PROFESSIONAL WRITING · STUDY GUIDE

Exam 7 Study Guide

This guide covers chapters 13 and 14, the last two in the course. First, writing in healthcare: the chart and its readers, the clinical note, handoff with SBAR and I-PASS, corrections and dose safety, and writing for patients and the safety system. Then editing and quality control: three passes, sentence-level cuts, review that helps, verification, and a small quality system. Work one chapter at a time. Read the "what to know" paragraphs, copy the tables out by hand, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts every structure and number in one place.

WHAT THIS GUIDE COVERS

- Chapter 13 · the six readers of the record, the four beats, the chart as evidence and the audit trail, SOAP, APSO, DAR and charting by exception, observation versus inference and stigmatizing language, SBAR and I-PASS, read-back, corrections and late entries, unsafe abbreviations and copy-forward, open notes, discharge instructions and incident reports.
- Chapter 14 · three passes and the levels of edit, revising tests, cutting the run-up, nominalizations and expletives, the passive as a tool, one sentence one job, directed review and usable comments, taking feedback, verifying high-risk elements, style sheets, checklists, proofreading techniques, version control and sign-off.

CHAPTER 13

Writing in Healthcare: Documentation and Handoff

Read it in full: **Chapter 13 in the textbook**. Practice it in the lab: **The 2 a.m. Call: SBAR and I-PASS Composer** and **The Discharge Translator**.

What to know

In healthcare a sentence can change a dose. The chart has at least six readers: the next-shift clinician (hours later; what changed and what to watch), the consultant or covering provider (your reasoning), therapies, pharmacy and dietary (function and response), the coder (specific diagnoses

and acuity in your words), quality and accreditation reviewers (timed evidence that required assessments happened), and the attorney, patient or family (a consistent account years later). Every entry answers four beats: what did I observe, what did I think it meant, what did I do, and what happened next. The third and fourth beats are the ones most often missing.

The chart is evidence, generally admissible as a business record because it is made contemporaneously by people with a duty to record accurately. "If it isn't documented, it didn't happen" is a teaching slogan: undocumented care is not legally nonexistent, but it is legally expensive. Never chart care that did not occur; that is falsification. The electronic **audit trail** records who opened and edited what, and is generally discoverable. Purpose drives format: a routine assessment, an event note, a procedure note, a communication note and a discharge summary are different genres. The clinical record documents the patient; it does not adjudicate the system.

Formats are devices for not forgetting a beat. **SOAP** (Subjective, Objective, Assessment, Plan) sorts by source; **APSO** puts assessment and plan first; **DAR** or focus charting (Data, Action, Response) follows one problem through the intervention loop; PIE is a cousin; narrative is flexible and poor at retrieval; charting by exception records only deviations from a defined standard and is risky if that standard is not defined. "A: Pain" is not an assessment; state what you think and what you ruled out.

Separate observation from inference and own the inference. "Drug-seeking", "non-compliant" and "rude" are conclusory labels. Goddu and colleagues (Journal of General Internal Medicine, 2018) found that stigmatizing language in a vignette led trainees to more negative attitudes and less aggressive pain management; a 2021 JAMA Network Open analysis found such language in real notes, unevenly distributed. Replace the label with behavior, time and number; quote the patient; mark judgment honestly ("appears", "consistent with"). Lead with the time, use numbers, name the actor for anything accountable, close every notification loop, and drop editorial asides.

A handoff transfers information and responsibility. **SBAR** (Situation, Background, Assessment, Recommendation) came from U.S. Navy submarine communication, was adapted at Kaiser Permanente, and is part of AHRQ's TeamSTEPPS; use it to escalate one concern and get a decision. Novices skip the R. Gather vitals, labs, last doses, allergies and code status before you

