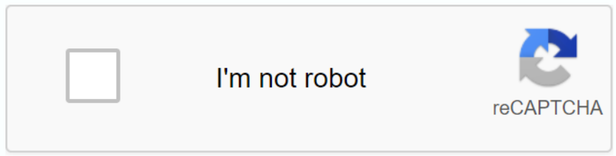


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# Historia clinica de enfermeria ejemplo pdf

Academia.edu no longer supports Explorer.To to Academia.edu wider and more secure, please take a few seconds to upgrade your browser. Academia.edu cookies to personalize content, tailor ads, and improve the user experience. By using our site, you agree to the collection of our information through cookies. For more information, click our Privacy Policy.× 1. This is the forensic medical document documenting identification data and processes related to patient care, in an orderly, integrated, sequencing and immediate manner of the treatment that the doctor or other professionals provide to Patient 2. medical conditions a proper medical document and a means to check the quality of care patients received. information for research and teaching purposes. 3. Each healthy being will install the templates for use in institutions within its jurisdiction, adapting its requirements to the diagram and designing them. 4. Identification of the patient (personal data of the patient and not of clinical history) Registration of health services (records all health services the patient had in which the appropriate health staff record it in a format suitable for them according to the treatment received. for example. (refers to patient auxiliary test results). 5. identification of person identification data is legally responsible for requesting entry. of the patient or his/her legal representative, names and surnames, signs and signs of the physician indicating detention or hospitalization 6. date and time of treatment. current effect: account of biological and oral functions. general personal effect; Family history. 7. general regional exam: head, neck, chest and lungs, breasts, cardiovascular system, abdomen, urinary tract gene system, nervous system. s a medical responsibility. 8. PCT name of essential signs of pretentious diagnosis or final diagnoses of the patient at the time of hospitalization. 9. date and time prescription therapeutic indications, nursing care diet as required, medications, dosage, frequency and route of management auxiliary laboratory tests, special tests, interconsultes, medical procedures or chirurgies. first name and last name, stamp and the doctor's signature. 10. medical condition describing the current state of the PCT, essential signs, if a particular procedure is done, the recommendations. for drugs and labs. 11. imaging results report. is the reason for and inter- the findings report and the Dx 12. In the case of special treatments, which may have a mental or physical effect An informed consent must be made and recorded for which the template whose content is described in this standard is used. She's exempt from the orders in emergency situations. The match was signed freely and volunteered by the patient or his/her legal representative as the case may be, entering names, surnames and cedula numbers. In the case of illiterate he placed your fingerprint. Signature names and surnames, stamp and tuition number of the professional responsible for care 13. , the date and manner in which the patient entered indicated and a brief description of the patient's condition. Essential functions. evolution during hospitalization. should not be descriptively specified. 14. of the medical product, dosage and way of managing a medical product. patient's first time, no clinical history date and date when it was terminated. hours it's managed. is also the patient care plan. names, nurse's signature, stamp and number of tuition. Patient identification data, identification data of the person legally responsible who applied for entry. Signature of the patient or his/her legal representative, first and last name, number of tuition, signer and signature of the physician indicating hospitalization or hospitalization 15. , weight income and decrease registration, according to shifts and the total day names and surnames, laenfermera's signature, stamp and registration number 16. should be prepared by the doctor in the making of the patient. you need to summarize the clinical picture that the patient presented in the treatment received. 17. The text will inform that the patient, or his legal representatives, have been informed of the risks associated with the withdrawal decision against an indication of a doctor and the waiver of any liability in the treatment of physicians and the health system. Signature of the patient or legal representative, fingerprint if illiterate and cedula number of one who applied for release 18. written documentation prepared by the nurse on the patient's observations, taking into account their physical, mental and emotional conditions, as well as the development of the disease and therapy. 19. : They tell us how the patient feels and how he expresses it. : These figures include measures of vital signs, diarrhea, and 20. keep a written record of changes in the patient's condition. to document the problems presented by the patient and the nursing care with the doctor at the patient's diagnosis. be used as a healthcare information tool as a forensic scientific document. Research 21. We can assess the evolution of patient disease. it serves as information to health staff as a scientific and legal document. can you... The patient's needs. 22. signature time signature content 23. observations made during patient hospitalization. patient's condition takes into account his physical, emotional state. medications and the state of hygiene and treatment provided objective and subjective observations effectiveness of certain medications or treatments provided instruction and support provided and evaluation of learning. 