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Designed for rapid on-the-job reference, Documentation in Action offers comprehensive, authoritative, practice-oriented, up-to-the-minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties. Need-to-know information is presented in bulleted lists, charts, flow sheets, sidebars, and boxes, with icons and illustrative filled-in samples. Coverage includes documentation for care of patients with various diseases, complications, emergencies, complex procedures, and difficulties involving patients, families, and other health care professionals. Suggestions are given for avoiding legal pitfalls involving telephone orders, medication reactions, patients who refuse care, and much more. A section addresses computerized documentation, HIPAA confidentiality rules, use of PDAs, nursing informatics, and electronic innovations that will soon be universal. "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. 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. Clinical Documentation Strategies for Home Health Elizabeth I. Gonzalez, RN, BSN Are you looking for training assistance to help your homecare staff enhance their patient assessment documentation skills? Look no further than Clinical Documentation Strategies for Home Health. This go-to resource features home health clinical documentation strategies to help agencies provide quality patient care and easily achieve regulatory compliance by: Efficiently and effectively training staff to perform proper patient assessment documentation Helping nurses and clinicians understand the importance of accurate documentation to motivate improvement efforts Reducing reimbursement issues and liability risks to address financial and legal concerns This comprehensive resource covers everything homecare providers need to know regarding documentation best practices, including education for staff training, guidance for implementing accurate patient assessment documentation, tips to minimize legal risks, steps to develop foolproof auditing and documentation systems, and assistance with quality assurance and performance improvement (QAPI) management. Clinical Documentation Strategies for Home Health provides: Forms that break down the functions and documentation requirements of the clinical record by Conditions of Participation, Medicare, and PI activities Tips for coding OASIS Examples of legal issues such as negligence Case studies and advice for managing documentation risk (includes a checklist) Comprehensive documentation and auditing tools that can be downloaded and customized Table of Contents: Key aspects of documentation Defensive documentation: Reduce risk and culpability Contemporary nursing practice Clinical documentation Nursing negligence: Understanding your risks and culpability Improving your documentation Developing a foolproof documentation system Auditing your documentation system Telehealth and EHR in homecare Motivating yourself and others to document completely and accurately 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. Nurses are now commonly cited or implicated in medical malpractice cases. With all the training and education nurses receive, there is little true explanation about the importance of documentation. Even in today's litigious culture and the backlash of services no longer reimbursable -- it is crucial we as nurses understand the rationale for our documentation practices. By creating specific systems to ensure license

protection, we in turn provide more effective hand-off communication. Every nurse knows it's the law and that you don't want to lose your license, but do we really know why the methods of documentation are so vital to our livelihood? Has the electronic medical record made this approach additionally arduous? Do the questions on the EMR provide an accurate picture of the actual care provided? Often times, these reports are not clear or complete. Through fictional and non-fictional stories, Rosale Lobo reveals proper nursing documentation techniques providing clarity and important best practice concepts that can be applied immediately. Extraneous situations will arise in nursing, making it imperative to develop intentional methods of documentation. By putting together an effective system you will decrease your chances of being sued. For the future of nursing documentation, the EMR is not the answer, a personal system of accountability is. Handbook of Home Health Standards: Quality, Documentation, and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards. This handbook offers detailed standards and documentation guidelines including ICD-9-CM (diagnostic) codes, OASIS considerations, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement, and resources for practice and education. The fifth edition of this "little red book" has been updated to include new information from the most recently revised Federal Register Final Rule and up-to-date coding. All information in this handbook has been thoroughly reviewed, revised, and updated. Offers easy-to-access and easy-to-read format that guides users step by step through important home care standards and documentation guidelines. Provides practical tips for effective documentation of diagnoses/clinical conditions commonly treated in the home, designed to positively influence reimbursement from third party payors. Lists ICD-9-CM diagnostic codes, needed for completing CMS billing forms, in each body system section, along with a complete alphabetical list of all codes included in the book in an appendix. Incorporates hospice care and documentation standards so providers can create effective hospice documentation. Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care. Includes the most current NANDA-approved nursing diagnoses so that providers have the most accurate and up-to-date information at their fingertips. Identifies skilled services, including services appropriate for the multidisciplinary team to perform. Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient's needs. Lists the crucial parts of all standards that specific members of the multidisciplinary team (e.g., the nurse, social worker) must uphold to work effectively together to achieve optimum patient outcomes. Resources for care and practice direct providers to useful sources to improve patient care and/or enhance their professional practice. Each set of guidelines includes patient, family, and caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns. Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions. Several useful sections make the handbook thorough and complete: medicare guidelines; home care definitions, roles, and abbreviations; NANDA-approved nursing diagnoses; guidelines for home medical equipment and supplies. Small size for convenient carrying in bag or pocket! Provides the most up-to-date information about the newest and predominant reimbursement mechanisms in home care: the Prospective Payment System (PPS) and Pay For Performance (P4P). Updated terminology, definitions, and language to reflect the federal agency change from Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS) and other industry changes. Includes the most recent NANDA diagnoses and OASIS form and documentation explanations. New interdisciplinary roles have been added, such as respiratory therapist and nutritionist. Clearly and concisely provides guidelines for appropriate and careful documentation of care. Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. In addition, it plays a large role in how third party payors make payment or denial decisions. This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment. Special attention focuses on the latest documentation issues specific to specialty settings, such as acute care, home care, and long-term care, and a variety of clinical specialties, such as obstetrics, pediatrics, and critical care.--Amazon.com. 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. The Fifth Edition of Nursing Care Plans and Documentation provides nurses with a comprehensive guide to creating care plans and effectively documenting care. This user-friendly resource presents the most likely diagnoses and collaborative problems with step-by-step guidance on nursing action, and rationales for interventions. New chapters cover moral distress in nursing, improving hospitalized patient outcomes, and nursing diagnosis risk for compromised human

