Home Health Nursing Documentation

Recognizing the mannerism ways to acquire this books **Home Health Nursing Documentation** is additionally useful. You have remained in right site to start getting this info. acquire the Home Health Nursing Documentation belong to that we offer here and check out the link.

You could buy lead Home Health Nursing Documentation or get it as soon as feasible. You could speedily download this Home Health Nursing Documentation after getting deal. So, subsequent to you require the books swiftly, you can straight get it. Its fittingly certainly easy and for that reason fats, isnt it? You have to favor to in this look

Handbook of Home Health Standards **Lippincott Williams & Wilkins**
Handbook of Home Health Standards, Revised Reprint
Chart Smart Mosby
Complete your charting at your patient's home and stay organized. EASY and CONVENIENT to use. 6x9 Inhces with 120 pages and Matte Finish.
Telehealth Nursing Elsevier Health Sciences
An all-inclusive guide to fundamentals and medical-surgical nursing for the LPN/LVN, Foundations and Adult Health Nursing, 7th Edition covers the skills you need for clinical practice, from anatomy and physiology to nursing interventions and maternity, neonatal, pediatric, geriatric, mental health, and community health care. Guidelines for patient care are presented within the framework of the five-step nursing process; Nursing Care Plans are described within a case-study format to help you develop skills in clinical decision-making. Written by Kim Cooper and Kelly Gosnell, this text includes all of the content from their Foundations of Nursing and Adult Health Nursing books, including review questions to help you prepare for the NCLEX-PN® examination! Full-color, step-by-step instructions for over 100 skills show nursing techniques and procedures along with rationales for each. The 5-step Nursing Process connects specific disorders to patient care - with a summary at the end of each chapter. Nursing Care Plans emphasize patient goals and outcomes within a case-study format, and promotes clinical decision-making with critical thinking questions at the end of each care plan. Clear coverage of essential A&P is provided by an Introduction to Anatomy and Physiology chapter along with an overview of A&P in all body systems chapters. Student-friendly features enhance the learning of nursing skills with summary boxes for Patient Teaching, Health Promotion Considerations, Complementary and Alternative Therapy, Cultural Considerations, Older Adult Considerations, Home Care Considerations, Safety Alert, and Prioritization, Assignment, and Supervision. UNIQUE! Mathematics review in Dosage Calculation and Medication Administration chapter covers basic arithmetic skills prior to the discussion of medication administration. A focus on preparing for the NCLEX examination includes review questions and Get Ready for the NCLEX Examination! sections with key points organized by NCLEX Client Needs Categories. Evidence-Based Practice boxes provide synopses of nursing research articles and other scientific articles applicable to nursing, along with nursing implications for the LPN/LVN. Nursing Diagnosis boxes summarize nursing diagnoses for specific disorders along with the appropriate nursing interventions. UNIQUE! Delegation Considerations boxes provide parameters for delegation to nurse assistants, patient care technicians, and unlicensed assistive personnel. Medication Therapy tables provide quick access to actions, dosages, precautions, and nursing considerations for commonly used drugs. NEW! Reorganized chapters make it easier to follow and understand the material. NEW! Icons in page margins indicate videos, audios, and animations on the Evolve companion website that may be accessed for enhanced learning. UDATED illustrations include photographs of common nursing skills.
The OASIS Nursing Narrative Note RefeRNce Blueprint Jones & Bartlett Publishers
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.
Nursing Documentation Made Incredibly Easy Hcpro Incorporated
"This text covers conceptual information, leadership skills and current issues and trends. It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care." --Cover.
Managing Documentation Risk Jones & Bartlett Learning
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 medial 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.,/LI>
Handbook of Home Health Care Administration Elsevier Health Sciences
Part of the popular LPN Threads series, this comprehensive text includes in-depth discussions of fundamental concepts and skills, plus medical-surgical content to help you provide safe and effective care in the fast-paced healthcare environment. Easy-to-read content, an enhanced focus on preparing for the NCLEX ® Examination, and a wealth of tips and study tools make Foundations and Adult Health Nursing, 6th Edition, your must-have text!
Nursing Interventions Classification (NIC) - E-Book Lippincott Williams & Wilkins
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
Improving Nursing Documentation and Reducing Risk Hcpro, a Division of Blr
Orientation to Home Care Nursing is a comprehensive reference text that covers all aspects of home health nursing. This text can be used as a primary text for home care and community nursing courses. Or it can be used concurrently with the agency's own materials to apply learned material to daily practice or with students who are learning about home care. This companion text to the Manual of Home Care Nursing Orientation, by the same authors, provides the nurse with an in-hand reference for orientation and beyond.
Mosby's Guide to Nursing Diagnosis Elsevier Health Sciences
Everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards is found in this handbook. Offers detailed standards and documentation guidelines for each of more than 60 clinical problems, including ICD-9 (diagnostic) codes, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, and more.
Handbook of Home Health Standards Jones & Bartlett Learning
Documenting Medical Necessity: A Practical Guide for Home Health Heather Calhoun, RN, BSN, HCS-D, COS-C Initial patient assessment in home health can be tricky. If documentation does not adequately provide a reason for skilled nursing care in the

