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Nursing Notes the Easy Way Saunders Guide to Success in Nursing School, 2017-2018 - E-Book Managing Documentation Risk Document Drafting Handbook Nursing Documentation The Clinical Documentation Sourcebook Documentation

Offering clear, practical guidelines for how, what, and when to document for more than 100 of the most common and most important situations nurses face, this essential resource details exactly what information to consider and document, to ensure quality patient care, continuity of care, and legal protection for the nurse and the institution where the nurse works. Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy!®, 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or

experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEWdiscussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don'ts of charting - a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient's health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation

practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter's content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans "Nurse Joy" and "Jake" – expert insights on the nursing process and problem-solving That's a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina. Written specifically for staff nurses, this easy-to-read and affordable resource helps nurses understand the value of good documentation, and the consequences of not documenting accurately and in a timely fashion. The handbook's case studies illustrate the legal threat nurses face from improper documentation, while the quick tips help them avoid common charting errors and improve their charting skills. Sold in packs of 25, the handbook includes a short post-test and certificate of completion, allowing nurses to

evaluate their documentation understanding. A Daviss Notes Book. The perfect pocket guide for charting; ensures that documentation is not only complete and thorough, but also meets the highest ethical and legal standards. Covers nuances that are relevant to various specialties, including pediatric, OB/GYN, psychiatric and outpatient nursing. Reviews terminology essential to communicate effectively in writing with doctors, other health care professionals, and staff. Includes how-tos for template, electronic and other forms of charting. Nursing can be nuts. On a twelve-hour shift, the last thing most nurses want to do is sit down and draft a lengthy note describing the craziness that occurred. Written by a nurse, for nurses, this book is chock full of narrative note examples describing hypothetical situations to help you describe the, well, the indescribable. Some shifts are just like that! Provides information on documentation issues, including electronic medical records, legal and ethical implications, and documentation in acute cases, along with a variety of charting examples. Background: Healthcare documentation not only allows for communication among healthcare providers and maintains patient care record keeping, it also archives essential information used to track, evaluate,

and consider valuable healthcare interventions. When documented properly, this information can be used in research to assess international and national healthcare topics like standards of care, quality of care, complication and infection rates, and many more. When documentation is not complete ad comprehensive, a false representation can be made and a patient's safety is at risk. The American Nurse Association suggests nursing documentation be clear, accurate, complete, and accessible, allowing nurses to be responsible and held accountable for their documentation. Foreground: The inpatient unit of interest for this project, like many other hospital units, demands several hours of direct patient care, potentially leaving little time for complete documentation. As a consequence, documenting on important aspects of a patient's record, like the removal of any intravenous device (IVD), are missed or incomplete. When these pieces of information are missing, opportunities to provide accurate data regarding patients, fall short. Therefore, it was this project's objective to influence staff nurses to be as comprehensive as possible when documenting overall, and to see an improvement on the removal of any IVD documentation after providing an educational in-service. Theoretical and EBP Support:

Lewin's Change Theory served as a supporting component in influencing and guiding the nurses of interest, transforming their care and making it a standard of practice when documenting on the removal of IVDs. In supporting this project's development, the Johns Hopkins Nursing Evidence-Based-Practice (EBP) Model served as guiding feature in the specific steps of EBP in nursing. Methods: Once both Institutional Review Boards granted approval for this Quality Improvement project, chart audits were performed within a three-week time frame pre- and post- nurse in-service. The provided in-service was given to staff nurses, float pool nurses, and nursing students over an 11-day period. The in-service included pertinent aspects of documentation, steps to improve current practice, which was supported by current evidence, and time for discussion regarding potential barriers to complete documentation. Findings: A clinically significant improvement of 11% was seen in comprehensive documentation on the removal of IVDs on a specific surgical patient population. The findings of this project predictively aligned with literature that supports the use of health information technology, like the electronic health record, were data are accurately and efficiently collected, which can be used to generate

knowledge that leads to improved outcomes. Although the practice improvement was seen in a limited amount of time, the direction was progressive, foretelling beneficial outcomes when these kinds of quality improvement projects are implemented. Armed with this portable handbook, nurses in any practice setting will know exactly what to document in any situation. Featuring an A-to-Z organization that makes finding information easy, this reference offers a new learn-by-example approach to charting and delivers clear examples for documenting more than 270 patient-care situations, from common diseases to legal and ethical issues. "Legal casebook" spotlights real-life court cases to help you avoid perilous charting. Completed "AccuChart" sample forms--such as OASIS, incident reports, and fall prevention reports--give readers the confidence to chart accurately at all times. Charting By Exception Applications is a new summary of critical issues related to the use of Charting By Exception (CBE) that offers various examples of CBE-type systems and review a national survey of institutions that use exception-based documentation. The perfect guide to charting! The popular Davis's Notes format makes sure that you always have the information you need close at hand to ensure your documentation is not only complete and