24. records of the nursing notes will be signed by the nurse who performs it. The signature includes the name and title. For example, professional nurse Alexandra Cardenas 25. patient's health by various nurses, e.g. pallor, presence of dark or cloudy urine. independent nursing interventions, such as special skincare or education for patients carried out at the initiative of the nurse. nursing home, such as medications or treatments prescribed by the doctor. 26. the effectiveness of any nursing intervention. measurements made by the doctor of health team members such as: nutritionist, physiotherapist, etc. In conclusion, a nursing approach indicates the causes and activities of the nursing care the patient receives, and describes what happens to the patient as a result of a medical diagnosis. 27. 1) Any change in behavior, for example: strong emotions, such as anxiety or fear. significant mood changes change in consciousness level 2) Any change in physical function such as: loss of balance loss of hearing loss or visual difficulty 28. 3) Any physical signs or symptoms that: It is severe, severe pain increase in body temperature gradual weight loss inability to urination after surgery 4) Any nursing intervention provided such as: medications provided in treatments Education 29. 's the patient? what the patient is looking at you and what does that mean? does that do to you? you know that? 30. that logic clear concrete accurate short objectives narrative with logical order vocabulary to be technical clear language avoid abbreviations 31. important that the lights in the logs be accurate and correct. Precise annotations consist of precise facts or observations, rather than observational opinions or interpretations. For example: it is more accurate to say that the patient rejected the drug, (fact) than to say that the patient is not cooperating. is essential to registry accuracy. If you think about how to write a word, you need to query a dictionary. 32. objective: registration must contain descriptive information i.e. what the nursing professional sees, hears, feels and smells. Example: Breathing 14 x'; With clean bilateral breath sounds. do not use good, normal or bad as they are subject to another person's interpretation, and do not use sample deductions: you have little appetite the fact that the sample should be recorded is to eat only the rice leaving the chicken, dessert and bread from the lunch tray. 33. subjective, the record should receive information obtained from the investigation, which is evaluated only by the person or the patient example: the patient refers to: I have abdominal pain. must be reliable, the information must be accurate to be reliable, for example: a 6-centimecond abdominal wound, with no more precise redness and more residal because a large abdominal wound heals well. 34. Do not use abbreviations or symbols, as they are confusing, for example: O.D. (once daily, once daily), can be interpreted as right eye or right ear, right omoplate, etc. Use correct spelling and readable letter: Correct spelling increases the accuracy of the documentation, so a readable letter helps to know the information, it is recommended to use printing when it is unreadable. Example: abdominal wound 6 s. Length, no redness 35. include observations by other therapists, made by other model professionals: surgical bandages removed by Dr. Henry Ramos. you must finish registering with the seal and signature, as well as the sister's signature N vocational school it should be concise: the information should be short, avoid unnecessary words for example: hot left toes, instead: patient with left toes who are perceived as very hot 36. the information needs to be updated: the information must be current and match the recorded day's shift. The following data should always be current: 1. Vital signs 2. Drug Management and Treatments 3. Preparation for diagnostic or surgical tests. 4. Entry, transfer, release or death. 5. Emergency Care. 37. must be confidential: the information should not be disclosed to other patients or other people who were not involved in the treatment, security is legally and ethically supported. not use draft or liquid paper because it has been viewed legally. move or put in illegal parentheses and sign on the side, in case of a mistake. leave a space between one record and another because it can be filled without the appropriate one. 38. This is a protocol that must be followed by the staff responsible for service to be performed at the end or beginning of the working day in which it informs what happened during their shift with patients and the treatment and procedures either their responses or if pending treatment remains a record in writing. 39. This is the procedure in which reports are received from each patient, including: diagnosis, evolution, treatment, activities and tests performed and/or I also get the existing items in the service inventory or report something that happened with them. 40. on the general condition of the patient, (auxiliary nurse). directly to the patient to identify needs. check the current status and changes that are displayed during the shift. to report nursing activities, medical procedures and diagnostic tests performed and/or pending. to develop the nursing care plan, depending on the patient's needs. , provide equipment assigned to the service by verifying news such as: (damage, loss, or requests made for maintenance). 