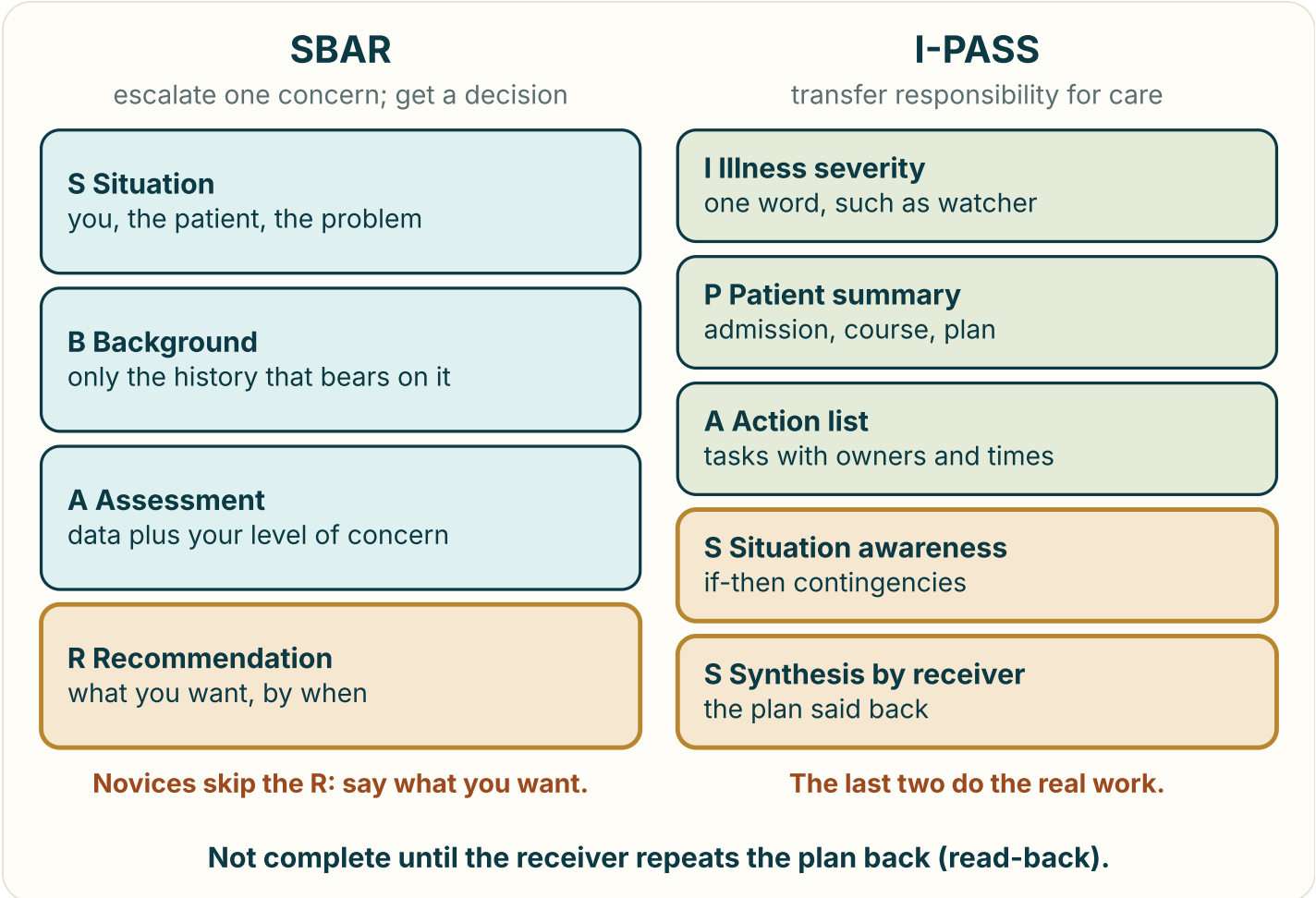
call, and say your level of concern in words. **I-PASS** (Illness severity, Patient summary, Action list, Situation awareness and contingency planning, Synthesis by receiver) was published by Starmer and colleagues in NEJM in 2014; the nine-site pediatric study reported a 23 percent drop in medical errors and 30 percent in preventable adverse events, while later work has been more mixed. Write contingencies as if-then thresholds. Synthesis by receiver is the same principle as **read-back**.

Correct openly. On paper, a single line through the entry, a reason, initials, date and time; electronically, the amendment function, never a silent edit. Label late entries with both times. Mark wrong-patient entries per policy and document in the right chart; do not change a colleague's entry; patients may request an amendment and file a statement of disagreement. Never write a trailing zero (1.0 mg) and always a leading zero (0.5 mg). Avoid U, IU, QD, QOD, MS and MgSO4 abbreviations, cc, µg, SC/SQ, D/C and HS. Copy-forward produces fossils (one analysis found only about 18 percent of note text was entered by the author): copy structure, not conclusions.

Since April 2021, Cures Act information-blocking rules mean most notes post to the patient portal promptly, with narrow exceptions. Stay honest but precise: "BMI 34" instead of "obese"; describe a history limit rather than "poor historian". Discharge instructions target roughly a sixth to eighth grade level, convert categories into observable events with numbers, put the trigger before the action, and close with teach-back documented as what the patient said and did. An incident report is a separate safety document: facts only, and never referenced in the chart. Write every message as if it will be printed.

