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INTERNATIONAL STANDARD ON AUDITING 230 AUDIT DOCUMENTATION ...

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The documentation in the health system takes place in order to fulfill administrative and clinical purposes, while in the bibliography various nursing documentation types are reported: notes of narrative type, the files which are directed to the problem, the files which are directed to the source, the recording by exception, the Kardex, the recording of each case and the electronic files.

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Proper and accurate documentation is essential to avoid types of nursing documentation errors, and for helping to avoid patient deaths or increased liability for the caregiving facility, physician, or nurse. This is where EMRs come in, and where effective EMR training of nursing students can play a vital role.

2 Improving Nursing Documentation and Reducing Risk 2016 CPro Chapter 1 include QSEN and the NOF core competencies. The NOF defines communication as the ability to "interact effectively with patients, families, and colleagues, fostering mutual respect and shared deci-sion-making, to enhance patient satisfaction and health outcomes."

This Policy addresses the documentation standards for all Specialty Mental Health Services except Psychiatric Inpatient, PHF and Nursing Facility Services. Types of Providers: The type of provider contract determines the documentation standards and method of claiming for reimbursement of services. Each provider's contract specifies which

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