution and use whole words. 4. What Tense Do You Write a Nursing Narrative Note?The tense a narrative nurses' note should be written in varies. For example, if you are documenting at a patient's bedside, you can chart in what you see in the present tense. On the other hand, if you must document an incident that occurred, you would document it in the past tense. A general rule of thumb is to document as much as possible at the patient's bedside or outside their hospital room. However, there may be times when documentation cannot be done until you are at a nurse's station. It is always best to verify your facility's protocol. 5. Are Nursing Narrative Notes Handwritten or Printed? Narrative nursing notes may be printed or handwritten. The most important thing is to make sure they are legible. If you print more clearly than you write in cursive or vice versa, that is the method you should use. 6. How To Sign Off a Nursing Narrative Note? All nurses' notes should be ended with the nurse's signature and title. For example: Darby Parker, RN, BSN. Some facilities require nurses to include the date and time at either the beginning, ending, or both of each entry. Be sure to verify your facility's protocol for nursing documentation. 7. What Happens If I Forget to Write a Narrative Note in the Time It Should Have Been Written?Failure to complete nurse's notes promptly and accurately can have negative consequences for nurses, the organizations who employ them, and patients. If you forget to write a narrative nursing note and do not remember until you have left work, call your employer immediately and ask to speak to the nursing supervisor. Report the oversight and any information about the patients you cared for that day. Your narrative note should be written as soon as possible. Create a nurse's note which includes events and other information with the date they occurred in your note. Be sure to document on the note that it is a late entry. For example, "2/14/22@0800 (Late entry for care provided on 2/13/22) On 2/13/22, Ms. Riley called the nurse's station with complaints of nausea and vomiting. On assessment, the patient had no fever or signs of dehydration. Administered Phenergan 25 mg. one po, as per PRN order. Upon reassessment, Ms. Riley reports decreased sensation of nausea and no additional occurrence of diarrhea." 8. Should I Write About a Patient Crying in My Nursing Narrative Note?Nursing narrative notes should be written in a way that they create a picture in the mind of the reader. If your patient is anxious, crying, or frustrated, these indicate emotional distress, which can occur in response to a medication, upsetting news, or physical illness. Therefore, it is important to write about your patient crying. 9. How to Note Pulses on a Nursing Narrative Note?Vital sign assessments, including pulses, should be assessed and documented carefully. When you write about a patient's pulse rate, the following information should always be included: the amount of time you assessed the pulse, the pulse rate, pulse quality, and which pulse site you assessed. For example: "Right radial pulse rate 74 X1 minute. Pulse rate is strong and steady. Patient denies any complaints." 10. How to Describe Lab Results in a Nursing Narrative Note?Clinical lab results are used to monitor and diagnose health issues and screen for possible illnesses and diseases. Results should be documented carefully, as up to 80% of treatment decisions are based on those results. When documenting lab results in a narrative nursing note, the name of the test and date and time the test was performed, the method by which the specimen was obtained, when results were received, and to whom results were reported should be included. For example, "On 2/15/22, patient was instructed on proper procedure to obtain a midstream clean catch urine specimen for analysis. Patient obtained the specimen and was submitted to medical center lab for testing. Results received on 2/17/22 were as follows: Color-dark yellow, Clarity- turbid, pH 7.0, Leukocyte esterase- positive, Nitrite- positive, WBCs 20. All other ranges are within normal limits. Results faxed to Dr. Smith, primary care provider, and reported to charge nurse, Ms. Smith." 11. Can A Nursing Student Write a Nursing Narrative Note?Nursing students can write narrative nursing notes. Students learn the steps to complete nursing narrative notes and what information to include in the classroom where they practice documentation. Some facilities require a nursing instructor or staff nurse to sign behind a student. 12. What Are the Common Mistakes Nurses Make When Writing Narrative Notes?Some of the most common mistakes nurses make when preparing narrative nursing notes include failing to record a patient's response to a PRN medication, failure to document when a medication such as an antibiotic is completed, or a medication is discontinued, not recording the date and time the note is written and delaying documentation. Darby Faubion BSN, RN Darby Faubion is a nurse and Allied Health educator with over twenty years of experience. She has assisted in developing curriculum for nursing programs and has instructed students at both community college and university levels. Because of her love of nursing education, Darby became a test-taking strategist and NCLEX prep coach and assists nursing graduates across the United States who are preparing to take the National Council Licensure Examination (NCLEX).