

## Nursing Documentation Dos And Donts

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!

Legal Issues in School Health Services offers a legal resource never before available for education and health professionals, and their legal advisors. All professionals involved in the development, implementation, and evaluation of school health services will find this an exceptional tool. This book addresses the spirit and letter of the laws, the related standards, the conflict between them, and how they affect the delivery of school health services in regular and special education. Special attention is given to pertinent issues for school administrators, school attorneys, and school nurses, in order to foster school practices that are safe and effective. Designed as a guide and reference work, this book is written by 15 highly-credentialed nurses, attorneys, and educators and offers detailed discussions of the legal challenges that exist in the 21st century. KEY FEATURES School nursing practice, standards, and performance issues Risk management strategies for school administrators, school boards, and attorneys Multi-disciplinary approaches in ethico-legal problem solving Collaborative approaches in promoting student learning and success Financial, special education, record confidentiality, and future genetic challenges In-depth legal references, citations, and research, plus a comprehensive glossary and table of federal statutes and regulations

Monitoring the Critically Ill Patient is an invaluable, accessible guide to caring for critically ill patients on the general ward. Now fully updated and improved throughout, this well-established and handy reference guide text assumes no prior knowledge and equips students and newly-qualified staff with the clinical skills and knowledge they need to confidently monitor patients at risk, identify key priorities, and provide prompt and effective care. This new edition includes the following five new chapters: Monitoring the critically ill child Monitoring the critically ill pregnant patient Monitoring the patient with infection and related systemic inflammatory response Monitoring a patient receiving a blood transfusion Monitoring pain

Please note that this eBook does not include the DVD accompaniment. If you would like to have access to the DVD content, please purchase the print copy of this title. Now in its 3rd edition, Potter & Perry's Fundamentals of Nursing continues to be the definitive text for nursing students in our region. The new edition builds on the strengths of the highly successful previous editions with greater authorship, increased local research, evidence and concepts particular to the health care systems of Australia and New Zealand. Fully revised and updated by leading Australian and New Zealand nurse educators. It presents essential nursing skills in a clear format consistent with Australian and New Zealand practice, placing greater emphasis on critical thinking skill explanations, revised procedural recommendations, infection control considerations and updated medications information. Health Care Delivery System (Chapter 2) – now includes New Zealand content and walks the student through the evolution of health care delivery systems in our region. Engaging in Clinical Inquiry and Practice Development (Chapter 5) written by Jackie Crisp and Professor Brendan McCormack provides a contemporary perspective on the processes underpinning nursing knowledge development, utilisation and their role in the ongoing advancement of nursing practice. Managing Client Care (Chapter 20) is an exciting newly revised chapter that engages the student in exploring nursing issues in managing client care within the context of contemporary health care systems. New Chapter on Caring for the Cancer Survivor New Zealand Supplement Legal Implications of Nursing Practice Now includes evolve e-books Now students can search across Potter & Perry's Fundamentals of Nursing 3E electronically via a fully searchable online version. Students can take notes, highlight material and more. The e-book is included with this edition

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at no extra cost. New Resources for Students and Instructors on Evolve: Nursing Skills Online for Fundamentals of Nursing provides students with 17 interactive modules which expand on textbook concepts, through the use of media rich animations. It encourages decision-making and critical-thinking skills through case-based and problem-oriented lessons. Nursing Skills Online for Fundamentals of Nursing may be purchased separately as a User guide & Access code (ISBN: 9780729539388) Online Study guide for students is an ideal supplement with Skills Performance Check lists designed to challenge students' abilities. Clinical knowledge can be further tested through additional short answer and review questions.

