

## Nursing Charting Guidelines

Nurses are now commonly cited or implicated in medical malpractice cases.

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

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. Each patient problem or diagnosis found in this handbook includes specific documentation guidelines for the following aspects of nursing care: \*Assessment of patient problem \*Associated nursing diagnosis \*Examples of objective findings for documentation \*Examples of subjective findings for documentation \*Examples of assessment of the data \*Examples of potential medical problems for this patient \*Examples of the documentation of potential nursing interventions/actions \*Examples of the evaluations of the interventions/actions \*Other services that may be indicated and their associated interventions and goals/outcomes \*Nursing goals and outcomes \*Potential discharge plans for this patient \*Patient, family, caregiver educational needs \*Resources for care and practice \*Legal considerations for documentation, as appropriate Introductory chapters describe documentation, the medical record systems of nursing documentation, and current JCAHO and ANA standards related to documentation. Specialty sections provide important and specific guidelines for hospice care and maternal-child care. Appendices provide the latest NANDA-approved nursing diagnoses, descriptions of services provided by other disciplines, abbreviations, and a listing of resources

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(i.e., directory of resources, clinical newsletters and journals, Internet resources, further reading). Includes Time Saving Tips boxes to help minimize the time needed for documentation responsibilities. Each diagnosis includes a Critical Assessment Components/Findings section to help nurses with their critical decision making and determine whether an assessment finding indicates immediate attention or patient follow up. The Goals/Outcomes section of each diagnosis now appears at the beginning so that nurses know the intended goals and outcomes up front before beginning the assessment. All documentation guidelines now include sections on Examples of Subjective Findings for Documentation and Resources for Care and Practice. Includes Legal Considerations for Documentation as appropriate to highlight important legal issues. Part One has been updated to reflect the current managed care environment, including new information required by the National Community of Quality Assurance [NCQA], so that nurses can incorporate and focus on these changes as they document University of Wisconsin-Milwaukee School of Nursing's comprehensive charting and documentation manual for students and practitioners. 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.

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

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Section 15: Infusion Assessment Documentation 15.1. Implanted Infusion Pump Assessment Documentation 15.2. Infusion Therapy Assessment Documentation 15.3. Vascular Access Device (VAD) Assessment Documentation

An essential reference for nursing students in developing and implementing the competencies necessary in caring for critically ill patients. Includes sample test questions relevant to the model that will assist nursing students in preparing for certification through AACN.

With a new focus on evidence-based practice, the 3rd edition of this authoritative reference covers every aspect of infusion therapy and can be applied to any clinical setting. Completely updated content brings you the latest advances in equipment, technology, best practices, guidelines, and patient safety. Other key topics include quality management, ethical and legal issues, patient education, and financial considerations. Ideal as a practical clinical reference, this essential guide is also a perfect review tool for the CRNI examination. Authored by the Infusion Nurses Society, this highly respected reference sets the standard for infusion nursing practice. Coverage of all 9 core areas of INS certification makes this a valuable review resource for the examination. Material progresses from basic to advanced to help new practitioners build a solid foundation of knowledge before moving on to more advanced topics. Each chapter focuses on a single topic and can serve as a stand-alone reference for busy nursing professionals. Expanded coverage of infusion therapy equipment, product selection, and evaluation help you provide safe, effective care. A separate chapter on infusion therapy across the continuum offers valuable guidance for treating patients with infusion therapy needs in outpatient, long-term, and home-care, as well as hospice and ambulatory care centers. Extensive information on specialties addresses key areas such as oncology, pain management, blood components, and parenteral nutrition. An evidence-based approach and new Focus on Evidence boxes throughout the book emphasize the importance of research in achieving the best possible patient outcomes. The user-friendly design highlights essential information in handy boxes, tables, and lists for quick access. Completely updated coverage ensures you are using the most current infusion therapy guidelines available.

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.

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.

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

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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.