LOCK THESE IN

- Four beats: observed, concluded, did, what happened next.
- The chart is evidence; undocumented care is legally expensive, and backfilling is falsification.
- SOAP sorts by source; DAR follows one problem; charting by exception needs a defined standard.
- Replace labels with behavior, time and number; own your inferences.
- SBAR to get a decision (do not skip the R); I-PASS to transfer care.
- Contingencies are if-then thresholds; synthesis by receiver is read-back.
- No trailing zero, always a leading zero; label late entries with both times.
- Chart and incident report are separate lanes; never reference the report in the chart.



Two handoff structures, two jobs. SBAR gets a decision about one concern; I-PASS transfers responsibility. The gold rows are the ones novices most often skip.

Key terms and comparisons

Format	Structure	Best for
SOAP	Subjective, Objective, Assessment, Plan	Separating report from measurement
APSO	Same content, assessment and plan first	Readers who want the conclusion first
DAR / focus	Data, Action, Response	One problem through its intervention loop
PIE	Problem, Intervention, Evaluation	A close cousin of DAR
Narrative	Chronological prose	Flexible; poor for retrieval
Charting by exception	Only deviations from a defined normal	Fast; risky if normal is undefined

Unsafe expressions

Do not write	Misread as	Write instead
U or u	0, 4 or cc	unit
IU	IV or 10	international unit
QD / QOD	QID; QD or QID	daily; every other day
1.0 mg	10 mg	1 mg
.5 mg	5 mg	0.5 mg
MS, MSO4, MgSO4	Morphine and magnesium confused	morphine sulfate; magnesium sulfate
µg	mg (thousandfold)	mcg
D/C	Discharge or discontinue	discharge; discontinue

Labels into observations

Weak charting	Better charting (shortened)
Patient is drug-seeking.	Requested more pain medication at 0810, 0905, 0940; last dose 0745; reports 8/10.
Non-compliant with insulin.	Took about 3 of 7 evening doses; ran out Tuesday; could not afford refill.
Refused to ambulate.	Declined at 1400 citing dizziness; orthostatics 128/76 to 98/60; provider notified.
Tolerated procedure well.	Stable throughout; 2/10 discomfort; no bleeding; post vitals with times.

Worked cases

WORKED CASE 1 · A FOUR-BEAT EVENT ENTRY

At 0215 a patient reports new shortness of breath. Write the entry so all six readers are served.

STEP 1 · OBSERVED

"0215: Patient reports shortness of breath, new since 0130. RR 28, SpO2 88% on room air, accessory muscle use, bilateral crackles to mid-lung."

STEP 2 · DID

"Placed on 2 L nasal cannula, head of bed elevated to 45 degrees."

STEP 3 · WHAT HAPPENED NEXT

"SpO2 94% at 0225."

STEP 4 · CLOSE THE LOOP

"Paged Dr. Okonkwo 0218; no response at 0230, escalated to charge nurse." Every notification has an outcome.

WORKED CASE 2 · BUILDING AN SBAR CALL

A post-op day one patient at 0210 is 38.9 Celsius, heart rate 118, blood pressure 88/52, respiratory rate 24, SpO2 94% on room air, more distended and newly confused. Build the call.

STEP 1 · SITUATION

Your name and unit, the patient and room, and the problem in one sentence: febrile and hypotensive in the last two hours.

STEP 2 · BACKGROUND

Only what bears on it: age, diabetes, atrial fibrillation on apixaban, uncomplicated surgery, afebrile until midnight, last antibiotic, allergies, code status.

STEP 3 · ASSESSMENT WITH CONCERN

The current vitals and exam, then: "I'm concerned he may be septic, possibly from an intra-abdominal source."

STEP 4 · RECOMMENDATION

"I'd like you to see him now. Can I get orders for cultures, lactate, labs, a fluid bolus and antibiotics? I'll recheck vitals in 15 minutes. If I don't hear back by 0230 I'll activate the rapid response team."

WORKED CASE 3 · A CONTINGENCY AND A LATE ENTRY

Turn "Watch her pressures overnight" into a contingency, then fix a 2200 assessment that was never charted and is being written at 0330.

STEP 1 · THRESHOLD AND ACTION

"If systolic blood pressure drops below 90, give a 500 mL normal saline bolus and page me."

STEP 2 · TEST IT

Could someone act on it at 0300 without calling you? Yes: a number and an action.

STEP 3 · LABEL THE LATE ENTRY

"0330: Late entry for 2200. Patient assessed at 2200: alert, oriented x4, lungs clear, no distress."

STEP 4 · EXPLAIN THE GAP

"Entry delayed due to concurrent rapid response on the unit." Both times appear, and the audit trail agrees.