Improve your staff's documentation for less than \$4 per person Documentation may be the least favorite part of a nurse's job--but it's also one of the most important aspects. Incomplete or improper documentation poses a huge financial and compliance threat, including citations from state, federal, and Joint Commission surveyors. Plus, nurse managers can legally be held accountable for their nurses' documentation. Now packages of 25 handbooks are only \$89 Improve your staffs' documentation with the handbook "Nursing Documentation: ""Reduce Your Risk of Liability, "Second Edition. Written specifically for staff nurses, this easy-to-read and affordable resource helps nurses understand the value of good documentation, and the consequences of not documenting accurately and in a timely fashion. The handbook's case studies illustrate the legal threat nurses face from improper documentation, while the quick tips help them avoid common charting errors and improve their charting skills. The handbook includes a short post-test and certificate of completion, allowing nurses to evaluate their documentation understanding. With this handbook as their guide, your staff will be motivated to a level of excellence that will be reflected in the medical record, resulting in improved overall quality of care at their facility. Take a look at the table of contents: What is clinical documentation? The purpose of documentation Your potential liability risks Threat to licensure Civil litigation Case study 1: Documenting completely to avoid allegations of negligent care Contemporary nursing standards Your state Nurse Practice Act The consequences of an incomplete medical record Case study 2: Failing to record pertinent health information Eight common charting errors to avoid Risk management recommendations Top 20 tips for improving your documentation Take a look at the companion book for nurse managers "Managing Documentation Risk: ""A Guide for Nurse Managers, "Second Edition provides nurse managers with strategies they can use to protect themselves, their staff, and their organization while continuing to offer the best quality of care. This resource guides nurse leaders through assessing their organization's risks and designing a system for auditing staff documentation. It features an accompanying CD-ROM, including all the customizable strategic forms and audit tools included in the book ready for immediate use in your facility.

With long hours, huge responsibilities, and average pay, nursing is often as challenging as it is rewarding. By teaching new nurses what to expect, how to get what they want, and how to succeed in today's medical environment, this book is the one-dose treatment to prevent burnout. Written in an easy-to-read, direct, and honest way, this helpful handbook will teach new nurses what they didn't learn in nursing school. Veteran R.N. Kathy Quan offers readers information on how to: balance a hectic new schedule (for work, sleep, and life) deal with doctors avoid illness themselves continue education while working cope with death of patients (the first time, and after) and more With this book, nurses get real-life advice on how to cope, perform, and excel in their field--one shift at a time!

Written in clear, accessible language, without legal jargon, the third edition of this text includes a new chapter on the laws relating to teenage pregnancy. It also covers many of the recommendations from NICE relevant to midwifery practice and considers their legal significance.

The 36th edition of the best-selling, original drug handbook for nurses provides complete monographs for more than 900 generic and thousands of brand-name drugs. Monographs are

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consistently formatted for ease of use and focus on the practical information that nurses need. Each monograph consists of generic and trade names, pronunciation key, pregnancy risk category, pharmacologic class, controlled substance schedule (if applicable), available forms, indications and dosages, administration (with drug incompatibilities for I.V. drugs), action (including tables showing route, onset, peak, duration, and half-life), adverse reactions, interactions, effects on lab test results, contraindications, nursing considerations, and patient teaching. Also includes chapters on general drug information (pharmacology/pharmacotherapeutics, pharmacogenomics, safe drug administration, therapeutic classifications) and numerous appendices. Text is complemented by free Toolkit containing hundreds of online resources.

Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal communication in nursing to help you.

This new edition focuses on preparing your students to assume the role as a significant member of the health-care team and manager of care, and is designed to help your students transition to professional nursing practice. Developed as a user-friendly text, the content and style makes it a great tool for your students in or out of the classroom. (Midwest).

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

"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 strengthen reimbursement claims with comprehensive documentation. Prove medical necessity and need for skilled care by practicing accurate documentation"--P. [4] of cover.

Staff Educator's Guide to Clinical Orientation, 2E guides readers in creating and sustaining a high-quality orientation and onboarding program that meets the needs of nurses, organizations, and patients. In this fully revised second edition, authors Alvin Jeffery, Robin Jarvis, and Amy Word-Allen provide all the tools staff educator's need to successfully develop a nursing and healthcare workforce. Whether the staff educator is new to leading orientation efforts or a seasoned nursing staff development specialist, this book will help readers: · Understand and use the ADDIE model · Analyze, design, and implement an orientation program · Evaluate an individual's competency · Conduct surveys and focus groups · Manage orientee errors and personality conflicts

Inside this comprehensive reference, you'll find in-depth coverage of the liability risks common to obstetric and neonatal settings. From the basics of healthcare law and its relation to clinical practice, to detailed discussions aimed at specific liability challenges, this resource prepares you for the professional and legal responsibilities of today's perinatal nursing.