The premier resource for professional nursing practice, *Nursing: Scope & Standards of Practice, 3rd Edition*, is informed by the advances in health care and professional nursing today. This keystone standard contains 17 national standards of practice and performance that define the who, what, where, when, why and how of nursing practice. The scope and standards of practice inform and guide nursing practice and are often used as a reference for: Quality improvement initiatives Certification and credentialing Position descriptions and performance appraisals Classroom teaching and in-service education programs Boards of nursing members' orientation programs and regulatory decision-making activities It also outlines key aspects of nursings' professional role and practice for any level, setting, population focus, or specialty and more! In sum, *Nursing Scope and Standards of Practice* is a detailed and practical discussion of the competent level of nursing practice and professional performance. It is a must-have for every registered nurse. - Publisher.

An excellent resource for new or seasoned NPs and PAs! *The Nurse Practitioner in Long-Term Care* addresses the growing trend to utilize the nurse practitioner in the skilled nursing facility (SNF) to manage patients in long-term care and serves as a practical resource for managing those conditions commonly encountered in the geriatric patient. It includes an introduction to nursing homes, medication management, practical health promotion/disease prevention, and management of common clinical conditions specific to the skilled and long term care nursing home settings. It will also address important topics such as elder abuse, legal issues, reimbursement, and regulatory issues. Subjects covered are pertinent to everyday practice and this text is useful in graduate programs for nurse practitioners and clinical nurse specialists as well as for physician's assistant (PA) students.

Introducing the only fully comprehensive skills text on the market, distinctly for Canadian students! *Canadian Clinical Nursing Skills and Techniques* helps equip you with the skills you need to successfully care for patients within the Canadian social and institutional context. Building on the strength of *Clinical Nursing Skills & Techniques'* comprehensive coverage of over 200 basic, intermediate and advanced skills, this textbook features nearly 1,000 full-colour photographs and drawings, a nursing process framework, step-by-step instructions with rationales, and a focus on critical thinking and evidence-informed practice. Written by the highly respected author team of Anne Griffin Perry,

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Patricia A. Potter, Wendy Ostendorf, and Canadian author Shelley L. Cobbett, it offers all the guidance and tools you need to perform nursing skills with complete confidence! Comprehensive coverage includes over 200 basic, intermediate, and advanced nursing skills. Streamlined theory content in each chapter features a quick, easy-to-read bullet format to help reduce repetition and emphasize the clinical focus of the book. Unique! Evidence-Informed Nursing Practice chapter covers the entire process of conducting research, including collecting, evaluating, and applying evidence from published research. Unique! Unexpected Outcomes and Related Interventions sections alert you to what might go wrong and how to appropriately intervene. Clinical Debriefs case-based review questions at the end of each chapter focus on issues such as managing conflict, care prioritization, patient safety, and decision-making to help you better prepare for the clinical setting. Nursing process framework incorporates the areas of delegation and collaboration; reporting and recording; safety guidelines; and teaching, pediatric, geriatric, and home care considerations. Basic skills presented in streamlined procedural guidelines format makes it easy learn and review basic nursing skills. Clinical Decision Points within skills address key safety issues or possible skill modifications for specific patient needs. Rationales for each skill step explain why steps are performed in a specific way, including their clinical significance and benefit, and incorporate the latest research findings. Video clip icons indicate video clips that are related to skills and procedures in the book and related lessons in Nursing Skills Online.

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.

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.

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

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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 Chapter 5: 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

Peer Review in Nursing: Principles for a Successful Practice is the first nursing publication that approaches the definition and implementation strategies for peer review within an organizational setting. Using a professional model, with shared governance as a framework, the authors discuss the difference between manager initiated staff performance evaluation of the past and the true peer review aspects of professional practice for the future. This text follows in line with the Magnet program requirement "that nurses at all levels use self appraisal performance review and peer review, including annual goal settings, for the assurance of competence and professional development" page 30 of the 2008 Magnet manual. This unique text teaches nurses the skills they need to demonstrate organizational processes, structures, and outcomes that help insure accountability, competence and autonomy.

