Skilled Nursing Documentation

Eventually, you will entirely discover a extra experience and attainment by spending more cash. yet when? attain you bow to that you require to get those every needs afterward having significantly cash? Why dont you attempt to get something basic in the beginning? Thats something that will guide you to understand even more a propos the globe, experience, some places, following history, amusement, and a lot more?

It is your utterly own become old to ham it up reviewing habit. in the course of guides you could enjoy now is **Skilled Nursing Documentation** below.

A Nursing Process Approach American Medical Association Press

There is a newer version of this book. You are viewing the first edition of this title. Check out the second edition for more up to date information. On August 8, 2011, the Centers for Medicare & Medicaid Services released the final ruling and commentary for the new implementation of the MDS changes set to take effect on Oct. 1, 2011. The Reimbursable Therapy Minutes will be the deciding factor in determining whether a Change of Therapy (COT) OMRA (Other Medicare Required Assessment) will be required, if at all. Most of our skilled nursing facilities are using some type of tracking tool for managing the prospective payment system minutes. Some are computerized, while others are still using paper forms. The Change of Therapy (COT) observation week must be scheduled exactly seven days following the previous MDS or observation week. If there has been a change in RUG category, then a Change of Therapy (COT) OMRA must be done and the reimbursement will drop or increase to the new RUG until another change occurs. CMS decided to assume all SNFs should offer seven-day rehab options, so facilities that traditionally offered Monday through Friday services will face immense challenges with the new Change of Therapy (COT) OMRAs. This book has been updated to discuss the new MDS assessment schedule, the allocation of group therapy minutes, the revised student supervision provisions, the End of Therapy (EOT) Other Medicare Required Assessment (OMRA) and new resumption items, and the new PPS assessment- Change of Therapy (COT) OMRA (Other Medicare Required Assessment). The long term care industry has anticipated the new MDS 3.0. RUG IV coding requires the therapist to specifically account for the time captured during the look back period. This book could help occupational therapists, physical therapists and speech therapists understand Medicare standards for subacute care programs to be compliant with Medicare MDS 3.0 standards and state regulations. Documenting and billing strategies are also discussed in this book to attain maximum reimbursement. A list of commonly used ICD-9 codes is also provided. Appropriate billing and documentation should be present in the medical record. Medicare is increasingly reviewing therapy claims to ensure that the therapy provided required the skills of a therapist. The Mandated program, Recovery Audit Contractions, recovered 1 billion dollars during their 3 year demonstration project. This book covers establishing medical necessity, refusing to care for a resident, restraints, safety, creating incident reports, supervising assistive personnel and resident privacy. Coding and billing for subacute and long term care settings are also encompassed in this book, along with denial and appeal management, regulatory guidelines for insurers and improving cash flow with denial management strategies. Proper coding and documentation ensures that facilities will keep their money upon a post payment medical record audit.

Long-Term Care Medicine HC Pro, Inc.

The development and evaluation of a system for the handling, maintenance and transcription of nursing home patient care orders are described. Before implementation of this documentation system, the study nursing home was found to be out of compliance with various state, federal and professional practice standards related to patient care orders. System implementation, with strict monitoring, extensive staff development and ancillary personnel education, both in the classroom and the patient care areas, occurred in two phases over a twelve month period. Following implementation of the system, there were no areas found to be out of compliance with state or federal standards in patient care order documentation. It is concluded that implementation of the documentation system can provide control of nursing home patient care orders, can be adopted with relative ease by both Intermediate Care Facilities and Skilled Nursing Facilities, and can provide methods to improve the performance of nursing home providers in all patient care order areas.

Quality, Documentation, and Reimbursement Home Health Assessment Criteria75 Checklists for Skilled Nursing DocumentationHome Health Assessment Criteria75 Checklists for Skilled Nursing Documentation

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.

Documentation Guidelines for Evaluation and Management Services Lippincott Williams & Wilkins

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

Hospice Nurse Patient Visit Notes Hcpro, a Division of Blr

"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.

An Evidence-based Approach HC Pro, Inc.

"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.