thorough, but also meets the highest ethical and legal standards. You'll even find coverage of the nuances that are relevant to various specialties, including pediatric, OB/GYN, psychiatric, and outpatient nursing. Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards, and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards, and documenting outcomes and interventions for key nursing diagnoses. Chart Smart: the A-to-Z Guide to Better Nursing Documentation tells nurses exactly what to document in virtually every type of situation they may encounter on the job, no matter where they practice--hospital, medical office, outpatient, rehabilitation facility, long-term care facility, or home. This portable handbook

has nearly 300 entries that cover documentation required for common diseases, major emergencies, complex procedures, and difficult situations involving patients, families, other health care team members, and supervisors. In addition to patient care, this book also covers documenta ICD-10-CM Documentation 2021 brings coders and physicians together to ensure documentation success, identifying all ICD-10-CM documentation requirements using detailed checklists. Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal comminication in nursing to help you. You can be an excellent nurse in the clinical setting and still fail to prove that you are an excellent nurse if your documentation is inadequate. Having worked in a variety of inpatient and outpatient settings, I understand the obstacles nurses face. There's just not time, nor do nurses have the mental energy to meticulously document every little thing on top of the rest of their to-do list. That's part of why I became passionate about documentation education. It doesn't have to be an overwhelming, endless challenge to chart exhaustively in hopes that you enter enough data into the chart to defend yourself one

day. Rather, leveraging the most critical data, knowing how to format notes and exactly what to say, and when to spend five minutes dumping information into the chart can be learned skills that make documentation faster, easier, and less stressful, while doing a better job of defending your actions. The Importance of Documentation & Overcoming Obstacles Purpose(s) of Documentation Defensive Charting Obstacles Impacting Quality of Medical Record Overcoming Obstacles Legal Responsibilities of the Nurse Duties of the Nurse Nurse Practice Acts Duties of the Hospital Hospital Policy vs. State Board of Nursing Regulations Reasonable Prudence Failure to Fulfill (Document) Responsibilities Fulfilling Responsibilities vs. Documenting Responsibilities What if Responsibilities Aren't Fulfilled? Mistakes Happen Professional Liability Insurance Malpractice Medical Negligence Acting with Malice Fraud What Happens When a Nurse is Charged with Malpractice? What to Do if You Receive Notification of a Claim Common Charting Mistakes & How to Avoid Them The Most Common Errors Charting By Exception & Charting to Capture Minimal Data "But I've Always Charted This Way, and Nothing Bad Has Happened Yet..." What You Should Be Charting How and What to Chart Quick Glance Charting Checklists What is

a Timely Manner? Documenting Assessments Sample Focused Assessment Criteria Sharing the Responsibility Modifying Electronic Data Abbreviations Standing Orders Early Warning Systems Scores & Scales Informed Consent Special Circumstances Paper Charting Writing an Incident Report Patient Leaving AMA Patient Threatening to Sue You Identifying Patient Belongings Another Member of the Team is Not Documenting Correctly Restraints Defective Equipment Suspected Abuse Patient Requesting to View Their EMR on Hospital Computer Narrative Notes When & How to Write Notes One Note or Several Notes? Daily Narrative Notes Examples of Common Notes Written As-Needed How to Title Narrative Notes How to Format Notes Using Patient Names in Notes Length of Notes Create a Template Tips for Less Stress When Charting BONUS: How I Chart on a "Typical" Shift ABOUT THE AUTHOR: I'm Andrea, RN-MSN. Perfecting my own documentation and working to find concrete guidelines to share with my fellow nurses has become my passion. As I gained more knowledge and researched the dusty, forgotten corners of the internet for obscure evidence-based practice and case studies, becoming a subject matter expert on nursing documentation lit a spark because sharing this information helps empower nurses to understand exactly what should appear in