41. on time upon receipt of the shift, as planned. the exact time of the shift receipt. direct observation, taking into account the intimacy and individuality of the patient. don't turn out to be reckless comments. ask family members to leave the room during the reception. say hello to the patient on his behalf. the report that clarifies doubts in time. to perform a cephalocaudal test, a fitness test. patient in the unit, observing the state of his consciousness. check vents, tsnat, etc. 42. to the patient by identifying him by name. to make a pslocodal observation. Determine the physical state and state of consciousness. listen carefully to the oral report is delivered, which includes: diagnostics, state of consciousness, degree of recruitment, type of oxygen administered, oral pathway type, if you have Orogastrica tracker quantity and type of drainage, intravenous fluids managed by peripheral or central line, type and quantity. 43. of a surgical wound: location, open or closed, presence or no signs of infection, or tube, quantity and characteristics. with plaster, check for dystal chrysal. and/or treatment will be performed or pending pending transfer, insurer approval or pending surgical procedures. doubt, please contact the nurse you are transferring. 44. is listed in nursing notes reading the following items: bed number, name, diagnosis, oral pathway type, type of managed oxygen, Diuresis, affidavit, vomiting, fluids and managed intravenous observations (diagnosis and/or therapeutic aids performed or pending, pending transfer, insurance approval or pending surgical procedures). a doctor's book on any changes in the patient's clinical condition (vital signs, changes in consciousness, etc.), during childbirth on duty. check the items and equipment recorded in the service inventory, subsistence, quantity, and Them. in the book with a clear letter, date and appropriate shift, of the items and equipment received as their observations. Sign with a clear letter. 45. This is the procedure in which the patient's clinical condition is fully reported, including vital signs, state of consciousness, oral resistance, tests taken and available and available designs, surgical wound characteristics and activities performed. As for the service, you must report all kinds of maintenance news, damage, inventory verification. 46. : The nursing activities of the treatment must be informed and continued to be carried out in the patient, in medical procedures and in the treatment of diagnostic tests performed or pending. (e.g. surgeries, outside the hospital pending tests, intercontinentals, clinical laboratories, etc.) provide an inventory vendor for items assigned to the service. 47 patient into the unit. if you sleep waking it up, if your head is covered to discover it so that people who accept and provide shifts understand the conditions under which the patient is. to identify the patient by name, not by diagnosis or bed number. remember that the yerti pathways are permeable, healing is performed, etc. keep bottles of drainage clean and in good condition. 48. F 0019 Nursing Records, AC-F-0020 Format AC-F 0021 in Mental Health Patients; Indicating the patient's time and conditions at the end of the shift, perform the fluid balance, registration of drugs format AC-F 022 – a sheet of treatments and changes introduced during the shift. your full name in a readable letter at the end of nursing notes in format AC-F 019, AC-F020 or AC-F021 in the case of a mental health patient. Seal place. when the patient's reference was delivered: name and bed number. , of consciousness, of recruitment, type of oxygen administered 49. oral pathway, if you have a amount of gastric gold test and a type of drainage, intravenous is managed by a peripheral or central line, type and quantity. of the surgical wound: location, open or closed, presence or not of signs of infection, or tube, quantity and characteristics. with plaster, check for dystal chrysal. and/or treatment will be performed or pending pending transfer, insurer approval or pending surgical procedures. provide the patient clean and comfortable. leave the unit in order. documentation in the receipts and delivery book on duty the news regarding income, disabled beds, damaged or pending equipment, infrastructure changes and the situation in which you leave the stop cart. 50. Patient's Confession Hospital services for various health conditions. It is a shared responsibility with the Admissions Office, administrative staff and medical staff. This can be done through the emergency department or through external consultation. 51. communicate directly and appropriately with the patient and family by providing general information and guidance within an inpatient area. immediate nursing care based on the patient's health. used established records to perform patient hospitalization. 52. the patient, as much as possible to confront identification with the identity document. to cordially greet the patient and his family and identify with their name and their person. specify the assigned bed or room and give you guidance on the service (bathroom, visiting hours, rules and mechanisms for receiving a business card. 53. the patient arrives at the ER, provide primary care and then comply with the procedure. to assess the patient's health and check the medical history. to help the patient locate himself on the assigned site. if necessary, bathe the patient, the appropriate health team, and the unit partner. Family guidance on visiting time, mechanism for receiving your business card, medications and necessary items for personal use. 54 the patient's objects to the family. if the patient enters alone, make a relationship of the value objects and give them to the service manager. your medical history and make sure it comes with all the established records. take vital signs and record them. look at the patient's general physical conditions. to ask the patient about their personal habits and religious practices. 