home, you might not get reimbursed at all. In Documenting Medical Necessity: A Practical Guide for Home Health, author Heather Calhoun, RN, BSN, HCS-D, COS-C, provides down-to-earth, conversational documentation tips with dozens of example scenarios to help nurses understand medical necessity and document in a manner that encourages proper and complete reimbursement. In addition to initial assessments for skilled services, continued skilled care must also be properly documented. This resource will help nurses provide skilled services based on critical thinking throughout the continuum of care. This book has: A grounded, conversational style that speaks directly to nurses who are responsible for the documentation Dozens of hypothetical examples that provide concrete learning opportunities Scenarios that are available electronically to provide handouts for ongoing and on-the-go learning Content that serves as a great resource for orientation and annual training TABLE OF CONTENTS Background of Medical Necessity Criteria Changes of 1997 Present-Day Payment Criteria Fundamentals of Medical Necessity Focus of Care - Mistakes that lead to rehospitalization Delivery of Care - Start of care narrative Frequency of Care Mutually Agreed-Upon Goals Documentation: Paint the Picture Observation and Assessment Teaching and Training Direct Skilled Care Management and Evaluation Psychiatric Nursing Therapy Initial Assessment Standardized Tools 30-Day Reevaluation Therapy Indications - Gait training - Range of motion - Use of modalities - Wound care - Occupational therapy - Speech therapy - Maintenance therapy

Nursing Care Plans Mosby Incorporated

Patient Visit Notes For Hospice Nurses Keeping concise and accurate notes is crucial for correct patient care, and legally required in the most situations. Although Bedside Charting is the generally preferred method of note taking for Hospice Nurses, you quickly realise that it is not always practical, given the hands-on, rapidly changing nature of Hospice Care. This book is designed to simplify the process of patient note taking, and contains all essential information for appropriate care. It's also a great resource that helps to compile all your records into one convenient location, which should be kept for a number of years should any legal situations arise. It was designed with consultation and guidance from Dr M. Smithe. It is designed specifically for Hospice and home care Nurses, and contains the following: Index page (Quick Recap of which patient is on each page and the date of visit. Patient Visit Logs, and Notes for each Patient (1 Double Page Spread per Visit) Blank Notes Pages at the end of the book Each Patient Note Spread Contains the following: Date Scheduled / PRN Start and Finish Time Patient Name Mileage start and finish (For traveling hospice workers) Patient Pain (1-10) and description Temperature Blood Pressure Respiratory rate Heart Rate SO2 O2 LPM Last BM Left and Right MAC Weight Family / Facility Updated (Yes / No) Next Visit Date Medication supply confirmed Lined notes (3 / 4 page per patient visit) Notes for next visit 6 x blank input columns for personal notetaking unique to each hospice nurse. Book Features: 130 Pages 6 x 9 inch - very convenient size Printed on white paper Perfect bound, softcover book

