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Mental Health and Psychiatric Nursing American Medical Association Press
Focusing on the legal implications in the US, this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice.

Nursing Diagnosis Manual Springer Publishing Company
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

Telehealth Nursing Lippincott Williams & Wilkins
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.

Documentation Guidelines for Evaluation and Management Services Lippincott Williams & Wilkins
Now in its Ninth Edition, this full-color text combines theoretical nursing concepts, step-by-step skills and procedures, and clinical applications to form the foundation of the LPN/LVN course of study. This edition features over 100 new photographs, exciting full-color ancillaries, end-of-unit exercises, and extensively updated chapters on nursing foundations, laws and ethics, recording and reporting, nutrition, fluid and chemical balance, safety, asepsis, infection control, and medication administration. Coverage includes new information on cost-related issues, emerging healthcare settings, concept mapping, malpractice, documentation and reporting, HIPAA, and more. All Gerontologic Considerations sections have been thoroughly updated by renowned experts.

The Authoritative Guide and Toolkit for the Medical-Surgical Nursing Clinical Instructor Jones & Bartlett Learning
"A Guide for International Nursing Students is an essential resource for overseas nurses and international students of nursing in Australia and New Zealand. It assists the reader to develop essential communication skills for practice as a student and registered nurse in the region. A companion CD allows the reader to become familiar with authentic nursing conversations and nursing handovers."--Provided by publisher.

Nursing Documentation Made Incredibly Easy Ballantine Books
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.

A Guide for All Care Settings Elsevier Health Sciences
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!

Writing what We Do National Academies Press
Here's the 5th Edition of the resource you'll turn to again and again to select the appropriate diagnosis and to plan, individualize, and document care for more than 850 diseases and disorders. A new, streamlined design makes reference easier than ever. Only in the Nursing Diagnosis Manual will you find for each diagnosis…defining characteristics presented subjectively and objectively - sample clinical applications to ensure you have selected the appropriate diagnoses - prioritized action/interventions with rationales - a documentation section, and much more!

Nursing Mosby Incorporated
Clearly and concisely provides guidelines for appropriate and careful documentation of care. Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. In addition, it plays a large role in how third party payors make payment or denial decisions. This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment. Special attention focuses on the latest documentation issues specific to specialty settings, such as acute care, home care, and long-term care, and a variety of clinical specialties, such as obstetrics, pediatrics, and critical care.--Amazon.com.

Chart to Save Your RN License Wilfrid Laurier Univ. Press
"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.

How to Navigate Clueless Colleagues, Lunch-Stealing Bosses, and the Rest of Your Life at Work Lippincott Williams & Wilkins
This text for nursing students features physical examination, history taking and health status assessment. Formulated into vertically set three portrait columns, its distinguishing emphasis on analysis of collected data and coverage of practical applications is clearly presented and user-friendly.

Successful Collaboration in Healthcare Lippincott Williams & Wilkins
Nursing Notes the Easy Way100+ Common Nursing Documentation and Communication Templates

Nursing and Clinical Informatics: Socio-Technical Approaches SAGE
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

Issues and Models of Care Lippincott Williams & Wilkins
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.

Health Assessment in 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.

Fundamental Nursing Skills and Concepts F.A. Davis
Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal comminication in nursing to help you.

Chart Smart SAGE Publications, Incorporated
"This book gives a general overview of the current state of nursing informatics giving particular attention to social, socio-technical, and political basic conditions"--Provided by publisher.

The A-to-Z Guide to Better Nursing Documentation IGI Global
"If these are your concerns... I'll never get time to finish my nursing notes! Is it legal? Can I use white-out? Can't they make a better form than this? How can I record this family set-up quickly? Weren't computers made for clerks, not nurses? There has to be something wrong with documenting for funding. How do you record the pain level of someone who has a dementing illness? Who walks down critical pathways? What happens if a home health record gets lost? How can I document my client's spiritual concerns realistically? Will managed care affect what I write? Is there a culturally appropriate way to document? What is charting by exception? How did nurses document before NANDA?... then this book is for you." -Back cover.

A Comprehensive Guide to What, When, and How to Document for Nurses Hcpro, a Division of Blr
Covering the full range of nursing interventions, Nursing Interventions Classification (NIC), 6th Edition provides a research-based clinical tool to help in selecting appropriate interventions. It standardizes and defines the knowledge base for nursing practice while effectively communicating the nature of nursing. More than 550 nursing interventions are provided — including 23 NEW labels. As the only comprehensive taxonomy of nursing-sensitive interventions available, this book is ideal for practicing nurses, nursing students, nursing administrators, and faculty seeking to enhance nursing curricula and improve nursing care. More than 550 research-based nursing intervention labels with nearly 13,000 specific activities Definition, list of activities, publication facts line, and background readings provided for each intervention. NIC Interventions Linked to 2012-2014 NANDA-I Diagnoses promotes clinical decision-making. New! Two-color design provides easy readability. 554 research-based nursing intervention labels with nearly 13,000 specific activities. NEW! 23 additional interventions

include: Central Venous Access Device Management, Commendation, Healing Touch, Dementia Management: Wandering, Life Skills Enhancement, Diet Staging: Weight Loss Surgery, Stem Cell Infusion and many more. NEW! 133 revised interventions are provided for 49 specialties, including five new specialty core interventions. NEW! Updated list of estimated time and educational level has been expanded to cover every intervention included in the text.

Lippincott Williams & Wilkins

The Second Edition of Johnny Saldaña's international bestseller provides an in-depth guide to the multiple approaches available for coding qualitative data. Fully up to date, it includes new chapters, more coding techniques and an additional glossary. Clear, practical and authoritative, the book: -describes how coding initiates qualitative data analysis -demonstrates the writing of analytic memos -discusses available analytic software -suggests how best to use The Coding Manual for Qualitative Researchers for particular studies. In total, 32 coding methods are profiled that can be applied to a range of research genres from grounded theory to phenomenology to narrative inquiry. For each approach, Saldaña discusses the method's origins, a description of the method, practical applications, and a clearly illustrated example with analytic follow-up. A unique and invaluable reference for students, teachers, and practitioners of qualitative inquiry, this book is essential reading across the social sciences.