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Time-consuming Inconsistent
quality demonstrated Used in
typical "source records"

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Documentation hospital charts with information organized by information sources

Examples & Functions of Nursing Documentation

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30+ SOAP Note Examples
(Blank Formats & Writing
Tips) SOAP note (An acronym

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Documentation, objective, analysis or assessment and plan) can be described as a method used to document a patient's data, normally used by health care providers. This data is written in a patient's chart

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Documentation and uses common formats. The four parts are explained below.

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The Nursing and Midwifery

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Conduct states that we all
must "keep clear and
accurate records".

Documentation and record-
keeping featuring is a
prominent feature in within
the NMC Code of Conduct. It

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Documentation is your duty as a nurse or midwife to keep your notes up to date, not only to protect your patients, but also to stay on the right side of the law.

How to write in Nursing

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Notes | Nursing Notes

sample Charting Entry: date:
time: Temp 98.4, radial
pulse 72, strong and
regular. Respirations deep
and regular at 14 per min.,
bp 124/66. Oriented x4.
Perrla, neck veins flat at

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45 degree angle. Apical pulse s1,s2 clear without rubs or murmurs. Radial and pedal pulses strong and regular bilaterally at 70 per min. Hand and leg strength strong bilat.

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c6350otyuybc8k uxb03q8dhr9
0mek6twjqpr xhqijeit7pchu

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103oxcabwe287 1zjq9ko4vdtm

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v34o6309nqdipj fr29y7sejh
t0iaavpyb9 rxf52itl12bha ...

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Example of real time
progress note entry: 09:40

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template.

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respirations. No accessory

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muscles used. Breath sounds
clear in all areas. GI :
abdominal shape, appearance
bowel sounds x 4 tenderness
last BM, usual pattern.
Abdomen round and soft.
Bowel sounds x 4. Tenderness
only in compromised areas.

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No BM since the day before
operation (3/4/08).

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provide continuous care for patient in the healthcare setting, and they are also the perfect way to wrap up your shift with ...

**Charting Made Easy: Example
of The SOAPI Note**

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practice workbook page 3

2. Now, consider your
documentation example and

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note down your thoughts related to the following questions:

- How effectively did you communicate information for other health care professionals?
- Does the information you recorded (and the way you recorded

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it) support the goal of
provision of ...

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Documentation, such as patient care documents, assessments of processes, and outcome measures across organizational settings, serve to monitor performance of health care practitioners' and the

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Documentation
health care facility's compliance with standards governing the profession and provision of health care. Such documentation is used to determine what credentials will be granted to health care practitioners

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within the organization.

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