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

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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. 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!

Develop the skills you need to effectively and efficiently document patient care for children and adults in clinical and hospital settings. This handy guide uses sample notes, writing exercises, and EMR activities to make each concept crystal clear, including how to document history and physical exams and write SOAP notes and prescriptions.

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

Home care clinicians everywhere depend on "the little red book" for essential, everyday information: detailed standards and documentation guidelines including ICD-9-CM diagnostic codes, current NANDA-I and OASIS information, factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement considerations, and evidence-based resources for practice and education. Completely revised and updated, this indispensable handbook now includes the most recently revised Federal Register Final Rule and up-to-date coding guidelines.

Part of the Springhouse Incredibly Easy! Series(TM), this Second Edition provides current information about charting in a comprehensible,

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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. 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.

Hospice & Palliative Care Handbook, Third Edition, offers concise, focused coverage of all aspects of hospice and palliative care for clinicians, managers, and other team members who provide important care while meeting difficult multilevel regulations. Author Tina M. Marrelli, Director of the first U.S. hospice program to attain Joint Commission accreditation for hospice services, helps caregivers meet quality, coverage, and reimbursement requirements in daily practice and documentation. Filled with key topics such as professional standards and guidelines, bereavement services considerations, outcomes, and goals, and quality control, this comprehensible book provides the tools hospice caregivers need for success. 2nd Place 2018 AJN Book of the Year

Completely revised and updated, this broad yet comprehensive edition contains twenty-nine chapters on nursing issues and clinical practice. Topics cover practice and process, documentation, legal issues, health promotion, physical assessment, I.V. therapy, surgical care, and

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more. Disorders are organized by body system and feature an overview of anatomy and physiology, assessment, diagnostic tests, medication, treatment, and home care, with coverage of care for maternal-neonatal, pediatric, geriatric, emergency, and psychiatric patients. Added features include grabbing nursing procedure graphics, complementary therapies, clinical pathways, and cultural information. Over 1,000 illustrations, charts, and graphs enhance the text, with a new appendix relating Internet sites for nurses.

With the recent new and radical developments in the health care field that have been introduced at a breathless pace, nurse administrators must work to stay informed of the developments that affect their nursing departments both directly and indirectly. The Nursing Administration Handbook has a long track record, both as a textbook and as a hands-on tool for nurse executives seeking insight and step-by-step guidance in all aspects of administration. The fourth edition of this text surveys the entire field of nursing administration and incorporates the most significant new developments and current practices.

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

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.

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

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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. 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 care -- 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>.

The decade ahead will test the nation's nearly 4 million nurses in new and complex ways. Nurses live and work at the intersection of health, education, and communities. Nurses work in a wide array of settings and practice at a range of professional levels. They are often the first and most frequent line of contact with people of all backgrounds and experiences seeking care and they represent the largest of the health care professions. A nation cannot fully thrive until everyone - no matter who they are, where they live, or how much money they make - can live their healthiest possible life, and helping people live their healthiest life is and has always been the essential role of nurses. Nurses have a critical role to play in achieving the goal of health equity, but they need robust education, supportive work environments, and

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autonomy. Accordingly, at the request of the Robert Wood Johnson Foundation, on behalf of the National Academy of Medicine, an ad hoc committee under the auspices of the National Academies of Sciences, Engineering, and Medicine conducted a study aimed at envisioning and charting a path forward for the nursing profession to help reduce inequities in people's ability to achieve their full health potential. The ultimate goal is the achievement of health equity in the United States built on strengthened nursing capacity and expertise. By leveraging these attributes, nursing will help to create and contribute comprehensively to equitable public health and health care systems that are designed to work for everyone. The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity explores how nurses can work to reduce health disparities and promote equity, while keeping costs at bay, utilizing technology, and maintaining patient and family-focused care into 2030. This work builds on the foundation set out by The Future of Nursing: Leading Change, Advancing Health (2011) report.

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