Nursing Notes Documentation

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

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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.

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 (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

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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.

How, What, and when Nurses Need to Document

Charting Made Incredibly Easy!

The A-to-Z Guide to Better Nursing Documentation

Nursing Diagnoses and Collaborative Problems

Charting

Nursing Know-how

Hospice Nurse Patient Visit Notes

A Daviss Notes Book. The perfect pocket guide for charting; ensures that documentation is not only complete and thorough, but also meets the highest ethical and legal standards. Covers nuances that are relevant to various specialties, including pediatric, OB/GYN, psychiatric and outpatient nursing. Reviews terminology essential to communicate effectively in writing with doctors, other health care professionals, and staff. Includes how-tos for template, electronic and other forms of charting. 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.

This portable handbook shows nurses in all practice settings exactly what to document in any situation. Nearly 300 alphabetically organized entries cover diseases, emergencies, procedures, legal and ethical problems, and difficult situations involving patients, families, and other health care professionals. Legal Casebooks provide examples of legal implications of documentation. AccuChart sample forms show how to accurately complete various forms. Thoroughly updated to reflect

current practice, this Second Edition provides information on the electronic health record. New entries cover situations such as surgical site verification, patient glucose self-testing, cultural needs identification, HIPAA, and reporting critical test values. A new appendix covers prohibited abbreviations.

First Steps in Outpatient CDI: Tips and Tools for Building a Program Anny P. Yuen, RHIA, CCS, CCDS, CDIP Page Knauss, BSN, RN, LNC, ACM, CPC, CDEO Find best practices and helpful advice for getting started in outpatient CDI with First Steps in Outpatient CDI: Tips and Tools for Building a Program. This first-of-its-kind book provides an overview of what outpatient CDI entails, covers industry guidance and standards for outpatient documentation, reviews the duties of outpatient CDI specialists, and examines how to obtain backing from leadership. Accurate documentation is important not just for code assignment, but also for a variety of quality and reimbursement concerns. In the past decade, outpatient visits increased by 44% while hospital visits decreased by nearly 20%, according to the Medicare Payment Advisory Commission. However, just because physicians are outside the hospital walls doesn't mean they're free from documentation challenges. For these reasons, CDI programs are offering their assistance to physician practices, ambulatory surgical centers, and even emergency rooms. This book will explore those opportunities and take a look at how others are expanding their record review efforts in the outpatient world. This book will help you: Target the outpatient settings that offer the greatest CDI opportunities Understand the quality and payment initiatives affecting outpatient services Understand the coding differences between inpatient and outpatient settings Identify data targets Incorporate physician needs to ensure support for program expansion Assess needs by program type

Nursing Interventions Classification (NIC) - E-Book

Understanding the Issues, Advancing the Profession

How to Navigate Clueless Colleagues, Lunch-Stealing Bosses, and the Rest of Your Life at Work

Guide for Implementation

DocuNotes

Nursing Narrative Note Examples to Save Your License

Scope and Standards of Practice

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.

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!

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.

Specialization and Credentialing in Nursing Revisited: Understanding the Issues, Advancing the Profession This book sheds light on a recurring issue in nursing: the specialization and credentialing of

nurses. Substantial changes in educational expectations and certification requirements, and the proliferation of nursing specializations have sparked debates on appropriate credentials, scope of practice, and state-by-state regulation of nursing scope of practice. With an emphasis on advanced practice, this book frames the issues around nursing specialization, subspecialization, and credentialing in a manner that will inform all parties involved. The authors examine the past and present of the issues, including such key topics as: The ongoing conceptual and practical debates about specialties and subspecialties on both basic and advanced practice levels. The questions and challenges about what constitutes appropriate credentials and what scope of practice and privileges should be associated with them. The numerous new educational curricula that prepare APRNs and the increasing pressure by state boards of nursing to control entry into APRN practice. The increasing confusion about the respective and complementary roles of credentialing agents. The mismatches that can occur between graduate curricula and certification and licensing requirements. Finally, the book offers the profession a unity model and pathway to create a consistent and supported methodology to define specialty and subspecialty practice, as well as a call to action. The lead author of this book, Margretta Madden Styles, spent much of her career framing and outlining specialty practice. Indeed, this current volume builds on her influential 1989 book, On Specialization in Nursing: Toward a New Empowerment, which described and analyzed the growth of specialization and the power of credentialing. Included as an appendix here, that book also informed a 2004 meeting of APRN st

Nursing Care Plans & Documentation

Surefire Documentation

Chart Smart

Charting patient care

Nursing Documentation in Aged Care

Charting, Recording, and Reporting

Nursing Documentation Handbook

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.

Nursing Notes the Easy Way100+ Common Nursing Documentation and Communication

Templates

Nursing Informatics and the Foundation of Knowledge covers the history of healthcare informatics, current issues, basic informatics concepts, and health information management applications. The text includes key terms, case studies, best practice examples, critical thinking exercises, and web resources.

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.

