Documentation For Nurses In Long Term Care

This critically acclaimed work makes the case for collaboration and shows that it can be greatly enhanced with conscious understanding and systematic effort. As a healthcare specialist who has worn many hats from direct care giver to case manager to documentation specialist, Colleen Stukenberg is able to – Show how to build trust and communication and demonstrates specific opportunities where collaboration can make all the difference Identify ways that quality of care and financial factors overlap and the advantages that can be garnered through an understanding of this Explain how those in different roles view information through different types of knowledge and how an understanding of each perspective makes it easier to find the best source for important answers Discuss the education and ever-increasing role of the clinical documentation specialist who is often involved in all facets of a patient's progress, from intake and admission right up through discharge. As the author points out, good healthcare is dependent on the right person performing the right role, which promotes excellent collaboration. And when people are allowed to function in their proper roles, job satisfaction increases, which in itself leads to better

attitudes, which then leads to even deeper levels of collaboration and with it, the successful promotion of safe, quality care.

Provide quality resident care with 395 expert-reviewed, regulatory-compliant procedures. Ensure consistent documentation and care across all disciplines-a critical component to survey success. Every nursing home needs procedures to ensure quality care is provided and for legal protection. Don't put your facility in jeopardy with in-house procedures that may not be up to current clinical and regulatory standards. This book offers: - A quick reference when treating residents-The procedures will guide frontline staff through clinical issues they encounter every day. - Preparation for your next survey-Surveyors will check your facility's procedures to verify you're providing quality care that meets the regulations. - Training for new long-term care nurses-Many nurses have little formal long-term care training before they start working in nursing homes. These procedures will provide guidance and ensure that nursing staff provide consistent, compliant care. - A consistent format-Every procedure includes a list of supplies and the exact steps to take to perform it.

Comprehensive manual for the new or experienced Director of Nursing. All the essential information on Staffing, Resident Care, Quality Assurance, MDS Essentials, Nursing Policy and Procedure, Long

Term Care Regulations, Survey Protocols. 2021 Updated Survey Section with F-Tags List, Survey Focus Areas for F-Tag Deficiencies, Federal Regulatory Groups for Long Term Care, Matrix for Providers, and Surveyor's Entrance Conference Worksheet. Forms in the Director of Nursing book and on the CD for Nursing budget, Staffing, Scheduling, Employee records, Staff education, Quality assurance audits, Infection control. Includes 23 Skilled Charting Guidelines Current with all RAI Manual Updates, PDPM updates, Surveyor Guidelines and Federal Regulatory Changes. This Director of Nursing book aims to give all of the basic information a long term care Director of Nursing needs today. For the experienced Director of Nursing it provides a good reference for long term care regulations, standards, and laws. The forms included in the Director of Nursing book can greatly expedite job performance. Information is given on organizing the job, managing resident care, staffing, and quality assurance issues. For the new Director of Nursing, or the nurse aspiring to that position, the book outlines all of the major responsibilities of the job. Applicable federal regulations are quoted in each chapter, and forms are throughout the book. Forms and care plans have been updated to ensure compliance with the change to MDS 3.0 and with all of the federal regulations and guidelines updated during the past year.

Providing holistic care to patients includied care to the spirit, mind and body. Spiritual care needs to be administered and documented; however, in many instances, spiritual care and documentation of the care is greatly lacking. One barrier to the delivery of spiritual care by nurses is a lack of education regarding spiritual care. The purpose of this research project was to determine the influence of increased spiritual care education on nursing documentation of spiritual care in a long-term, acute-care hospital. The theoretical framework of the theory of human caring by Watson was chosen due to the relationship of the components of the spirit, mind, and body and how each one is interdependent on the other. Stoll's spiritual care assessment was incorporated into the education presentation. Knowles' theory of adult learning was used to deliver the information. The educational program was presented to a self-selected sample of 14 nurses and included pretest and posttest, PowerPoint presentation, and a review of the hospital's computerized documentation procedures. The nurses read two literature sources showed no change in the median scores of the pretest (90%) and posttest (90%). The chart audits completed before and after the education offering revealed no increase in the percentage of documentation of spiritual care. Implications for practice, research, and education were identified that will promote proper documentation of spiritual care

to patients.

