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records”. Documentation and record-keeping featuring is a prominent feature in within the NMC Code of Conduct. It is your duty as a nurse or midwife to keep your notes up to date, not only to protect your patients, but also to stay on the right side of the law.

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Scenario Below is an example of an OSCE which is based in the community setting. Other scenarios will be based in a variety of care settings including Hospital based care. The OSCE covers all ages from children to

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Mock Scenario for Nursing Associate OSCE

Nursing documentation: How to avoid the most common medical documentation errors When it comes to nursing documentation, knowing how to accurately document a patient can literally mean life or death. Some of the most common medical documentation errors can also be the most disastrous.

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accordance with the steps of the nursing process. Nursing documentation is the principal clinical information source to meet legal and professional requirements, care nurses' k

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both patient care and nursing practice. Proper documentation promotes safe patient care, good communication among staff members, and the advancement of the nursing profession. To find out more about the specific documentation standards where you practice, contact your state board of nursing.

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