Introduction: Documentation of patient records is key to all areas of nursing practice.title) (7) Unfinished documentation should be signed before starting a new page.Effective documentation requires clear ,concise accurate recording of all client and other significant events in an organized and chronologic fashion representative of each phase of the nursing process.their families and health care organizations administration of tests, procedures treatments, and client education and result of or client's response to, diagnostic tests and interventions Eggland & Heinemann.Reflect ethical & professional conduct and responsibility Standards of Nursing Documentation (1) Use only your institution's approved forms.(2) All nursing documentation must be written in black or blue ink (including narcotics & blood transfusion) (3) Place the patient identification (sticker) on every page or record patient's identification on each page (full name, age, sex, hospital no., bed no........etc) (4) Use standard date at the beginning of each shift (day, month and year).(security system) Standards of Nursing Documentation Computerized Charting Has become one of the most widespread trends in nursing documentation.1994) Standards of Nursing Documentation 10) Use only standard and institution's approved abbreviations.(12) All documentations must be eligible, relevant, accurate & concise (e.g. clear hand writing).Policy on Verbal Order Documentation Carefully follow your institutional policy for Verbal orders art on We del stded when no physicians are available on site and in case of emergency.(11) Do not alter previous documented pt. records.1800 hours.

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