

# Free reading Nursing charting guidelines (2023)

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3 4 5 6 7 lippincott nursingcenter s team of clinical experts have reviewed condensed and  
extracted key information from lengthy practice guidelines and put them into streamlined  
comprehensive guideline summaries charting doctor s orders must be noted medication  
administration must be documented on medication sheets and vital signs must be graphed flow  
sheets must be checked off filled out or initialed admission assessments may involve primarily  
checklists or may require extensive documentation documentation clear comprehensive and  
accurate documentation is an integral part of safe and effective nursing practice documentation  
provides a record of the judgment and critical thinking used in professional practice and provides  
an account of the nurse s unique contribution to health care the documentation practice standard  
describes documentation matters toolkit providers are responsible for documenting each patient  
encounter completely accurately and on time because providers rely on documentation to  
communicate important patient information incomplete and inaccurate documentation can result  
in unintended and even dangerous patient outcomes

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