Pamphlet is a succinct statement of the ethical obligations and duties of individuals who enter the nursing profession, the profession's nonnegotiable ethical standard, and an expression of nursing's own understanding of its commitment to society. Provides a framework for nurses to use in ethical analysis and decision-making.

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

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.

Critical Thinking in Long-Term Care Nursing, Second Edition Shelley Cohen, RN, BS, CEN Resident outcomes have come under growing scrutiny, both through new quality measures and the overall star rating. Nurses are the frontline staff who engage with residents daily, and it's crucial for them to understand how to apply critical thinking. When caring for residents and creating documentation, critical thinking can improve facility and resident outcomes while reducing medical errors, which will ultimately lead to more accurate reimbursement. Raise the standard of professional nursing practice and teach clinical care providers how to function at a higher level by developing their critical thinking abilities.Critical Thinking in Long-Term Care Nursing, Second

Edition, provides nurse managers and educators with accessible ways to teach these valuable skills to their staff. This easy-to-read resource explains the principles of critical thinking and how to encourage nurses to use critical thinking methods. Author Shelley Cohen, RN, BS, CEN, provides guidance on how to lead classroom sessions for new graduates and experienced nurses to develop critical thinking skills, including classroom processes and learning strategies. The book includes handouts to supplement classroom training. Who should read this book? Nursing home administrators MDS coordinators Directors of nursing Charge nurses Frontline staff involved in care planning Other clinical managers This book will help you: Identify key aspects of critical thinking Explain how nurses develop competency in critical thinking Determine classroom strategies to teach, promote, and support the development of critical thinking Determine ways to evaluate nurses' progress in critical thinking throughout orientation Develop strategies for the development of critical thinking skills during the orientation process Discuss the role played by managers and educators in promoting environments that support critical thinking Analyze the challenges that both new and experienced nurses face when incorporating critical thinking skills in the practice setting Explain interventions to help new and experienced nurses meet their managers' and preceptors' expectations for critical thinking Understand the new quality measures and how nurses' actions and documentation affect a facility's star ratings Educate staff by developing a culture of critical thinking Coach new nurse graduates through bad resident outcomes by setting expectations Encourage experienced staff to continually apply critical thinking Apply critical thinking to nursing and documentation to improve resident outcomes This book provides nurse managers and educators with easy ways to teach critical thinking to their

staff, including customizable resources specific to long-term care, such as: Assessment tools Worksheets Sample questions Case studies What's New? Developing a culture of critical thinking in nursing is crucial in today's long-term care industry. Resident outcomes have come under growing scrutiny, both through surveys (new quality measures) and overall star ratings. Nurses are the frontline staff that engage with residents daily, and they need to understand how to apply critical thinking to nursing. Critical thinking during documentation can improve outcomes in their facility, which will ultimately lead to accurate reimbursement. This update will cover the new quality measures and discuss how nurses' actions and documentation affect the facility's star ratings. "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 strenthen reimbursement claims with comprehensive documentation. Prove medical necessity and need for skilled care by practicing accurate documentation"--P. [4] of cover.

A charting reference that's authoritative and enjoyable. Helps you document patient care with incredible skill and confidence.