55. patient comfortable and safe in his bed. , operate and obey medical instructions according to the patient's needs. can prepare the nursing care plan. enter all the observations and data obtained in the different records. to notify the head nurse or doctor of the patient's entry. to organize medical history and leave it in its rightful place. 56. to engage in cardiac care with the patient and family, reduces their anxiety and eases family communication with the work staff. patient's location and guidance allows for adjustment during hospitalization. , clear and timely timely to establish effective treatment. help reduce anxiety and make it easier to adapt to the hospital environment. 57. This is the patient's departure from an outpatient room for each of the following destinations: home, other health institution, other service, amphitheatre, voluntary discharge, permit or escape. 58. provide nursing care to the patient when Causes service or institution. explain to the patient and the family the health conditions and treatment that will be performed at their new destination. steadily and complete the records set by the institution to carry out the patient's off. steps necessary to transfer or refer the patient to another service, healthcare institution or amphitheatre. 59. returned home on a medical for referral to another institution fugue high risk voluntarily assisted by death 60. Gender: P. Gill: 84 years old. Date of investigation. 04/02 A patient with vascular dementia of several years of evolution, with a complete loss of functional independence, soaking in bed for about 3 years, for the regular treatment of her 2 daughters, carried in addition to extended cardiomiopathy, currently serving with Digoxin, Furosemida, Enalapril, AAS and baso active in the brain. For 10 days she had difficulty swallowing food, exhibiting access to coughing during consumption, and for 48 hours, fever, advanced respiratory distress, constant sleepiness and lining anticipation. Biomedical value stream status. Patient in general ill condition, with incomprehensible language, with severe malnutrition, pale skin, dry and inflexible, with persistent folding, general muscle hypotrophis, dry mucous membrane, litosis, den dentural teeth in poor condition; It displays the ingurgitated neck veins, nasal flutage, intercostelic attraction, lip blue and under-ungueal. Vital signs. Heart rate: 90 x' -FR: 26 x' -T A: 110/70 mmHg -Melody house temperature: 36.8o. A. Rasp. Thin sub-subs are dispersed to control lower fields; Some expiration beeps; Frank hippo ventilation of beloved bases. 61. A 14-year-old patient, natural and from the urban area of Bokarmanga, student, informants: patient and parents. Reason for counseling and high fever current disease, chill, severe headache, myalgias, non-humps, asthenia, adinamia, 3 days of evolution. Epistasy, abdominal pain, vomiting, intense thirst, rash with falafelentr itching, one day of evolution. Physical test weight: 45 c Size: l.65 m, T: 37.20C. FC 120 x Min FR 20 x Min Cell 90/60. Bad general situation. Dry oral lining, over. Macular exantoma is common, not jaundice. Positive arterial blocker test. T.I. in the extremities and neck. Episicsus. Pain for eye movements. Right undersympety, reduced ultrasonic fluorite, no astraators, no cyanosis. Abdomen is swollen, painful for banging, acetyte wave, heavy at 4 s. x DRCD. Neurological: Drowsy, no signs of memmingogenic or pathological reflexes. 62. A 20-year-old woman with no personal history of interest, smokes from the age of 16 out of 10 cigarettes a day, without other toxic habits, vaccination is correct during it And his usual treatment is taking oral contraceptives. Healthy, until she consults at our main treatment center for a scattered abdominal pain of vocal nature, thermotrade fever up to 39oAx of three days of evolution and an episode of vomiting of the eating nature, also hosted a certain odinophagia, but her bowel leg was intact and also does not refer to hethey syndrome. During aneminza he is asked for family epidemiology, work and travel, and does not relate to any history. Two days earlier she had been treated in an emergency department at a hospital, where she underwent the following supplemental tests: Mammogram: Hto 39'2, Tess 4'37, HB 13'7 Lococytes 6'50; Platelets 342. Biochemistry: Glucose 84, Urea 51, Criticalinin 0'7, Sodium 138, Potassium 4'2 Urine Tattoo: Negative Rx Abdomen, Sinuses and Torix: No Changes Abdominal Ultrasound: No Changes Diagnosis Was Possible Ryriasis. 64. Anamnesis abdominal pain has been occasionally for about two months and is exacerbated by deep inspiration, focusing on the right hypochondrium. The cough he presents is morning and refers to him for his smoking habit, has not changed the color of his expectancy, no anorexia or weight loss, as well as thenia blaming him for her work. He was studied: cell index 38'2 Ax, cell 120/70, showing good moisture and color of skin and m² membranes. 65. Head and neck: oropharynx with very high hyperamia, no almond exudados, normal oral, non-adenopathic • ACP: rhythmic, breathless, mild hypoponzis on the right base • Abdomen: discomfort to the plefa of the right hypochondrium, but without Murphy's mark, Bloomberg was negative. the rest of the scan was normal. in the face of diagnostic suspicion, a new urgent orcas test was required and this time showed proper tsidal effusion and a test to read Mantoux was carried out at 72. Given the patient's involvement, he's sentenced to entry. Income.