WORKED CASE 4 · INSTRUCTIONS A FRIGHTENED PERSON CAN FOLLOW

Rewrite "Weigh daily; report significant weight gain" and "Continue antihypertensive regimen as prescribed. Hold if hypotensive."

STEP 1 · MAKE IT OBSERVABLE AND TIMED

"Weigh yourself every morning after you use the bathroom, before you eat, in the same clothing. Write it down."

STEP 2 · GIVE THE NUMBER AND TRIGGER FIRST

"Call us if you gain 3 pounds in one day or 5 pounds in one week."

STEP 3 · NAME THE MEDICINE AND THE CHECK

"Keep taking your blood pressure pill (lisinopril) every morning. Check your blood pressure first. If the top number is under 100, skip that dose and call us the same day."

STEP 4 · VERIFY WITH TEACH-BACK

"I want to make sure I explained this well. Tell me how you will take your pill tomorrow." Document what the patient said, not "verbalized understanding".

TRAPS PEOPLE FALL INTO

- **Documenting findings but not your response.** The third and fourth beats are what protect the patient and you.
- **Backfilling the chart.** Charting care that did not occur is falsification. Label late entries instead.
- **"A: Pain."** That re-labels the data. State what you think is going on and what you ruled out.
- **Trait labels.** "Non-compliant" hides a solvable barrier and shapes how every later reader acts.
- **An SBAR with no R.** Describing a patient beautifully and stopping leaves the physician to guess.
- **A broadcast handoff.** Without synthesis by receiver, responsibility has not been transferred.
- **Trailing and missing zeros.** 1.0 mg reads as 10 mg; .5 mg reads as 5 mg.
- **"Incident report filed" in the chart.** It can weaken the report's protection. Keep the lanes separate.

Chapter 13 self-test · ten items

1. Which four beats should every clinical entry answer?

A. Subjective, objective, plan, sign-off
B. Who, what, where, and why it all went wrong
C. Observed, concluded, did, what happened next
D. Data, action, response, and who to blame

C. Observed, concluded, did, what happened next The four-beat spine underlies every charting format; the last two are most often missing.

2. Why is the health record generally admissible as evidence?

A. It is signed by a physician, which makes every single entry legally binding
B. It is stored electronically, so it cannot be challenged in any court
C. It is written in medical language that only experts can interpret
D. It is a business record made at the time by people bound to be accurate

D. It is a business record made at the time by people bound to be accurate Contemporaneous entries by people with a duty to record accurately are the basis for the business-record rule.

3. What is wrong with "A: Pain" in a SOAP note?

A. It belongs in the Subjective section, not the Assessment
B. It re-labels the data instead of stating an assessment
C. It is too long for the Assessment line of the note
D. Pain may never be recorded in a SOAP note at all

B. It re-labels the data instead of stating an assessment An assessment states what you think is happening and what you ruled out.

4. Which entry replaces a label with observations?

A. Took about 3 of 7 evening insulin doses; ran out Tuesday
B. Patient is non-compliant with his evening insulin doses
C. Patient clearly does not care about his insulin at all
D. Patient refuses to follow the insulin plan as it was ordered

A. Took about 3 of 7 evening insulin doses; ran out Tuesday Behavior, numbers and the barrier replace a trait label.

5. What part of SBAR do novices most often omit?

A. S, the problem now
B. B, the history
C. A, your concern
D. R, what you want

D. R, what you want Name what you want, by when, and what you will do meanwhile.

6. When is I-PASS the right structure rather than SBAR?

A. When calling a physician about one single urgent concern
B. When writing a discharge instruction for a patient
C. When transferring responsibility for a patient's care
D. When filing an incident report after a patient fall

C. When transferring responsibility for a patient's care SBAR gets a decision about one concern; I-PASS transfers care.

7. Which is a proper contingency for a handoff?

A. Below a systolic of 90, give a 500 mL bolus and page me
B. Keep a close eye on her blood pressure through the night
C. Her pressures have been a little soft, so please watch them
D. Call me if anything at all seems off with her overnight

A. Below a systolic of 90, give a 500 mL bolus and page me A contingency has a measurable threshold and a specific action.

8. You find at 0330 that a 2200 assessment was never charted. What do you do?

A. Enter it with a 2200 timestamp so the record looks complete
B. Write a late entry showing both the event time and the entry time
C. Leave it out, since the assessment is no longer current
D. Ask a colleague to chart it under their own login instead of you

B. Write a late entry showing both the event time and the entry time Backdating is falsification, and the audit trail records the true entry time anyway.