Mosby Incorporated

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

Documenting Medical Necessity F A Davis Company

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

Parish Nursing Springer Publishing Company

Publisher's Note: Products purchased from 3rd Party sellers are not guaranteed by the Publisher for quality, authenticity, or access to any online entitlements included with the product. Feeling unsure about the ins and outs of charting? Grasp the essential basics, with the irreplaceable Nursing Documentation Made Incredibly Easy! ®, 5th Edition. Packed with colorful images and clear-as-day guidance, this friendly reference guides you through meeting documentation requirements, working with electronic medical records systems, complying with legal requirements, following care planning guidelines, and more. Whether you are a nursing student or a new or experienced nurse, this on-the-spot study and clinical guide is your ticket to ensuring your charting is timely, accurate, and watertight. Let the experts walk you through up-to-date best practices for nursing documentation, with: NEW and updated, fully illustrated content in quick-read, bulleted format NEWdiscussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation Easy-to-retain guidance on using the electronic medical records / electronic health records (EMR/EHR) documentation systems, and required charting and documentation practices Easy-to-read, easy-to-remember content that provides helpful charting examples demonstrating what to document in different patient situations, while addressing the different styles of charting Outlines the Do's and Don ' ts of charting – a common sense approach that addresses a wide range of topics, including: Documentation and the nursing process—assessment, nursing diagnosis, planning care/outcomes, implementation, evaluation Documenting the patient ' s health history and physical examination The Joint Commission standards for assessment Patient rights and safety Care plan guidelines Enhancing documentation Avoiding legal problems Documenting procedures Documentation practices in a variety of settings—acute care, home healthcare, and long-term care Documenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior Special features include: Just the facts – a quick summary of each chapter ' s content Advice from the experts – seasoned input on vital charting skills, such as interviewing the patient, writing outcome standards, creating top-notch care plans " Nurse Joy " and " Jake " – expert insights on the nursing process and problem-solving That ' s a wrap! – a review of the topics covered in that chapter About the Clinical Editor Kate Stout, RN, MSN, is a Post Anesthesia Care Staff Nurse at Dosher Memorial Hospital in Southport, North Carolina.

Patient Safety and Quality Elsevier Health Sciences

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 medial 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.,/LI >

Community Health Nursing Clinical Documentation Strategies for Home Health The "whys" and "hows" of charting for home health care.

Home Health Assessment Criteria Lippincott Williams & Wilkins

Table of Contents Foreword Introduction Ch. 1 Home health administration : an overview 3 Ch. 2 The home health agency 16 Ch. 3 Medicare conditions of participation 27 Ch. 4 The joint commission's home care accreditation program 63 Ch. 5 CHAP accreditation : standards of excellence for home care and community health organizations 71 Ch. 6 Accreditation for home care aide and private duty services 81 Ch. 7 ACHC : accreditation for home care and alternate site health care services 86 Ch. 8 Certificate of need and licensure 92 Ch. 9 Credentialing : organizational and personnel options for home care 101 Ch. 10 The relationship of the home health agency to the state trade association 111 Ch. 11 The national association for home care and hospice 115 Ch. 12 The visiting nurse association of America 124 Ch. 13 Self-care systems in home health care nursing 131 Ch. 14 Home health care documentation and record keeping 135 App. 14-A COP standards pertaining to HHA clinical record policy 147 App. 14-B Abington Memorial Hospital home care clinical records 150 Ch. 15 Computerized clinical documentation 161 Ch. 16 Home telehealth : improving care and decreasing costs 176 Ch. 17 Implementing a competency system in home care 185 Ch. 18 Meeting the need for culturally and linguistically appropriate services 211 Ch. 19 Classification : an underutilized tool for prospective payment 224 Ch. 20 Analysis and management of home health nursing caseloads and workloads 236 Ch. 21 Home health care classification (HHCC) system : an overview 247 Ch. 22 Nursing diagnoses in home health nursing 261 Ch. 23 Perinatal high-risk home care 274 Ch. 24 High technology home care services 279 Ch. 25 Discharge of a ventilator-assisted child from the hospital to home 291 Ch. 26 Performance improvement 301 Ch. 27 Evidence-based practice : basic strategies for success 310 Ch. 28 Quality planning for quality patient care 315 Ch. 29 Program Evaluation 320 App. 29-A Formats for presenting program evaluation tools Ch. 30 Effectiveness of a clinical feedback approach to improving patient outcomes 341 Ch. 31 Implementing outcome-based quality improvement into the home health agency 352 Ch. 32 Benchmarking and home health care 383 Ch. 33 Administrative policy and procedure manual 395 Ch. 34 Discharge planning 399 Ch. 35 Strategies to retain and attract quality staff 421 Ch. 36 Evaluating productivity 436 Ch. 37 Labor-management relations 448 Ch. 38 Human resource management 459 Ch. 39 Staff development in a home health agency 474 Ch. 40 Transitioning nurses to home care 484 Ch. 41 Case management 495 Ch. 42 Managed care 499 Ch. 43 Community-based long-term care : preparing for a new role 507 Ch. 44 Understanding the exposures of home health care : an insurance primer 519 Ch. 45 Budgeting for home health agencies 527 Ch. 46 Reimbursement 535 Ch. 47 How to read, interpret, and understand financial statements 549 Ch. 48 Management information systems 558 Ch. 49 Legal issues of concern to home care providers 571 Ch. 50 Understanding the basics of home health compliance 590 Ch. 51 The HIPAA standards for privacy of individually identifiable health information 616 Ch. 52 Ethical practice in the daily service to home care client, their families, and the community 666 Ch. 53 Participating in the political process 675 Ch. 54 Strategic planning 693 Ch. 55 Marketing : an overview 708 Ch.

