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documentation even. Heres my you see, hear,
problem: I need EXAMPLES
of how things are WORDED
when charting. Anyone Page
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The nursing process requires assessment, diagnosis (nursing), planning, implementation, and

evaluation. 2 This process must be reflected in the documentation of interactions with the patient during care. Many facilities have streamlined this critical thinking process with acronyms such as PIE (Problem-Intervention-Evaluation), which provide a simplified process to remind the nurse what needs to be documented in accordance with board of nursing directives.

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The legalities of nursing

documentation :

Nursing2020

Nursing 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 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 within the organization.

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nursing care performed or not performed by a nurse. Documentation & Reporting in Nursing - Nurseslabs
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example would be: 10am. P.
- Nausea. "I feel like I'm
going to throw up." I. -
Abdomen rounded and soft
with bowel sounds all four
quadrants. Remains NPO.
IV fluids infusing at
100cc/hr. Medicated with
Compazine 10mg IM for the
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The most common types of nursing documentation include the following:

Nursing Progress Notes.

Nursing progress notes are one of the most frequent and time consuming of nursing documentation tasks. In addition to the historical narrative notes, several other systems have been devised over the years to save time, improve documentation and standardized nursing notes.

Types of progress note documentation systems include: Narrative Nursing

Notes. Traditional

Nursing Pie Documentation

ADPIE is an acronym representing the five phases of the nursing process. Pronounced “add-pie,” it’s considered standard-of-care for nurses and helps you remain professional and effective. The five phases

are: Assessment When you first encounter a patient, you will be expected to perform an assessment to identify the patient’s health ...

Good documentation is an important part of improving both patient care and nursing practice. Proper documentation promotes safe patient care, good communication among staff members, and the advancement of the nursing profession. To find out more about the specific documentation standards where you practice, contact your state board of nursing.