Your shortcut to accurate assessment and compliant documentation The quick and easy way to document quality resident care! The Long-Term Care Clinical Assessment and Documentation Cheat Sheets is the ultimate blueprint for how to provide resident- centered care for any symptom or condition. Available on CD, this electronic-only resource provides nurses with a thorough list of what to check and what to document during every shift, based on the specific circumstances of a given resident. Best of all, the new electronic format of this content enables long-term care

clinicians to easily search for the condition they need to treat and access the appropriate checklist within seconds. Each checklist can be downloaded and printed to fit directly into the resident's record to ensure thorough, focused, and regular assessments and documentation. Long-Term Care Clinical Assessment and Documentation Cheat Sheets is the most convenient way to guarantee your residents receive the proper care and your facility maintains compliant documentation. Long-Term Care Clinical Assessment and Documentation Cheat Sheets will help you: * Save time finding the correct guidelines for a resident's condition with the searchable, electronic checklists * Maintain complete and accurate clinical records for each resident to authenticate that physician orders were followed and residents were provided with the highest quality of care * Ensure consistency of care across each nurse's shift by including the relevant checklist in each resident record * Assess and document resident status, including cardiovascular, hematologic, and neurological conditions with more than 190 guidelines, tools, and cheat sheets * Avoid survey citations, lost reimbursement, and legal implications arising from improper documentation * Minimize nurses' stress by providing them with reliable guidance and data for each resident, in an easy-to-use format that fits seamlessly in their everyday work flow

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!

Your shortcut to accurate assessment and compliant documentation The quick and easy way to document quality resident care! The "Long-Term Care Clinical Assessment and Documentation Cheat Sheets" is the ultimate blueprint for how to provide resident-centered care for any symptom or condition. Available on CD, this electronic-only resource provides nurses with a thorough list of what to check and what to document during every shift, based on the specific circumstances of a given resident. Best of all, the new electronic format of this content enables long-term care clinicians to easily search for the condition they need to treat and access the appropriate checklist within seconds. Each checklist can be downloaded and printed to fit directly into the resident's record to ensure thorough, focused, and regular assessments and documentation. "Long-Term Care Clinical Assessment and Documentation Cheat Sheets" is the most convenient way to guarantee your residents receive the proper care and your facility maintains compliant documentation."Long-Term Care Clinical Assessment and Documentation Cheat Sheets"will help you: Save time finding the correct guidelines for a resident's condition with the searchable, electronic checklists Maintain complete and accurate clinical records for each resident to authenticate that physician orders were followed and residents were provided with the highest quality of care Ensure consistency of care across each nurse's shift by including the relevant checklist in each resident record Assess and document resident status, including cardiovascular, hematologic, and neurological conditions with more than 190 guidelines, tools, and cheat sheets Avoid survey citations, lost reimbursement, and legal implications arising from improper documentation Minimize nurses' stress by providing them with reliable guidance and

data for each resident, in an easy-to-use format that fits seamlessly in their everyday work flow What's New Electronic, searchable checklists, which enable you to upload the information to the resident's EHR or print to file in their paper record! Special chapter covering the most frequent diagnoses for hospital readmissions and strategies for how to prevent them.

Expanded and Revised, LEADING THE WAY: THE BUSY NURSE'S GUIDE TO SUPERVISION IN LONG-TERM CARE, 3rd Edition gives charge nurses and supervisors the tools they need to experience and create success in any long-term care environment. This easy-to-read handbook applies proven methods from the latest research, and covers everything from mentoring and motivating employees to dealing with job stress and ethical dilemmas. Succinct yet thorough, LEADING THE WAY: THE BUSY NURSE'S GUIDE TO SUPERVISION IN LONG-TERM CARE, 3rd Edition delivers the essentials of management and leadership, such as team building, communication, staff development, performance issues, and organization, all with a specific, long-term care focus. New discussions on effectively managing conflict, diffusing tension with humor, and achieving work/life balance make this always-popular text even more useful for nurses, nursing assistants, and students everywhere. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.