9. How should a dose of half a milligram be written?

A. .5 mg
B. 0.50 mg
C. 1/2 mg
D. 0.5 mg

D. 0.5 mg Always a leading zero, never a trailing zero.

10. Where should the existence of an incident report be recorded?

A. Only in the safety system, never in the patient's chart
B. In the progress note, so that the next shift knows about it
C. In the discharge summary, so the patient is informed
D. In both the chart and the report, for completeness

A. Only in the safety system, never in the patient's chart Referencing the report in the chart can weaken its protection. Keep the lanes separate.

CHAPTER 14

Editing, Review and Quality Control

Read it in full: **Chapter 14 in the textbook**. Practice it in the lab: **The Three-Pass Desk** and **The 20 Percent Cut**.

What to know

A first draft is a hypothesis and editing is the experiment. Most damaging writing is not badly conceived but unfinished. Editing is three activities with different failure modes, done in order by altitude. **Revising** asks whether the document does its job for this reader (cut sections, reorder, rewrite the opening); about 40 to 50 percent of the time. **Editing** asks whether each sentence carries its weight (tighten, un-bury verbs, fix tone); about 30 to 40 percent. **Proofreading** asks whether anything is wrong on the surface (spelling, numbering, links, attachments); about 15 to 25 percent. A 1976 NASA Jet Propulsion Laboratory handbook, *The Levels of Edit*, named nine types of edit in five levels; the habit underneath is deciding the level of edit from stakes, audience and shelf life.

Revising tests: the headline test (subject line, first sentence and headings alone carry the message), the so-what test (why does the reader need each paragraph?), and the order test (most important to least, not chronology). Deleting 30 percent of a first draft and moving two sections is normal. Editing needs a stable structure first. Proofreading is inspection of marks and comes last because every earlier change creates new surface errors.

Sentence editing is mostly subtraction. Cut run-ups ("It is important to note that"), swap phrases for words (due to the fact that = because; in the event that = if; at this point in time = now; in order to = to; has the ability to = can), and use the **20 percent rule**: rewrite to 80 percent of the words with no fact lost. Put the action in the verb by undoing **nominalizations** (conduct a review = review) and **expletive constructions** (There are three factors that...). The passive is a tool, not a sin; the test is whether the reader needs to know who acted. Give each sentence one job and vary length. Readability formulas are a smoke detector, not a measure of comprehension. Spellcheck and grammar check cannot tell you a sentence is empty.

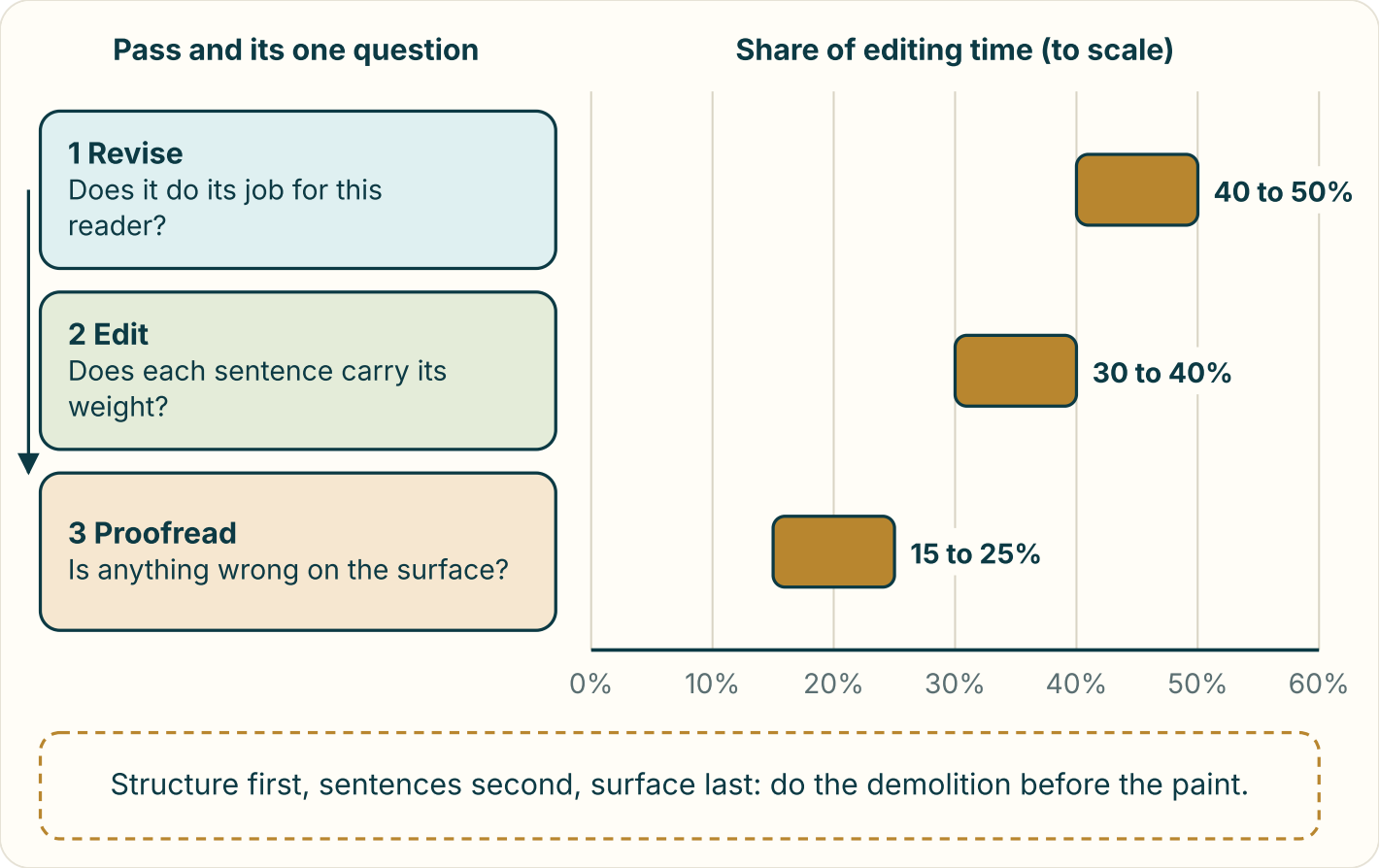
Review needs direction. A **directed review request** names the stage, the ask and the deadline, matched to the reviewer (manager for risk and politics, expert for accuracy, target reader for usability). A usable comment has location, problem and a possible fix, labeled blocking or preference; praise specifically. The reader's reaction is data; the reader's proposed fix is a suggestion. Do not explain your way out of confusion, and do not silently accept wrong edits.