their patient charts, where, when it should entered, and how it should be phrased. In its Fourth Edition, Charting Made Incredibly Easy! provides up-to-the-minute guidelines on documentation in a comprehensive, clear, concise, practical, and entertaining manner. The book reviews the fundamental aspects of charting such as the medical record, the nursing process, and legal and professional requirements, guidelines for developing a solid plan of care, and the variety of charting formats currently being used. It also addresses the specific requirements for charting in acute care, home care, and long-term care and rehabilitation settings. Special elements found throughout the book make it easy to remember key points. This edition includes new information on cultural needs assessment, HIPAA, National Patient Safety Goals, and electronic health records. "If these are your concerns... I'll never get time to finish my nursing notes! Is it legal? Can I use white-out? Can't they make a better form than this? How can I record this family set-up quickly? Weren't computers made for clerks, not nurses? There has to be something wrong with documenting for funding. How do you record the pain level of someone who has a dementing illness? Who walks down critical pathways? What happens if a home health record

gets lost? How can I document my client's spiritual concerns realistically? Will managed care affect what I write? Is there a culturally appropriate way to document? What is charting by exception? How did nurses document before NANDA?... then this book is for you." - Back cover. The quality of coding is an important factor in determining the financial health of a practice. When problems occur they must be solved quickly. But before they can be solved, they must be found. Medical Record Chart Analyzer includes medical record documentation with a systematic guide to the medical record review process for the physician's or outpatient office. Learning objectives are included at the beginning of most chapters to overview chapter content and help measure progress. Medical chart review and coding tips are located throughout the book. The application exercises allow the reader to master each topic one chapter at a time. Also included is a final examination to test documentation and auditing skills. By the end of the book, the reader will be able to conduct reviews independently. Authored by Deborah J. Grider, CPC, CPC-H, CCS-P, CCP, an experienced professional in the fields of reimbursement, procedural and diagnostic coding, medical practice management and compliance. Readers can earn up to 10 CEU

credits from AAPC. Nurses are now commonly cited or implicated in medical malpractice cases. Part of the Springhouse Incredibly Easy! Series(TM), this Second Edition provides current information about charting in a comprehensible, clear, fun and concise manner. Three sections cover Charting Basics, Charting in Contemporary Health Care, and Special Topics. New features include expanded coverage of computerized documentation and charting specific patient care procedures, plus current JCAHO standards both in the text and appendix, chapter summaries, and a new section with case study questions and answers. Amusing graphics and cartoon characters call special attention to important information. Entertaining logos throughout the text alert the reader to critical information, Thought Pillows identify key features of documentation forms, and the glossary defines difficult or often-misunderstood terms. The complete guide for streamlining and improving nursing documentation for virtually every system. Nurses will find instructions for virtually every common and not-so-common charting method. From progress notes to protocols, there is a wealth of easy-to-follow examples throughout the book. Includes JCAHO-approved nursing abbreviations, ANA standards of practive, and JCAHO and Medicare guidelines

for nursing documentation. The popular Saunders Guide to Success in Nursing School is a versatile organizational tool, a practical nursing orientation handbook, a clinical quick reference, and a resource directory all in one. This compact and affordable guide helps busy nursing students manage their time and perform to their fullest potential inside the classroom and during clincial rotations. The Guide not only provides time management and stress-reduction strategies, advise on study skills, and yearly, monthly, and weekly planners, but also comes equipped with a variety of helpful clincial tools like pain and neurological assessment scales, Joint Commission safety guidelines, information on common drug and lab values, and NCLEX preparation tips. An orientation section covers the latest developments in computer-based testing and flipped classroom instruction. A clinical reference section features information on electronic documentation and content on Post-Traumatic Stress Disorder Plus all the must-have information you need to survive nursing school including: NCLEX Exam strategies Time management and study tips Stress reduction techniques Common medication and IV therapy guidelines The Joint Commission's Do Not Use lists High-alert medications Normal vital

signs, lab values, measurements, and conversions Updated weekly, monthly, and yearly calendars with prefilled dates from May 2017 through December 2018 help students organize their schedule at school and at home. New content on electronic devices and social medial alerts students to the hazards and pitfalls of using phones and engaging in social media while in nursing school and on the job. Now nurses can chart the Incredibly Easy! way with this remarkable reference. They'll find easy-to-follow directions for charting thoroughly and accurately in all clinical situations. And they'll learn to improve speed and efficiency, reduce legal risks, and meet requirements for licensing, accreditation, and reimbursement. Contents include charting basics: understanding charting, the nursing process, plans of care, and charting systems; charting in contemporary health care: acute care, home health care, longterm care, and rehabilitation; and special topics: enhancing charting, avoiding legal pitfalls, and documenting procedures. Feeling unsure about documenting patient care? Learn to document with skill and ease, with the freshly updated Document Smart, 4th Edition. This unique, easy-to-use resource is a must-have for every student and new nurse, offering more than 300 alpha-organized topics that