Improving Nursing Documentation and Reducing Risk Patricia A. Duclos-Miller, MSN, RN, NE-BC In the age of electronic health records (EHR) and value-based purchasing, accurate and complete nursing documentation is crucial. Proper documentation affects not only quality of care, but also facilities' costs and

revenues. Redundant documentation wastes time and money, while inadequate documentation negatively affects Joint Commission core measures and can result in license suspensions or legal action against a healthcare facility--an expensive and often damaging outcome. Improving Nursing Documentation and Reducing Risk helps nurse managers create policies, processes, and ongoing auditing practices to ensure that complete and accurate documentation is implemented by their staff, without creating additional time burdens. Nurse managers, especially new nurse managers, do not clearly understand their legal accountability for poor or inadequate documentation created by nursing staff who report to them. While each state's nurse practice act (NPA) differs, every NPA addresses nursing liability for documentation; however, many nurse managers remain unaware of these and other regulations that hold them accountable for the documentation crafted by their nurses. This book helps nurse managers protect themselves and their staff by clearly explaining to their employees the impact of documentation practices on reimbursement, educating them on the consequences of failure to document, and training them on how to document properly. This book will help you: Work directly with your staff to ensure accurate documentation Train nurses during orientation Educate your staff on the consequences of inaccurate documentation Create steps to share with your staff that will improve documentation Ensure complete comprehension of documentation issues through sample forms, auditing tools, and case studies Table of Contents Chapter 1: Contemporary

Nursing Practice Includes Good Documentation Chapter 2: Contemporary Nursing Standards: Why it's Important for Nurses to Document Well Chapter 3: Reducing Professional Risk Through Documentation Chapter 4: Barriers to Good Nursing Documentation Chapter5: Improving Nursing Documentation Chapter 6: Electronic Medical Records: Advantages and Challenges to Good Nursing Documentation Chapter 7: Ways to Engage and Motivate Staff to Document Well Chapter 8: Improving Documentation and Outcomes

The Future of Nursing explores how nurses' roles, responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in America's increasingly complex health system. At more than 3 million in number, nurses make up the single largest segment of the health care work force. They also spend the greatest amount of time in delivering patient care as a profession. Nurses therefore have valuable insights and unique abilities to contribute as partners with other health care professionals in improving the quality and safety of care as envisioned in the Affordable Care Act (ACA) enacted this year. Nurses should be fully engaged with other health professionals and assume leadership roles in redesigning care in the United States. To ensure its members are well-prepared, the profession should institute residency training for nurses, increase the percentage of nurses who attain a bachelor's degree to 80 percent by 2020, and double the number who pursue doctorates. Furthermore, regulatory and institutional obstacles -- including limits on nurses'

scope of practice -- should be removed so that the health system can reap the full benefit of nurses' training, skills, and knowledge in patient care. In this book, the Institute of Medicine makes recommendations for an action-oriented blueprint for the future of nursing.

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.

"Nurses play a vital role in improving the safety and quality of patient car -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

This manual offers a quality documentation system using nursing diagnosis developed specifically for long-term care. it provides practical quality tools to guide professional nurses and interdisciplinary staff members in meeting documentation requirements under OBRA '87.

Today, more than 10 million people in the United States require some form of long-term care, a number that is

rapidly increasing and will continue to do so for years to come. This concise and user-friendly resource contains the fundamental information long-term care nurses need to provide all aspects of safe and effective care to their patients in nursing homes and assisted living facilities. Written by a renowned and highly respected nurse leader in long-term care and gerontology, it presents key facts and core competencies related to the clinical and managerial responsibilities of nurses in these settings. Details on the specific skills required for this challenging specialty, as well as must-know information on regulatory standards, site visits, management and leadership, and dementia care, are presented in a concise format for quick access to information. The book embodies a holistic approach to nursing that recognizes the importance of quality of life in addition to quality of care. It provides an overview of the unique features of long-term care, addressing the operational differences between these settings and those of acute settings, the distinct responsibilities of long-term care nurses, special needs of the residents, and major clinical challenges. The text offers guidance on the use of evidence-based knowledge within the constraints of long-term care settings. Topics such as legal risks, documentation essentials, and the importance of self-care are covered, along with management and leadership issues relevant to the supervision of unlicensed personnel. The Fast Facts in a Nutshell feature assists readers in reinforcing and applying content, and a comprehensive resource list supplements the text. The book will also serve as a useful study tool for long-term nursing care certification.