56 The internet in home health and hospice care 723 Ch. 57 Disease management programs 736 Ch. 58 The process of visiting nurse association affiliation with a major teaching hospital 756 Ch. 59 Grantsmanship in home health care : seeking foundation support 771 Ch. 60 Home care volunteer program 778 Ch. 61 The manager as published author : tips on writing for publication 796 Ch. 62 Student placements in home health care agencies : boost or barrier to quality patient care? 810 Ch. 63 A student program in one home health agency 818 Ch. 64 The role of the physician in home care 834 Ch. 65 Research in home health agencies 840 Ch. 66 Hospice care : pioneering the ultimate love connection about living not dying 850 App. 66-A State of Connecticut physician assisted living (PAL) directive 863 App. 66-B Summary guidelines for initiation of advanced care 864 Ch. 67 Safe harbor : a bereavement program for children, teens, and families 866 Ch. 68 Planning, implementing, and managing a community-based nursing center : current challenges and future opportunities 872 Ch. 69 Adult day services - the next frontier 883 Ch. 70 Partners in healing : home care, hospice, and parish nurses 891 Ch. 71 Meeting the present challenges and continuing to thrive in the future : tips on how to be successful as an administrator in home health and hospice care 899.

Nursing Documentation Handbook Jones & Bartlett Learning

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.

Handbook of Home Health Standards E-Book Springer Publishing Company

This pocket-sized reference is ideal for use in clinicals, in class and at the bedside! A condensed version of the Nursing Diagnosis Handbook, 10th Edition, Mosby's Guide to Nursing Diagnosis, 4th edition uses a quick-access format to help you diagnose and formulate care plans with confidence and ease. It includes the most recent NANDA-I approved nursing diagnoses based on more than 1,300 specific symptoms and a step-by-step guide to creating care plans featuring desired outcomes, interventions, and patient teaching. UNIQUE! Care plans for every NANDA-I approved nursing diagnosis, including pediatric, geriatric, multicultural, home care, client/family teaching and discharge planning, and safety interventions Alphabetical thumb tabs provide quick access to specific symptoms and nursing diagnoses Pocketsize portability makes this book easy to carry and use in clinicals, in class, or at the bedside NEW! 4 Color Text NEW! Updated 2012-2014 NANDA-I-approved nursing diagnoses NEW! 16 new and 22 revised diagnoses NEW! Added content on safety, one of QSEN's six competencies