

**Proper documentation in the patient's medical record is crucial. All patient's interventions and management are reflected in the patient's medical record by all the rehabilitation team. Documentation should be carefully and fully made. Writing on a patient's chart should be taken seriously as providing quality patient care. Failure to report matters adequately may be evidence of negligence & possible legal action. The rule is, what is not documented, is not done. Documentation should be concise and specific, stating facts and findings, refrain from writing subjective statements or personal opinion. Following the proper rules and guidelines for documentation will not only protect the patient, but you the employee as well.**

# Long Term Care Documentation Standards

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RN, MSN**



## **Long Term Care Documentation Standards:**

## Unveiling the Energy of Verbal Art: An Emotional Sojourn through **Long Term Care Documentation Standards**

In a world inundated with screens and the cacophony of quick communication, the profound energy and mental resonance of verbal artistry often diminish in to obscurity, eclipsed by the regular assault of noise and distractions. Yet, set within the lyrical pages of **Long Term Care Documentation Standards**, a captivating perform of literary brilliance that pulses with fresh feelings, lies an wonderful journey waiting to be embarked upon. Written by a virtuoso wordsmith, this enchanting opus courses visitors on a psychological odyssey, softly exposing the latent potential and profound impact stuck within the complex web of language. Within the heart-wrenching expanse with this evocative analysis, we shall embark upon an introspective exploration of the book is central themes, dissect their captivating writing style, and immerse ourselves in the indelible effect it leaves upon the depths of readers souls.

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