Key Features: Embodies the essential competencies for long-term care nursing practice Presents information in a concise easy-to-access format with bulleted facts and the Fast Facts in a Nutshell feature Addresses management and leadership issues germane to the long-term care setting Includes must-know information on regulatory standards, site visits, legal risks, documentation essentials, and more Guides nurses in using evidence-based knowledge in long-term care settings

Clinical Documentation Quick Reference for Long-Term Care Barbara Acello, MS, RN Save time while achieving accurate, comprehensive documentation for every resident in your facility This resource, designed to be used at the resident's bedside, will help nurses improve their efficiency and quality of documentation by guiding them through 150 of the most common conditions, procedures, and situations encountered in a long-term care facility. With a detailed and comprehensive description of each symptom or condition, nurses will have a thorough list of what to check for and what to document during every shift, based on the specific circumstances of a given resident. Guarantee your residents receive the best quality of care and ensure your facility maintains compliant documentation with the help of "Clinical Documentation Quick Reference for Long-Term Care." "Clinical Documentation Quick Reference for Long-Term Care" will: Help nurses save time while achieving accurate, comprehensive documentation for every resident in their care Provide clinicians with documentation procedures for the 150

most common conditions, procedures, and situations encountered in long-term care Aid in identifying problems and related interventions through assessment guidelines by system

This unique, spiral-bound handbook is compact, portable, and written with busy home health nurses in mind! Organized by body system, it offers instant advice on assessment and care planning for the disorders home health nurses are likely to encounter. Providing assessment guides for all body systems, the home environment, and the client's psychological status, it includes full care plans for over 50 illnesses and conditions most commonly encountered in the home. Each plan lists nursing diagnoses, short- and long-term expected outcomes, nursing interventions, and client caregiver interventions. Care plans are organized by body systems to allow for quick retrieval of information. Both short-term and long-term outcomes are included in the care plans to aid evaluation of the care provided. Detailed assessment guidelines are provided for all body systems to facilitate complete and comprehensive client examinations. Guidelines for environmental and safety assessments aid in the appraisal and improvement of clients' living conditions. Client and caregiver interventions are outlined in the care plans to promote active client participation in self-care. The convenient pocket size makes transportation and use convenient to home health nurses. Appendices on documentation guidelines, laboratory values, medication administration, home care resources, and standard precautions provide quick access to useful home care information. Related

OASIS items are identified in the assessment section, and ICD-9 diagnostic codes in the care plans section assist with proper home care documentation. Visit frequency and duration schedules are suggested within each care plan to assist nurses in evaluating and planning care. NANDA nursing diagnoses are consistent with the latest 2001-2002 nomenclature. An increase in suggested therapy referrals within the care plans and in a new appendix helps nurses identify indicators for specialized services. A fully updated Resources Appendix includes websites for easy access to home health service information.

Clinical documentation can significantly affect a nursing home's survey results, reimbursement received, and most importantly, resident care. Yet, little formal training is given on how to complete this complicated, and often confusing, process. With so much at stake, it's critical that nurses have a resource they can turn to in order to help achieve accurate, comprehensive documentation for all residents.

Building on the revolutionary Institute of Medicine reports To Err is Human and Crossing the Quality Chasm, Keeping Patients Safe lays out guidelines for improving patient safety by changing nursesâ€™ working conditions and demands. Licensed nurses and unlicensed nursing assistants are critical participants in our national effort to protect patients from health care errors. The nature of the activities nurses typically perform â€" monitoring patients, educating home caretakers, performing treatments, and rescuing patients who are in crisis â€" provides an indispensable resource in detecting and

remedying error-producing defects in the U.S. health care system. During the past two decades, substantial changes have been made in the organization and delivery of health care â€" and consequently in the job description and work environment of nurses. As patients are increasingly cared for as outpatients, nurses in hospitals and nursing homes deal with greater severity of illness. Problems in management practices, employee deployment, work and workspace design, and the basic safety culture of health care organizations place patients at further risk. This newest edition in the groundbreaking Institute of Medicine Quality Chasm series discusses the key aspects of the work environment for nurses and reviews the potential improvements in working conditions that are likely to have an impact on patient safety.