A Guide to Practice

Planning, Individualizing, and Documenting Client Care

Focus Charting

Hospice Nurse Reference and Nursing Assessment Notebook | Log Book for Quick Patient Documentation and Home Or Hospital Care Visits

Guide to Clinical Documentation

Nursing

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.

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.

From the creator of the popular website Ask a Manager and New York’s

work-advice columnist comes a witty, practical guide to 200 difficult professional conversations—featuring all-new advice! There's a reason Alison Green has been called "the Dear Abby of the work world." Ten years as a workplace-advice columnist have taught her that people avoid awkward conversations in the office because they simply don't know what to say. Thankfully, Green does—and in this incredibly helpful book, she tackles the tough discussions you may need to have during your career. You'll learn what to say when • coworkers push their work on you—then take credit for it • you accidentally trash-talk someone in an email then hit "reply all" • you're being micromanaged—or not being managed at all • you catch a colleague in a lie • your boss seems unhappy with your work • your cubemate's loud speakerphone is making you homicidal • you got drunk at the holiday party Praise for Ask a Manager "A must-read for anyone who works . . . [Alison Green's] advice boils down to the idea that you should be professional (even when others are not) and that communicating in a straightforward manner with candor and kindness will get you far, no matter where you work."—Booklist (starred review) "The author's friendly, warm, no-nonsense writing is a pleasure to read, and her advice can be widely applied to relationships in all areas of readers' lives. Ideal for anyone new to the job market or new to management, or anyone hoping to improve their work experience."—Library Journal (starred review) "I am a huge fan of Alison Green's Ask a Manager column. This book is even better. It teaches us how to deal with many of the most vexing big and little problems in our workplaces—and to do so with grace, confidence, and a sense of humor."—Robert Sutton, Stanford professor and author of The No Asshole Rule and The Asshole Survival Guide "Ask a Manager is the ultimate playbook for navigating the traditional workforce in a diplomatic but firm way."—Erin Lowry, author of Broke Millennial: Stop Scraping By and Get Your Financial Life Together

This key textbook equips all nurses with the knowledge and skills required to care for the deteriorating patient in the clinical environment. The book emphasises the importance of systematic assessment, interpretation of clinical signs of deterioration, and the need to escalate the patient in a timely manner. Using a unique system-based approach, each chapter contains structured learning outcomes and concludes with a competence-based skills assessment to perfect the reader's practice skills. These skills are recommended as essential for every nurse in an acute area and key to successful practice. Restructured for ease of use, this new edition has been fully updated to match current guidelines, with new chapters on pain management and the ethics and ceilings of treatment. Written by senior nurses, this key textbook uses real life case studies to link knowledge to practice and is essential reading for all nurses working in acute care settings and undertaking study in the field.

Mosby's Surefire Documentation

New Nurses Charting Don't Have To Be Complicated

Nursing's Social Policy Statement

Home Health Assessment Criteria
Successful Collaboration in Healthcare
Clinical Pocket Guide to Effective Charting
Nursing Documentation

As another volume in Ausmed's 'Guide to Practice' series of textbooks and audiobooks, this is an essential text for all aged-care nurses who wish to enhance their documentation skills and deliver higher quality care to the elderly. AudioBooks are ideal teaching tools.

"Essentials of Correctional Nursing is the first new and comprehensive text about this growing field to bepublished in the last decade. Fortunately, the editors have done a great job in all respects...This book should be required reading for all medical practitioners and administrators working in jails or prisons. It certainly belongs on the shelf of every nurse, physician, ancillary healthcare professional and corrections administrator."--Corhealth (The Newsletter of the American Correctional Health Services Association) "I highly recommend Essentials of Correctional Nursing, by Lorry Schoenly, PhD, RN, CCHP-RN andCatherine M. Knox, MN, RN, CCHP-RN, editors. This long-awaited book, dedicated to the professionalspecialty of correctional nursing, is not just a ìgood read,î it is one of ìthose booksî that stays on your desk and may never make it to the bookshelf."--American Jails "Correctional nursing has minimal published texts to support, educate, and provide ongoing bestpractices in this specialty. Schoenly and Knox have successfully met those needs with Essentialsof Correctional Nursing."--Journal of Correctional Health Care Nurses have been described as the backbone of correctional health care. Yet the complex challenges of caring for this disenfranchised population are many. Ethical dilemmas around issues of patient privacy and self-determination abound, and the ability to adhere to the central tenet of nursing, the concept of caring, is often compromised. Essentials of Correctional Nursing supports correctional nurses by providing a comprehensive body of current, evidence-based knowledge about the best practices to deliver optimal nursing care to this population. It describes how nurses can apply their knowledge and skills to assess the full range of health conditions presented by incarcerated individuals and determine the urgency and priority of requisite care. The book describes the unique health needs and corresponding care for juveniles, women, and individuals at the end of life. Chapters are devoted to nursing care for patients with chronic disease, infectious disease, mental illness, or pain, or who are in withdrawal from drugs or alcohol. Chapters addressing health screening, medical emergencies, sick call, and dental care describe how nurses identify, respond to, and manage these health care concerns in the correctional setting. The Essentials of Correctional Nursing was written and reviewed by experienced correctional nurses with thousands of hours of experience. American Nurses Association standards are woven throughout the text, which provide the information needed by nurses studying for certification exams in correctional nursing. The text will also be of value to nurses working in such settings as emergency departments, specialty clinics, hospitals, psychiatric