Close the loop. Keep track changes and comments distinct, clear them before sending outward, keep a **single source of truth**, set an end point, and get "approved" in writing.

Spend verification where the consequences live: numbers, names, dates, money, links and attachments, quotations and citations, and identifiers. Check high-risk elements against the source character by character; recompute rather than re-read. Borrow clinical controls: an **independent double-check** by someone working from the source without being primed, and **read-back** digit by digit with units. Use safe number formatting (1 mg, 0.5 mg, spell out units). Open the original of every cited claim, check quotations and ellipses, click links in a private window, and check the boring things: attachment, recipients, file name, placeholders. Spellcheck flags non-words, not wrong words.

Build a quality system. A **style sheet** records local decisions with examples, built by accretion. A pre-send checklist has seven to ten binary items you can check in ten seconds, with **killer items** first, plus the two or three your own last mistakes would have caught. Break familiarity to proofread: incubation, a change of medium or font (paper's advantage is debated), text-to-speech, reading aloud, reading backwards for short high-stakes text. Name files date first (2026-03-05_FallPrevention_v6_DRAFT.docx), record sign-off (who, which version, what date, what scope), and mark superseded versions rather than deleting them. Keep an error log.

> **LOCK THESE IN**
>
> - Three passes in order: revise (structure), edit (sentences), proofread (surface).
> - Rough time shares: revise 40 to 50%, edit 30 to 40%, proofread 15 to 25%.
> - Decide the level of edit from stakes, audience and shelf life.
> - 20 percent rule: cut a fifth of the words and none of the facts.
> - Passive is fine when the actor is unknown, irrelevant or obvious; not when accountability matters.
> - Directed review: stage, ask, deadline. Comment: location, problem, fix.
> - Verify high-risk elements against the source; unprimed double-check; read-back.
> - Style sheet, 7 to 10 item checklist, date-first file names, written sign-off.



Three passes, drawn to scale. The time ranges come from the chapter. Spend the most on structure, because polishing a paragraph you later delete is the most expensive error.

Key terms and comparisons

Pass	The one question	Deliberately ignore
1 Revise	Does this document do its job for this reader?	Grammar, word choice, commas, formatting
2 Edit	Does each sentence and paragraph carry its weight?	Whether the section belongs; typos
3 Proofread	Is anything wrong on the surface?	Meaning: you inspect, not read

Phrase for a word

Deadwood	Plain
due to the fact that	because
in the event that	if
at this point in time	now
in order to	to
has the ability to	can
conduct a review of	review
make a determination	decide
It is important to note that	(delete)

High-risk elements

Element	How it fails	How to verify
Doses and units	Transposed digits; trailing zero; mg vs mcg	Read back digit by digit; safe formatting
Names and credentials	Misspelling; outdated title; autocorrect	Copy from an official roster
Dates	Wrong weekday; last year; ambiguous format	Write Thursday, March 5, 2026; check a calendar
Money and percentages	Sums do not match; percent vs points	Recompute independently
Links and attachments	Dead or internal-only link; missing file	Private window; attach first
Quotations and citations	Source does not say it; outdated	Open the original; find the sentence
Identifiers	Right format, wrong record	Two-identifier match; second check

Worked cases

WORKED CASE 1 · THE 20 PERCENT CUT

Edit: "It is important to note that there are several factors that have contributed to the delay in the implementation of the new module."