"The Long-Term Care Restorative Nursing Desk Reference" is a new all-inclusive desk reference that describes the clinical aspects of restorative nursing in detail and provides a much-needed guide for nurses in a long-term care facility. This book offers the help you need to create or sustain an effective restorative care program that puts your resident s needs first."

Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation Barbara Acello, MS, RN and Lynn Riddle Brown, RN, BSN, CRNI, COS-C Initial assessments can be tricky--without proper documentation, home health providers could lose earned income or experience payment delays, and publicly reported quality outcomes affected by poor assessment documentation could negatively impact an agency's reputation. 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. This indispensable resource provides the ultimate blueprint for accurately assessing patients' symptoms and conditions to ensure regulatory compliance and proper payment. It will help agencies deliver more accurate assessments and thorough documentation, create better care plans and improve patient outcomes, prepare for surveys, and ensure accurate OASIS reporting. All of the book's 75-plus checklists are also available electronically with purchase, facilitating agency-wide use and letting home health clinicians and field staff easily access content no matter where they are. This book will help homecare professionals: Easily refer to checklists, organized by condition, to properly assess a new patient Download and integrate checklists for use in any agency's system Obtain helpful guidance on assessment documentation as it relates to regulatory compliance Appropriately collect data for coding and establish assessment skill proficiency TABLE OF CONTENTS Section 1: Assessment Documentation Guidelines 1.1. Medicare Conditions of Participation 1.2. Determination of Coverage Guidelines 1.3. Summary of Assessment Documentation Requirements 1.4. Assessment Documentation for Admission to Agency 1.5. Case Management and Assessment Documentation 1.6. Assessment Documentation for Discharge Due to Safety or Noncompliance 1.7. Start of Care Documentation Guidelines 1.8. Routine Visit Documentation Guidelines 1.9. Significant Change in Condition Documentation

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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.

This guide will help Long Term Care nurses everywhere with quick references for documentation, medications, assessments, lab information, post mortum care, survey preperation and much more. Almost 400 pages of resources that are needed on a daily basis. Resources that you will not find anywhere else. A must have for every Long Term Care nurse.

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.

DOCUMENTATION SKILLS FOR QUALITY PATIENT CARE is written for students & professional nurses who want to develop or strengthen existing documentation skills. Documentation meets many needs & requirements.

This book reviews those needs & outlines the regulations that nurses must adhere to. JCAHO & ANA standards of nursing practice that relate to documentation are featured. Nursing process & writing NANDA nursing diagnoses are reviewed. The book describes what needs to be documented as well as techniques, & pitfalls of documentation. Numerous examples of nursing notes, based on the author's long & varied clinical experiences, are included to guide the reader. Written in a clear & accessible style, the book is intended for use as a primer & refresher guide. A busy teacher or hospital educator could use the book as a guideline for instruction. Order from: Awareness Productions, P.O. Box 85, Tipp City, OH 45371-0085. 513-845-3617.

Critical Thinking in Long-Term Care Nursing: Skills to Assess, Analyze and Act, is an easy-to-read resource that explains the principles of critical thinking and how to encourage nurses to use critical thinking methods. This essential book covers how to lead classroom sessions for new graduate nurses and experienced nurses to develop critical thinking skills, including successful classroom processes and learning strategies.

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!

From pain assessment methods to intravenous drip calculations, the Long-Term Care Nursing Desk Reference offers long-term care nurses virtually every tool they need to provide high-quality, regulation-compliant, long-term resident care. Written by accomplished author and speaker Barbara Acello, MS, RN, this authoritative reference is jam-packed with practical, need-to-know patient care information, essential policies and procedures, and vital regulatory and safety requirements. In short, the Long-Term Care Nursing Desk Reference is the book you and your nurses have been waiting for!

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

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