treatment units, community health clinics, substance abuse treatment programs, and long-term care settings, where they may encounter patients who are currently or have previously been incarcerated. Key Features: Addresses legal and ethical issues surrounding correctional nursing Covers common inmate-patient health care concerns and diseases Discusses the unique health needs of juveniles, women, and individuals at the end of life Describes how nurses can safely navigate the correctional environment to create a therapeutic alliance with patients Provides information about health screening, medical emergencies, sick call, and dental care Serves as a core resource in the preparation for correctional nursing certification exams

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

Focuses on the communicatiion skills that are the key to good documentation.

Documentation for Patient-centered Care
Tips and Tools for Building a Program
Chart Like A Pro
Managing Documentation Risk
100+ Common Nursing Documentation and Communication Templates
First Steps in Outpatient CDI
75 Checklists for Skilled Nursing Documentation

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

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.

his one-of-a-kind text covers every aspect of independent nursing care -- it's a must-have resource for every practicing and student nurse! Content includes nursing care plans for the care of all adults regardless of their clinical situation; detailed care plans for specific clinical problems; collaborative problems and nursing diagnoses; and a strong emphasis on documentation. It also includes research validated identification of frequently encountered nursing diagnoses and collaborative problems. This edition contains 15 new care paths for common diseases/disorders

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.

Ask a Manager

A Guide for Physicians, Nurses and Clinical Documentation Specialists
Specialization and Credentialing in Nursing Revisited
ChartSmart
Nursing Diagnosis Manual
Care of the Acutely Ill Adult
Nursing Quality Indicators

If as a new nurse, you've been having sleepless nights understanding the whole concept of charting and how to do it like the pros, keep reading....You Are About To Learn How To Master The Craft Of Charting Fast, Accurately And Efficiently, Just Like The Pros And Ultimately Become A Valuable Member Of The Healthcare Provider You Work For!As nurses, we're always thinking about all the ways we can apply our wealth of medical knowledge to care for patients in need. But after we complete our program, pass our exams and ace our first interview, we come across some aspects of beginning our career that we didn't anticipate, and that we probably didn't hear in school. One of those is definitely the process of charting information in our new role. The fact that you're here means that you've heard about it before.Maybe you're already trying to come to grips with it but are finding a hard time doing so, or want to improve how you handle it.If that's the case, then I guess you've been asking yourself: What is the best and most efficient way to chart?What kind of information am I supposed to chart and how?Why does it seem like too much work? Is there a way to do it quickly?How do I get started?Lucky for you, this book has all the answers to these and other related questions. It is designed to help you understand the concept of chatting well, cart off the feeling of intimidation by offering you all the facts and details you require and get you started with the process like a pro to make sure you have the easiest time, and become the efficient, stress-free nurse you've always desired to become.Here is what you'll learn from it: -How to manage and handle time, date, signature and error-What you need to know before you chart-How to use objective and subjective data-How to use abbreviation and medical terminology -How to do assessment charting -How to chart admission and discharge information-How to chart refusals-How to chart about medication -How to chart co-workers' names-How to chart for pain and antibiotics...and so much more!The well-being of your patients highly depends on accurate information recorded and passed across different departments or levels of the health institution, including between physicians and pharmacists.Even if charting seems complex at the moment, this book's easy to follow and practical approach to charting will literally dissolve your fears and concerns and hold you by the hand until you start charting like the pros!If you're ready to learn the basics and get a new perspective of this seemingly demanding task, then all

you have to do is grab your own copy of this practical, straightforward guide today and get started!Click Buy Now With 1-Click or Buy Now to get started!

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

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!

The perfect guide to charting! The popular Davis's Notes format makes sure that you always have the information you need close at hand to ensure your documentation is not only complete and thorough, but also meets the highest ethical and legal standards. You'll even find coverage of the nuances that are relevant to various specialties, including pediatric, OB/GYN, psychiatric, and outpatient nursing.

Essentials of Correctional Nursing

An Incredibly Easy Pocket Guide

Documentation Skills for Quality Patient Care

Improving Nursing Documentation and Reducing Risk

Nursing Informatics and the Foundation of Knowledge

Documentation Guidelines for Evaluation and Management Services

Nursing Documentation Made Incredibly Easy

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 (¾ 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

Offering clear, practical guidelines for how, what, and when to document for more than 100 of the most common and most important situations nurses face, this essential resource details exactly what information to consider and document, to ensure quality patient care, continuity of care, and legal protection for the nurse and the institution where the nurse works.

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

Nursing Notes the Easy Way

Code of Ethics for Nurses with Interpretive Statements

Long-term Care Pocket Guide to Nursing Documentation

A Guide for Nurse Managers

Charting and Documentation Suggestions for RNs and LPNs Who Have to Describe the Indescribable in a Medical Record