The fast and painless way to ace your IV Therapy course Are you an aspiring nurse, nurse practitioner, or physician's assistant struggling with IV therapy? Help is here! IV Therapy For Dummies tracks to a typical IV therapy course and gives you current, easy-to-follow guidance on everything you'll encounter in class, such as delivery methods, flow rates, legal issues, profession standards, and documentation. IV Therapy For Dummies also discusses the necessary components of peripheral and central venous therapy, including access sites, equipment, preparation, maintenance, and the discontinuation of therapy. Plus, you'll get the 4-1-1 on the administration of IV medications, including special considerations for pediatric, elderly, and home care patients. Tracks to a typical IV Therapy course Provides current, comprehensive information in plain English If you're enrolled in an IV Therapy course or a healthcare worker looking for a refresher on this important form of medical treatment, IV Therapy For Dummies has you covered.

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.

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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

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

Uniquely organized around the AONE competencies, this trusted resource gives you an easy-to-understand, in-depth look at today's most prevalent nursing leadership and management topics. Coverage features the most up-to-date, research-based blend of practice and theory related to topics such as: the nursing professional's role in law and ethics, staffing and scheduling, delegation, cultural considerations, care management, human resources, outcomes management, safe work environments, preventing employee injury, and time and stress management. UNIQUE! Chapters divided according to AONE competencies for nurse leaders, managers, and executives. Research Notes in each chapter summarize relevant nursing leadership and management studies and highlight practical applications of research findings. Case Studies at the end of each chapter present real-world leadership and management situations and illustrate how key concepts can be applied to actual practice. Critical Thinking Questions at the end of each chapter present clinical situations followed by critical thinking questions to help you reflect on chapter content, critically analyze the information, and apply it to the situation. NEW! Full-color design makes content more vivid and realistic. NEW! Chapter on Communication and Care Coordination covers these integral topics. NEW! Updates to critical thinking exercises, case studies, research notes, and references offer the most current information. NEW! Updated sections on Current Issues and Trends reflect the latest topics in the field. NEW! Relevant Web Sites boxes provide authoritative resources for additional research.

As more people live longer, the need for quality long-term care for the elderly will increase dramatically. This volume examines the current system of nursing home regulations, and proposes an overhaul to better provide for those confined to such facilities. It determines the need for regulations, and concludes that the present regulatory system is inadequate, stating that what is needed is not more regulation, but better regulation. This long-anticipated study provides a wealth of useful background information, in-depth study, and discussion for nursing home administrators, students, and teachers in the health care field; professionals involved in caring for the elderly; and geriatric specialists.

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

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 don'ts, 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.

Textbook for Nursing Pharmacology.

"The authors not only encourage data gathering, they emphasize the qualities of personal interactions, courtesy and sensitivity, and consideration to upgrade triage category when history is hampered by youth, age, impairment of faculties, or language ability that might otherwise conceal potential problems. Appropriate treatments to initiate at triage are indicated where needed. This book puts forward a practical way of coming back to basics and helps categorize priority for patients. As an educator or manager, I would feel confident that, with it, my nurses are being prepared to make safe decisions with an accurate program that reflects current thinking in triage strategy." -Tom Trimble, RN, CEN, BA, ASN, AA Editor and Publisher Emergency Nursing World This critical-thinking blueprint for the triage nurse delivers essential knowledge for accurate decision-making in emergency triage situations. Formatted to provide easily accessible and retrievable information, the manual facilitates rapid recognition and

understanding of acuity levels and their application to patient care. The newly updated second edition reflects current health conditions and scenarios in EDs, urgent care centers, offices, and first aid centers, both domestic and international. It contains important new information on program development, training, and quality management along with useful tips and tools. Completely new protocols, additional case studies, and quality management guidelines and tools further add to the merit of the second edition. The resource addresses a wide range of both adult and pediatric conditions that are system-based and listed in alphabetical order. Each protocol has been developed to ensure accuracy and consistency, regardless of which 5-tier triage system is in use. Abundant case studies and multiple appendices provide additional information to support the protocols, broadening the nurse's scope of knowledge and prompting in-depth examination of potentially lethal conditions. Additionally, appendices contain valuable training materials for program development, training, and quality management tips and tools. New to the Second Edition: Updated protocols reflecting current health conditions/situations in EDs, urgent care centers, offices, and first aid centers Important new information on program development, training, and quality management tips and tools Additional material including mass casualty, exposure (biological, chemical, disease), military care, infections (isolation concerns), behavioral issues (violence), and narcotic overdose New case studies Developing a triage program Quality management guidelines and tools Key Features: Facilitates consistency in triage decisions among different nurses Uses health care resources appropriately and efficiently Sets minimum expectations for triage decisions Guides nurses in asking the right questions, determining how soon the patient must be seen, and interventions to consider Serves as a valuable reference for both new and experienced nurses Serves as a training tool in orientation

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

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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

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!

