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Clinical documentation

Core Nursing Essentials Core Clinical Concepts

Record observations, decisions, care, response and escalation promptly and objectively. Correct errors using the approved audit-preserving process; never conceal a mistake.

For educational purposes only.

Introduction & key concepts

Record observations, decisions, care, response and escalation promptly and objectively. Correct errors using the approved audit-preserving process; never conceal a mistake.

Nursing responsibilities

- Check identity, consent, the relevant observations and the purpose of the assessment.
- Record the finding, context and response using the approved clinical record.
- Escalate uncertainty or deterioration to the responsible professional; do not use a study note as a standing treatment order.

Clinical example & examination focus

In a viva, explain clinical documentation in your own words, identify the observations needed and state a limitation. Compare the finding with the patient's baseline rather than assuming one number or label gives a diagnosis.

Quick Revision

Record observations, decisions, care, response and escalation promptly and objectively. Correct errors using the approved audit-preserving process; never conceal a mistake.

Frequently asked question

Can this summary replace practical training?

No. Use your prescribed learning material and the institution's current protocol with qualified supervision.

References & review status

- Open RN - Nursing Process (https://wtcs.pressbooks.pub/nursingfundamentals/chapter/4-3-assessment/) - Nursing Fundamentals 2e, 2024. Original concise explanation of assessment, ADPIE and documentation concepts; no reproduced checklist.

Sources checked for the stated scope on 26 November 2026. Original study synthesis; independent clinical review is not claimed. Source attribution is not a copyright-clearance certificate.

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