Assessment and Care Planning Lippincott Williams & Wilkins

The purpose of this book is to create a system of documentation that supports the delivery of resident care. The clinical record may be either handwritten or electronic, but its purpose is to provide the activity professional with information to: *assess each resident's needs *develop a plan of care *establish goals to be achieved and outcomes expected *document interventions *evaluate the success or need for revision of the care plan Throughout this book there are references specific to activity programs in nursing facilities and other situations that fall under OBRA guidelines. Federal regulations with interpretive guidelines and sections of the Resident Assessment Instrument (RAI) Version 3.0 Manual that describe documentation requirements are included.

The Skilled Services Troubleshooter Elsevier Health Sciences

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 CreateSpace

Complete & accurate documentation is one of the essential skills for a physical therapist. This book covers all the fundamentals & includes practice exercises & case studies throughout.

12 Case Studies : Treatment Intervention and Documentation Examples for Occupational Therapists Working in Skilled Nursing Facilities, and Much More Createspace Independent Publishing Platform

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

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach Elsevier Health Sciences

On October 1, 2014 the ICD-9 code sets used to report medical diagnoses and inpatient

procedures will be replaced by ICD-10 code sets. The transition to ICD-10 is required for everyone covered by the Health Insurance Portability Accountability Act (HIPAA). Also, the Middle Class Tax Relief and Jobs Creation Act of 2012 (MCTRJCA; Section 3005(g)) published at http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt399/pdf/CRPT-112hrpt399.pdf states that " The Secretary of Health and Human Services shall implement, beginning on January 1, 2013, a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services subject to the limitations of section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)). Such strategy shall be designed to provide for the collection of data on resident function during the course of therapy services in order to better understand resident condition and outcomes. " This reporting and collection system requires claims for therapy services to include non-payable G-codes and related modifiers. These non-payable G-codes and severity/complexity modifiers provide information about the beneficiary's functional status at the outset of the therapy episode of care, at specified points during treatment, and at the time of discharge. These G-codes and related modifiers are required on specified claims for outpatient therapy services – not just those over the therapy caps. This book can help occupational therapists, physical therapists, and speech therapists understand Medicare standards for subacute care programs that aim to be compliant with Medicare MDS 3.0 standards and state regulations. Documenting and billing strategies are also discussed in this book.This book has been updated to discuss the new MDS assessment schedule, distinct days of therapy, co-treatment, the allocation of group therapy minutes, the revised student supervision provisions, the EOT (End of Therapy) OMRA (Other Medicare Required Assessment) and new resumption items, and the new PPS assessment-COT (Change of Therapy) OMRA. Appropriate billing and documentation should be present in the medical record. Medicare is increasingly reviewing therapy claims to ensure that the therapy provided did require the skills of a therapist. This book discusses establishing medical necessity, refusing to care for a resident, restraints, safety, creating incident reports, supervising assistive personnel, and resident privacy. Coding and billing for subacute and long-term care settings are also covered in this book, along with denial and appeal management, regulatory guidelines for insurers, and improving cash flow with denial management strategies. Proper coding and documentation ensures that facilities will keep their money upon a post-payment medical record audit.The information provided here in no way represents a guarantee of payment. Benefits for all claims will be based on the resident's eligibility, provisions of the law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and its requirements.

A Pocket Guide Mosby Incorporated

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.

Manual of Nursing Home Practice for Psychiatrists National Academies Press

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 Guidelines 1.10. Transfer Documentation Guidelines 1.11. Resumption of Care Documentation Guidelines 1.12. Recertification Documentation Guidelines 1.13. Discharge Documentation Guidelines Section 2: General Assessment Documentation 2.1. Vital Sign Assessment Documentation 2.2. Pain Assessment Documentation 2.3. Pain Etiology Assessment