STEP 1 · COUNT

23 words. The 20 percent target is 23 × 0.8 = 18.4, so 18 words or fewer.

STEP 2 · CUT THE RUN-UP AND THE EXPLETIVE

Delete "It is important to note that there are".

STEP 3 · UN-BURY THE VERBS

"Contributed to the delay in the implementation of" becomes the single verb "delayed".

STEP 4 · SPEND THE SAVINGS ON FACTS

"Three things delayed the module: short staffing, a firmware update and a late vendor invoice." 15 words, and it now names the factors.

CHECK IT A SECOND WAY

15 ÷ 23 = 65%, a 35% cut, with information added rather than lost.

WORKED CASE 2 · PASSIVE: KEEP OR CHANGE

Decide for each: "The medication was administered at 0900" (incident report); "Samples were centrifuged for ten minutes" (methods); "Your dressing should be changed daily" (patient handout).

STEP 1 · THE TEST

Does the reader need to know who did this?

STEP 2 · INCIDENT REPORT

Yes: accountability is the point. Name the actor.

STEP 3 · METHODS

No: the actor is irrelevant and the procedure is the subject. Keep the passive.

STEP 4 · PATIENT HANDOUT

Yes: the reader is the actor. "Change your dressing every day."

WORKED CASE 3 · A DIRECTED REVIEW REQUEST

You need a subject-matter expert to check the escalation path in a draft policy whose structure is not final. Write the request.

STEP 1 · NAME THE STAGE

"Attached is a structural draft of the fall-prevention policy: content is not final and I have not proofread it."

STEP 2 · NAME THE ASK

"What I need from you: does the escalation path in Section 3 match what actually happens on nights? Please ignore wording."

STEP 3 · NAME THE DEADLINE

"I need this by Thursday noon."

STEP 4 · SEND DIFFERENT ASKS TO DIFFERENT REVIEWERS

Manager: risk and politics. Target reader: can the instructions be followed? Three non-overlapping sets of findings.

WORKED CASE 4 · VERIFYING A DATE AND A DOSE

A memo says "Effective Monday, March 5, 2026" and a colleague asks you to "confirm 250 milligrams" from an order.

STEP 1 · CHECK THE WEEKDAY

March 5, 2026 falls on a Thursday, so "Monday" is wrong. Writing the weekday with the date is what exposed the error.

STEP 2 · FIX IT FROM THE SOURCE

Find the intended effective date in the approved document; do not guess which half is right.

STEP 3 · AVOID PRIMING

"Confirm 250" tells the checker what to see. Ask them to read the dose from the original order independently, then compare.

STEP 4 · READ BACK

Repeat the dose digit by digit with the unit, and have the sender confirm.

TRAPS PEOPLE FALL INTO

- **One crawling pass.** Fixing commas on page one spends attention you need for the structural problem on page four.
- **Editing an unstable structure.** Every sentence you polish may be deleted. Finish the argument first.
- **Treating passive as always wrong.** It is a normal construction; ask whether the reader needs the actor.
- **Writing to a readability score.** Choppy text can score well and teach nothing.
- **"Any thoughts?"** You get commas on a draft that needs restructuring. Direct the review.
- **Arguing a reader out of confusion.** The reaction is data even when the proposed fix is wrong.

- **Re-reading instead of verifying.** Recognition is what fails. Check against the source.
- **Trusting spellcheck.** Hypotension for hypertension is a correctly spelled wrong word.

Chapter 14 self-test · ten items

1. Which order of editing passes does the chapter set?

A. Proofread, then edit, then revise
B. Revise, then edit, then proofread
C. Edit, then revise, then proofread
D. All three at once, line by line

B. Revise, then edit, then proofread Structure first, sentences second, surface last, because each earlier pass creates new surface errors.