Simplifies the wound care process with clear, succinct information and the newest treatment protocols Freshly updated with the newest evidence-based techniques and protocols, this practical clinical resource distills the fundamentals of wound care for novice nurses and nurses new to wound care. This guide walks through the common, complex and atypical wounds nurses see and includes abundant full-color images. Chapters have been thoroughly revised and now contain critical updates in technological advances in wound care, dramatic changes in documentation and new Medicare and reimbursement guidelines. Fast Facts for Wound Care Nursing, Second Edition is an invaluable companion for the day-to-day care of wound patients, reinforcing knowledge needed in acute care, critical care, long-term care, homecare, operating

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room and outpatient settings. Written concisely in easy-to-access bulleted format with brief paragraphs, each chapter explains, step-by-step, the essential principles of wound care. Part I defines and describes the spectrum of wounds and the fundamentals of wound healing while Part II discusses how to assess, document and photograph wounds. Part III presents the newest treatments and protocols for wound care, and Part IV concludes with legal issues and regulations guiding safe and cost-effective wound care. New to the Second Edition: Updated with key technological advances and treatments in wound care including stem cell and ionized silver products Four new chapters! The Phases of Wound Healing and Types of Wound Closure Acute Wounds Pressure Injuries Hyperbaric Oxygen Therapy Covers new Medicare and reimbursement guidelines Addresses qualifications and certification for wound care and faculty accreditation Key Features: Written in succinct, easy-access format with bulleted information and brief paragraphs Includes "Fast Facts" to highlight key concepts for essential care Contains abundant information on wound care treatments and protocols to promote wound care accountability and clinical confidence Provides full color images of different types of wounds Helps nurses to provide optimal wound care cost-efficiently

Nursing Documentation Made Incredibly Easy Lippincott Williams & Wilkins

You can be an excellent nurse in the clinical setting and still fail to prove that you are an excellent nurse if your documentation is inadequate. Having worked in a variety of inpatient and outpatient settings, I understand the obstacles nurses face. There's just not time, nor do nurses have the mental energy to meticulously document every little thing on top of the rest of their to-do list. That's part of why I became passionate about documentation education. It doesn't have to be an overwhelming, endless challenge to chart exhaustively in hopes that you enter enough data into the chart to defend yourself one day. Rather, leveraging the most critical data, knowing how to format notes and exactly what to say, and when to spend five minutes dumping information into the chart can be learned skills that make documentation faster, easier, and less stressful, while doing a better job of defending your actions. The Importance of Documentation & Overcoming Obstacles Purpose(s) of Documentation Defensive Charting Obstacles Impacting Quality of Medical Record Overcoming Obstacles Legal Responsibilities of the Nurse Duties of the Nurse Nurse Practice Acts Duties of the Hospital Hospital Policy vs. State Board of Nursing Regulations Reasonable Prudence Failure to Fulfill (Document) Responsibilities Fulfilling Responsibilities vs. Documenting Responsibilities What if Responsibilities Aren't Fulfilled? Mistakes Happen Professional Liability Insurance Malpractice Medical Negligence Acting with Malice Fraud What Happens When a Nurse is Charged with Malpractice? What to Do if You Receive Notification of a Claim Common Charting Mistakes & How to Avoid Them The Most Common Errors Charting By Exception & Charting to Capture Minimal Data "But I've Always Charted This Way, and Nothing Bad Has Happened Yet..." What You Should Be Charting How and What to Chart Quick Glance Charting Checklists What is a Timely Manner? Documenting Assessments Sample Focused Assessment Criteria Sharing the Responsibility Modifying Electronic Data Abbreviations Standing Orders Early Warning Systems Scores & Scales Informed Consent Special Circumstances Paper Charting Writing an Incident Report Patient Leaving AMA Patient Threatening to Sue You Identifying Patient Belongings Another Member of the Team is Not Documenting Correctly Restraints Defective Equipment Suspected Abuse Patient Requesting to View Their EMR on Hospital Computer Narrative Notes When & How to Write Notes One Note or Several Notes? Daily Narrative Notes Examples of Common Notes Written As-Needed How to Title Narrative Notes How to Format Notes Using Patient Names in Notes Length of Notes Create a Template Tips for Less Stress When Charting BONUS: How I Chart on a "Typical" Shift ABOUT THE AUTHOR: I'm Andrea, RN-MSN. Perfecting my own documentation and working to find concrete guidelines to share with my fellow nurses has become my passion. As I gained more knowledge and researched the dusty, forgotten corners