Documentation 2.4. Change in Condition Assessment Documentation 2.5. Sepsis Assessment Documentation 2.6. Palliative Care Assessment Documentation 2.7. Death of a Patient Assessment Documentation 2.8. Cancer Patient Assessment Documentation Section 3: Neurological Assessment Documentation 3.1. Neurological Assessment Documentation 3.2. Alzheimer's Disease/Dementia Assessment Documentation 3.3. Cerebrovascular Accident (CVA) Assessment Documentation 3.4. Paralysis Assessment Documentation 3.5. Seizure Assessment Documentation 3.6. Transient Ischemic Attack (TIA) Assessment Documentation Section 4: Respiratory Assessment Documentation 4.1. Respiratory Assessment Documentation 4.2. Chronic Obstructive Pulmonary Disease (COPD) Assessment Documentation 4.3. Pneumonia/Respiratory Infection Assessment Documentation Section 5: Cardiovascular Assessment Documentation 5.1. Cardiovascular Assessment Documentation 5.2. Angina Pectoris Assessment Documentation 5.3. Congestive Heart Failure (CHF) Assessment Documentation 5.4. Coronary Artery Bypass Graft Surgery (CABG) Assessment Documentation 5.5. Coronary Artery Disease (CAD) Assessment Documentation 5.6. Hypertension Assessment Documentation 5.7. Myocardial Infarction Assessment Documentation 5.8. Orthostatic Hypotension Assessment Documentation 5.9. Pacemaker and Defibrillator Assessment Documentation Section 6: Gastrointestinal Assessment Documentation 6.1. Gastrointestinal Assessment Documentation 6.2. Cirrhosis Assessment Documentation 6.3. Crohn's Disease Assessment Documentation 6.4. Hepatitis Assessment Documentation 6.5. Peritonitis, Suspected Assessment Documentation 6.6. Pseudomembranous Colitis Assessment Documentation 6.7. Ulcerative Colitis Assessment Documentation Section 7: Genitourinary Assessment Documentation 7.1. Genitourinary Assessment Documentation 7.2. Acute Renal Failure Assessment Documentation 7.3. Chronic Renal Failure Assessment Documentation 7.4. Urinary Tract Infection (UTI) Assessment Documentation Section 8: Integumentary Assessment Documentation 8.1. Integumentary Assessment Documentation 8.2. Skin Tear Assessment Documentation 8.3. Herpes Zoster Assessment Documentation 8.4. Leg Ulcer Assessment Documentation 8.5. Necrotizing Fasciitis (Streptococcus A) Assessment Documentation 8.6. Pressure Ulcer Assessment Documentation Section 9: Musculoskeletal Assessment Documentation 9.1. Musculoskeletal Assessment Documentation 9.2. Arthritis Assessment Documentation 9.3. Compartment Syndrome Assessment Documentation 9.4. Fall Assessment Documentation 9.5. Fracture Assessment Documentation Section 10: Endocrine Assessment Documentation 10.1. Endocrine Assessment Documentation 10.2. Diabetes Assessment Documentation Section 11: Eyes, Ears, Nose, Throat Assessment Documentation 11.1. Eyes, Ears, Nose, Throat Assessment Documentation 11.2. Dysphagia Assessment Documentation Section 12: Hematologic Assessment Documentation 12.1. Hematologic Assessment Documentation 12.2. Anticoagulant Drug Therapy Assessment Documentation 12.3. Deep Vein Thrombosis (DVT) Assessment Documentation 12.4. HIV Disease and AIDS Assessment Documentation Section 13: Nutritional Assessment Documentation 13.1. Nutritional Assessment Documentation 13.2. Dehydration Assessment Documentation 13.3. Electrolyte Imbalances Assessment Documentation 13.4. Weight Loss, Cachexia, and Malnutrition Assessment Documentation Section 14: Psychosocial Assessment Documentation 14.1. Psychosocial Assessment Documentation 14.2. Delirium Assessment Documentation 14.3. Psychotic Disorder Assessment Documentation 14.4. Restraint Assessment Documentation 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

Infusion Nursing Aspen Publishers

The skilled services troubleshooter takes the mystery out of skilled services and explains exactly when to skill a resident based on government regulations and proven strategies. Never again will you miss out on the benefits and reimbursement you and your resident deserve because you were unsure about the proper rules.