2. Which pass should usually take the largest share of editing time?

A. Proofreading, at about 40 to 50 percent
B. Editing, at about 60 to 70 percent
C. Revising, at about 40 to 50 percent
D. All three take equal shares of time

C. Revising, at about 40 to 50 percent Revising 40 to 50, editing 30 to 40, proofreading 15 to 25 percent.

3. What does the so-what test ask during revision?

A. Is every word in the draft spelled right?
B. Does each sentence use the active voice?
C. Is the draft below the target grade level?
D. Why does the reader need each paragraph?

D. Why does the reader need each paragraph? If the honest answer is "because I did the work", cut the paragraph.

4. A 23-word sentence is cut with the 20 percent rule. What is the most it may keep?

A. 18 words
B. 20 words
C. 15 words
D. 21 words

A. 18 words 23 × 0.8 = 18.4, so 18 words or fewer, with no fact lost.

5. Which revision removes a nominalization?

A. We will conduct a review
B. We will review it Tuesday
C. A review will be conducted
D. There will be a review held

B. We will review it Tuesday "Conduct a review" hides the action in a noun; "review" restores the verb.

6. When is the passive voice the better choice?

A. When accountability for an incident is the point
B. When the reader is the one who must take action
C. Whenever a sentence would otherwise be too short
D. When the actor is unknown, irrelevant or obvious

D. When the actor is unknown, irrelevant or obvious In a methods section, "Samples were centrifuged" is standard because the procedure is the subject.

7. What three things should a directed review request name?

A. The author, the word count and the font size
B. The topic, the audience and the file format
C. The stage, the specific ask and the deadline
D. The title, the version number and the owner

C. The stage, the specific ask and the deadline It prevents comma corrections on a draft whose structure is still moving.

8. Three reviewers stumble on the same paragraph and each proposes an unconvincing fix. What should you do?

A. Rewrite the paragraph your own way
B. Explain the paragraph in the meeting
C. Accept all three of their proposed fixes
D. Leave it, since none of the fixes work

A. Rewrite the paragraph your own way The reader's reaction is data; the proposed fix is only a suggestion.

9. Why is "I think it's 250 milligrams, can you confirm?" a weak check?

A. It uses milligrams instead of the safer micrograms
B. It primes the checker, so the check is not independent
C. It should have been sent by email, not asked out loud
D. It asks a colleague instead of asking a pharmacist

B. It primes the checker, so the check is not independent An independent check means the second person reads the source and reaches their own conclusion first.

10. Which file name follows the chapter's convention?

A. fall policy FINAL final (2) REAL.docx
B. FallPrevention_final_approved_new.docx
C. 2026-03-05_FallPrevention_v6_DRAFT.docx
D. 03-05-26 fall prevention draft v6 new.docx

C. 2026-03-05_FallPrevention_v6_DRAFT.docx Date first in year-month-day form, then name, version and status, so files sort and status is visible.

ONE PAGE

Cram sheet

Everything from chapters 13 and 14 in one place. Cover the right column and see if you can rebuild each row.

Structures to know

Structure	Parts	Use it for
Four beats	Observed, concluded, did, what happened next	Every chart entry
SOAP / APSO	Subjective, Objective, Assessment, Plan	Notes sorted by source
DAR	Data, Action, Response	One problem through its loop
SBAR	Situation, Background, Assessment, Recommendation	Escalating one concern
I-PASS	Illness severity, Patient summary, Action list, Situation awareness, Synthesis	Transferring care
Correction (paper)	Single line, reason, initials, date, time	Original stays legible
Three passes	Revise, edit, proofread	Every important document
Review comment	Location, problem, possible fix	Label blocking vs preference

Numbers to know

Item	Value	Note
I-PASS study (2014)	23% fewer errors; 30% fewer preventable adverse events	Nine pediatric sites; later results mixed
Copy-forward analysis	About 18% of note text typed by the author	The rest copied or imported
Cures Act access	Since April 2021	Narrow exceptions
Discharge reading level	About grade 6 to 8	Universal precaution
Dose format	1 mg, 0.5 mg	No trailing zero; always a leading zero
Edit time shares	40 to 50%, 30 to 40%, 15 to 25%	Revise, edit, proofread
20 percent rule	Keep at most 80% of the words	No fact lost
Checklist size	7 to 10 binary items	Killer items first

Rules that are not formulas

Topic	The rule
Records	Evidence, not diary; never backfill; label late entries.
Language	Behavior, time and number instead of labels; own your inferences.
Handoff	Not done until the receiver says it back.
Copy-forward	Copy structure, not conclusions; delete what you did not verify.
Safety reports	Facts only; never referenced in the chart.
Passive	Ask whether the reader needs the actor.
Verification	Against the source, unprimed, with read-back.
Versions	Date-first names; written sign-off; mark superseded, do not delete.

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