

Clinical Record Documentation Standards for community health nurses:

- 1. Contents of a clinical record must meet all regulatory, accrediting and professional organization standards. Common requirements specific to nursing documentation include, but are not limited to:
 - a. The nursing assessment and care provided;
 - b. Informed consent for any/all procedures;
 - c. Teaching provided either to the client directly or to his/her family; and
 - d. Response and reaction to teaching.
- 2. Determine and assure adequate security measures for the entire documentation system, electronic and/or paper.
- 3. Record the client's name on every page.
- 4. Record the date and time on all entries.
- 5. Sign every entry with full name and initials of professional and educational titles (e.g., RN, APRN, FNP).

Clinical Record Documentation Standards Valueoptions

Brendan G. Carr



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