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of the internet for obscure evidence-based practice and case studies, becoming a subject matter expert on nursing documentation lit a spark because sharing this information helps empower nurses to understand exactly what should appear in their patient charts, where, when it should entered, and how it should be phrased.

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

THE #1 Drug Guide for nurses & other clinicians...always dependable, always up to date! Look for these outstanding features: Completely updated nursing-focused drug monographs featuring 3,500 generic, brand-name, and combination drugs in an easy A-to-Z format NEW 32 brand-new FDA-approved drugs in this edition, including the COVID-19 drug remdesivir—tabbed and conveniently grouped in a handy “NEW DRUGS” section for easy retrieval NEW Thousands of clinical updates—new dosages and indications, Black Box warnings, genetic-related information, adverse reactions, nursing considerations, clinical alerts, and patient teaching information Special focus on U.S. and Canadian drug safety issues and concerns Photoguide insert with images of 439 commonly prescribed tablets and capsules It's not the quantity of clinical documentation that matters—it's the quality. Is your clinical documentation improvement (CDI) program identifying your outliers? Does your documentation capture the level of ICD-10 coding specificity required to achieve optimal reimbursement? Are you clear on how to fix your coding and documentation shortfalls? Providing the most complete and accurate coding of diagnoses and site-specific procedures will vastly improve your practice's bottom line. Get the help you need with the Clinical Documentation Reference Guide. This start-to-finish CDI primer covers medical necessity, joint/shared visits, incident-to billing, preventative care visits, the global surgical package, complications and comorbidities, and CDI for EMRs. Learn the all-important steps to ensure your records capture what your physicians perform during each encounter. Benefit from methods to effectively communicate CDI concerns and protocols to your providers. Leverage the practical and effective guidance in AAPC's Clinical Documentation Reference Guide to triumph over your toughest documentation challenges. Prevent documentation deficiencies and keep your claims on track for optimal reimbursement: Understand the legal aspects of documentation Anticipate and avoid documentation trouble spots Keep compliance issues at bay Learn proactive measures to eliminate documentation problems Work the coding mantra—specificity, specificity, specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR templates—and the pitfalls of auto-populate features Master documentation in the EMR with guidelines and tips Conquer CDI time-based coding for E/M The Clinical Documentation Reference Guide is approved for use during the CDEO® certification exam.

Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation Barbara Acello, MS, RN and Lynn Riddle Brown, RN, BSN, CRNI, COS-C Initial assessments can be tricky--without proper documentation, home health providers could lose earned income or experience payment delays, and publicly reported quality outcomes affected by poor assessment documentation could negatively impact an agency's reputation. Ensure that no condition or symptom is overlooked and documentation is as accurate as possible with Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation. This indispensable resource provides the ultimate blueprint for accurately assessing patients' symptoms and conditions to ensure

regulatory compliance and proper payment. It will help agencies deliver more accurate assessments and thorough documentation, create better care plans and improve patient outcomes, prepare for surveys, and ensure accurate OASIS reporting. All of the book's 75-plus checklists are also available electronically with purchase, facilitating agency-wide use and letting home health clinicians and field staff easily access content no matter where they are. This book will help homecare professionals: Easily refer to checklists, organized by condition, to properly assess a new patient Download and integrate checklists for use in any agency's system Obtain helpful guidance on assessment documentation as it relates to regulatory compliance Appropriately collect data for coding and establish assessment skill proficiency

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

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.

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.

Offering step-by-step guidance on how to properly document patient care, this updated Second Edition presents 90 of the most common clinical problems encountered on the wards and clinics in an easy-to-read, two-page layout using the familiar "SOAP" note format. Emphasizing the patient's clinical problem, not the diagnosis, this pocket-sized quick reference teaches both clinical reasoning and documentation skills and is ideal for use by medical students, Pas, and NPs during the Family Medicine rotation.

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,

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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:

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