Nursing Narrative Shift Note

For end-of-shift and event documentation. Tells the patient story chronologically, with the fields that make it defensible.

Patient / MRN	
Date & time of entry	*Date _____ · time _____ : _____ · late entry? Y / N*
Unit / room · shift	*Unit _____ · room _____ · shift _____*

1 Assessment

Findings on your assessment this shift

2 Interventions

What you did, when, and why

3 Patient Response

How the patient responded · reassessment

4 Communication

Provider notified · orders received · family updated

Provider notified	*Name _____ · time _____ : _____ · method _____*
Response / orders	
Patient and family education	*Topic _____ · understanding verbalised Y / N*

5 Safety

Falls · restraints · skin · lines

Safety checks	*Fall risk score ___ · precautions in place Y / N · skin assessed Y / N*

6 Attestation

Signature	*Nurse signature _____ · name and credentials _____ · date and time signed _____ · co-signature if required _____*

Before you sign. Date, time, and patient identifier on every entry. Chart what you observed and what you did, not conclusions you cannot support. A **late entry** carries the current date and time, is labelled as a late entry, and is signed. To correct an error, draw a **single line** through it so it stays readable, then date and initial the correction. Never erase, overwrite, or obscure an original entry. Sign with your name and credentials per your facility and state policy.