dignity. The book includes over 70 care plans that translate theory into clinical practice. Online Tutoring powered by Smarthinking--Free online tutoring, powered by Smarthinking, gives students access to expert nursing and allied health science educators whose mission, like yours, is to achieve success. Students can access live tutoring support, critiques of written work, and other valuable tools. 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. Designated a Doody's Core Title! The Preeminent Nursing Terminology Classification System "The Clinical Care Classification (CCC) System described in this manual is the only standard coded nursing terminology that is based on sound research using the nursing process model framework and that meets the Patient Medical Record Information (PMRI) comparability requirement. The CCC System allows patient care data generated by nurses to be incorporated into the PMRI database, and enables nurses' contributions to patient outcomes to be studied and acknowledged." -- From the Foreword by Sheryl L. Taylor, BSN, RN, Senior Consultant, Farrell Associates

TESTIMONIES: "ABC Coding Solutions-Alternative Link developed ABC codes for nursing in collaboration with Dr. Virginia Saba, developer of the CCC system. Approximately two hundred ABC codes were developed from the CCC System of Nursing Interventions to accurately document nursing and integrative health care processes, classify and track clinical care, and develop evidence-based practice models, thus filling significant gaps in older medical code sets." --Connie Koshewa, Practitioner Relations Director, ABC Coding Solutions-Alternative Link "The International Classification for Nursing Practice (ICNPÆ) is a program of the International Council of Nurses (ICN). One of the first steps in the development of the ICNPÆ was to collect and compare all the nursing concepts in existing nursing terminologies, including the CCC. To facilitate the goal of ICNPÆ as a unified nursing language system, a project is under way to map the CCC to the ICNPÆ Version 1.0. This work will facilitate evaluation and ongoing development of both terminologies and allow ICN to compare data using CCC codes with data from other standard nursing terminologies." --Amy Coenen, PhD, RN, FAAN, Director, ICNPÆ Program, International Council of Nurses "This resource will help you: Align with MDS 3.0 documentation requirements. Coordinate documentation between nurses and therapists to improve resident care. Gain the perspective of nursing or therapy to appreciate their specific approach to skilled services. Reduce your audit risk and strengthen reimbursement claims with comprehensive documentation. Prove medical necessity and need for skilled care by practicing accurate documentation"--Page 4 of cover