Nursing and Therapy Documentation in Long-Term Care McGraw Hill Professional

The shifting demographic toward a "graying" population -- coupled with today's reality of managed care -- makes the need for high-quality, cost-effective psychiatric services within the nursing care setting more urgent than ever. As we increase the number of our years, it is also imperative that we enhance the quality of those years. The product of the American Psychiatric Association's (APA's) Council on Aging and its Committee on Long-Term Care and of the Elderly, the Manual of Nursing Home Practice for Psychiatrists stands out because it focuses on the "how" -- not the "why" -- of nursing home care. Of exceptional importance is its detailed discussion of the Minimum Data Set (MDS), a structured assessment required by both Medicare and Medicaid for all residents of skilled nursing facilities. Divided into six sections, this "how to" volume contains practical information readers can use right away, from getting reimbursed by insurance companies to handling nursing facility politics: Clinical -- History; evaluation and management of psychiatric problems in long-term care patients; an overview of the MDS; sexuality within the nursing home care setting Regulatory -- Introduction to the Nursing Home Reform Act of 1987 (part of OBRA-87) and its implications for psychiatric care; details about the Resident Assessment Instrument (RAI), which includes the MDS, the Resident Assessment Protocols (RAPs), and Utilization Guides specified in the State Operations Manual (SOP) Financial -- Documentation, reimbursement, and coding; what to look for when contracting with nursing homes Legal and ethical -- The dehumanizing effect of diagnostic labels and the ethical issues inherent in regulating daily schedules (e.g., bed, meal, and bath times); nursing home placement; competence and decision-making ability; comfort care for end-stage dementia; coping with Alzheimer's disease; and the role of caregivers Summary and Future Perspectives -- A detailed vision about how psychiatrists can improve the diagnosis and treatment of nursing home patients Appendixes and bibliography -- Staffing recommendations and assessment instruments Edited by a distinguished authority and former chair of the APA's Committee on Long-Term Care and Treatment of the Elderly, this comprehensive volume will appeal to a wide audience of professionals: from general psychiatrists, nurse practitioners, and clinical nurse specialists, to primary care physicians and residents.

A Guide for the Physical Therapist Assistant Mosby Incorporated

As the baby-boomer generation ages, nursing home care is likely to become a major social problem. New residents will put huge strains on already short staffing at a time when funding to government-assisted homes (75 percent of all nursing homes) is lower than ever.Based on her ten years of experience working as a Licensed Practical Nurse in many care facilities, attorney Donna M. Reed shares her insider knowledge to help ensure that nursing home residents receive the best care possible. Reed focuses on the following key points:?The legal requirements of nursing homes regarding delivery of care?The ways in which many nursing homes regularly break these laws?Detailed descriptions of how the typical nursing home operates?The responsibilities of each nursing home employee?Nursing home inspections?Residents' rights?How to avoid substandard

care?What actions to take to improve nursing home lifeReed's firsthand knowledge of nursing home care and her in-depth understanding of the legal requirements that protect residents offer invaluable information to readers concerned about a loved one in a nursing home.Donna M. Reed worked as a nursing assistant and Licensed Practical Nurse in numerous nursing homes in California and New England. She is now an attorney and lives in North Carolina.

Nursing Documentation Made Incredibly Easy CreateSpace

Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. This book clearly and concisely provides guidelines for appropriate and careful documentation of care. This new edition includes the latest changes and trends in nursing documentation as they relate to the newly restructured healthcare environment.

Skills for Collaboration and Compliance Springer Publishing Company

cs.hlth_prof.gerontol

A Professional Guide for Acute Inpatient Care and Inpatient Rehabilitation Jones & Bartlett Publishers

"Provides primary care providers with information specific to the medical management of acutely ill adult and elder patients with multiple comorbid health problems. It also contains material on advanced directives, end of life care and regulatory and compliance concerns that often affect treatment decisions in these settings. A section on staff education is also included for nurse practitioners who are directing patient care given by both skilled and unskilled staff in subacute and long term care." --Cover.

100+ Common Nursing Documentation and Communication Templates Springer Publishing Company

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.