demonstrate the latest nursing, medical and government best practices for documenting a wide variety of patient conditions and scenarios. Whether you are assessing data, creating effective patient goals, choosing optimal interventions or evaluating treatment, this is your road map to documentation confidence and clarity. ICD-10-CM Documentation 2020 brings coders and physicians together to ensure documentation success, identifying all ICD-10-CM documentation requirements using detailed checklists. This open access volume is the first academic book on the controversial issue of including spiritual care in integrated electronic medical records (EMR). Based on an international study group comprising researchers from Europe (The Netherlands, Belgium and Switzerland), the United States, Canada, and Australia, this edited collection provides an overview of different charting practices and experiences in various countries and healthcare contexts. Encompassing case studies and analyses of theological, ethical, legal, healthcare policy, and practical issues, the volume is a groundbreaking reference for future discussion, research, and strategic planning for inter- or multi-faith healthcare chaplains and other spiritual care providers involved in the new field of

documenting spiritual care in EMR. Topics explored among the chapters include: Spiritual Care Charting/Documenting/Recording/Assessment Charting Spiritual Care: Psychiatric and Psychotherapeutic Aspects Palliative Chaplain Spiritual Assessment Progress Notes Charting Spiritual Care: Ethical Perspectives Charting Spiritual Care in Digital Health: Analyses and Perspectives Charting Spiritual Care: The Emerging Role of Chaplaincy Records in Global Health Care is an essential resource for researchers in interprofessional spiritual care and healthcare chaplaincy, healthcare chaplains and other spiritual caregivers (nurses, physicians, psychologists, etc.), practical theologians and health ethicists, and church and denominational representatives. This pocket-size guide saves nurses precious time while ensuring that a complete patient record is created and that legal, quality assurance, and reimbursement requirements are met. This handbook provides specific verbiage for charting patient progress, change or tasks accomplished for approximately 50 common problems. The new third edition has been completely updated to include Critical Assessment Findings, Subjective Findings for Documentation, Resources for Care and Practice, Legal Considerations, Time Saving Tips, and new Managed Care information. Plus,

roughly 15 additional common problems and diagnoses have been added making this practical resource more valuable than ever. Diagnoses are in alphabetical order allowing for fast and easy access. All the forms, handouts, and records mental health professionals need to meet documentation requirements—fully revised and updated The paperwork required when providing mental health services continues to mount. Keeping records for managed care reimbursement, accreditation agencies, protection in the event of lawsuits, and to help streamline patient care in solo and group practices, inpatient facilities, and hospitals has become increasingly important. Now fully updated and revised, the Fourth Edition of The Clinical Documentation Sourcebook provides you with a full range of forms, checklists, and clinical records essential for effectively and efficiently managing and protecting your practice. The Fourth Edition offers: Seventy-two ready-to-copy forms appropriate for use with a broad range of clients including children, couples, and families Updated coverage for HIPAA compliance, reflecting the latest The Joint Commission (TJC) and CARF regulations A new chapter covering the most current format on screening information for referral sources Increased coverage of

clinical outcomes to support the latest advancements in evidence-based treatment A CD-ROM with all the ready-to-copy forms in Microsoft® Word format, allowing for customization to suit a variety of practices From intake to diagnosis and treatment through discharge and outcome assessment, The Clinical Documentation Sourcebook, Fourth Edition offers sample forms for every stage of the treatment process. Greatly expanded from the Third Edition, the book now includes twenty-six fully completed forms illustrating the proper way to fill them out. Note: CD-ROM/DVD and other supplementary materials are not included as part of eBook file. Charting: An Incredibly Easy! Pocket Guide provides time-starved nurses with essential documentation guidelines in a streamlined, bulleted format, with illustrations, logos, and other Incredibly Easy! features. The book is conveniently pocket sized for quick reference anytime and anywhere. The first section reviews the basics of charting, including types of records, dos and dont's, and current HIPAA and JCAHO regulations. The second section, alphabetically organized, presents hundreds of examples and guidelines for accurately charting everyday occurrences. Logos include Help Desk best practices tips; Form Fitting completed forms that exemplify

top-notch documentation; Making a Case documentation-related court cases; and Memory Jogger mnemonics. Focuses on the communicatiion skills that are the key to good documentation. A time-efficient and cost-effective method of documentation of nursing care through a system of charting by exception (the documentation of abnormal or significant findings using a standard normal base) is described in this book. The method eliminates time-consuming documentation of normal findings and repetitious information, allowing the nurse to spend less time at the desk and more time caring for patients.

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