This practical guide to 50 frequently encountered problems, their diagnosis and management, includes documentation which will fulfill legal, quality assurance and reimbursement requirements. Alphabetically organized, the book helps identify interventions, data, and outcomes appropriate for specific patients. 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 NEW discussion 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 Doshier Memorial Hospital in Southport, North Carolina. Designed to help students learn how to create nursing care plans and effectively document care, this practical book focuses on the nursing plans that are most important, ensuring that students learn what they need to know and that they can find the information they need easily without being distracted by irrelevant information. Packed with easy-to-understand information and focused on helping students develop critical reasoning skills, this respected text presents the most likely nursing diagnoses and collaborative problems with step-by-step guidance on nursing actions and rationales for interventions. More than 85 nursing care plans translate theory into clinical practice. This exciting revision includes special risk consideration icons called "Clinical Alert" (derived from the most recent IOM report) that integrate patient-specific considerations into each care plan. Other enhancements include a streamlined format for easier use; new care plans for maternity, pediatric, and mental health nursing. Enter the world of nursing care planning with confidence! This informative guide is the perfect way to build your care planning and documentation skills. Practical and easy-to-read material covers each phase of care plan development and record-keeping for both surgical and non-surgical interventions. This clinical manual is an ideal and standardized platform for preparing nursing students with the essential tools for documenting their nursing process. It teaches nursing students how to gather important data about each client in the clinical setting. Using this manual, the student nurse will be able to perform high quality documentation that is accurate and consistent in the client profile and laboratory and diagnostics, and their correlation and significance to the client's diagnosis or diagnoses. This manual also covers the medication administration record, nursing interventions and rationales, and intake and output forms. The Situation Background Assessment Recommendation (SBAR) form and the use of a concept map complete the list of resources provided. Using this standardized documentation, the student will be able to:

- Identify the primary patient data (past and present), diagnosis, and treatment plan.
- Analyze patient data correlating and drawing conclusions relevant to patient outcome.
- Document finding in a systematic manner.
- Interpret diagnostic findings as relate to patient diagnosis

This manual is intended for use in medical, surgical, and critical care clinical nursing courses. 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. This handbook offers a thorough overview of nursing documentation, and its importance, within the context of the nursing process. Users learn the principles of effective documentation and methods of documenting and examine trends relevant to this aspect of nursing care. Example forms are included to provide readers with hands-on experience with the documentation format. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version. Ensure that no condition or symptom is overlooked and documentation is as accurate as possible with Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation. As another volume in Ausmed's 'Guide to Practice' series of textbooks and audiobooks, this is an essential text for all aged-care nurses who wish to enhance their documentation skills and deliver higher quality care to the elderly. AudioBooks are ideal teaching tools. 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 be entered, and how it should be phrased. "Tabbner's Nursing Care: Theory and Practice is the only Australian and New Zealand textbook written specifically for the enrolled nurse student. The new 5th edition of this best-selling text has been fully revised and updated throughout to reflect the content of the new National Curriculum. Unit 1 The evolution of nursing Unit 2 The health care environment Unit 3 Cultural diversity and nursing practice Unit 4 Promoting psychosocial health in nursing practice Unit 5 Nursing individuals throughout the lifespan Unit 6 The nursing process Unit 7 Assessing health Unit 8 Important component of nursing care Unit 9 Health promotion and nursing care of the individual Appendices."--Provided by publisher. Focuses on the communication skills that are the key to good documentation. This informative title provides nurses with specific, practical advice on documenting a wide range of situations from caring for a patient with a myocardial infarction to witnessing a patient sign his will. In clear, concise language, the book gives detailed explanations of how, what, and when to document in nearly 100 of the most common, most important situations nurses face in practice. Each entry tells exactly what to consider and what to document so that the nurse can ensure quality patient care, continuity of care, and legal protection for the nurse and the institution. \* Covers nearly 100 important nursing situations. \* Provides clinically and legally sound advice. \* Explains exactly what to do--and what not to do--for maximum protection for yourself and your institution. 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 practice, and JCAHO and Medicare guidelines for nursing documentation. University of Wisconsin-Milwaukee School of Nursing's comprehensive charting and documentation manual for students and practitioners. Tired Of Being Hassled for Documentation as a Nurse in a LTC/SNF? A Straight-To-The-Point Guide From MDS Coordinators: What Exactly It Is We Need From Your Medicare Documentation. An easy to use reference made for Nurses in the long term care setting. We have gathered that in Nursing school we're taught to document or "it didn't happen" and on the job tells you to document but you're never given the specifics of what exactly is needed. This is why this reference guide was created by MDS Coordinators for LTC/SNF Nurses. Who better to hear it from than MDS Nurses themselves? Bridging the knowledge gap 1 Nurse at a time! 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. Focusing on the legal implications in the US, this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice. Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal communication in nursing to help you.