Skilled Nursing Documentation

Fast Facts for the Long-Term Care NurseImproving the Quality of Long-Term CareHome Health Assessment CriteriaGuide to Coding ComplianceCritical Thinking in Long-term Care NursingClinical Documentation Strategies for Home HealthDocumentationMastering DocumentationHandbook of Home Health StandardsNursing Documentation Made Incredibly EasyTaking Action Against Clinician BurnoutInfusion NursingLegal Aspects of Documenting Patient Care for Rehabilitation ProfessionalsDocumentation BasicsSuccessful Collaboration in HealthcareNursing Policies and Procedures for Long Term CareCode of Ethics for Nurses with Interpretive StatementsEffective Documentation for Physical Therapy ProfessionalsDirector of Nursing Long Term CareNursing Notes the Easy WayHome Health NursingPhysical Therapy DocumentationSnf Nursing and Therapy CollaborationINSPIREd HealthcareThe Long-term Care Legal Desk ReferenceDocumenting CareComplete Guide to DocumentationA Guide for Nursing Home Social Workers, Second EditionDocumenting Medical Necessity12 Case Studies : Treatment Intervention and Documentation Examples for Occupational Therapists Working in Skilled Nursing Facilities, and Much MoreNotes on NursingNursing DocumentationCharting Made Incredibly Easy!Documentation for Physical Therapist Practice: A Clinical Decision Making ApproachA Guide For Nursing Home Social WorkersMosby's Surefire DocumentationNursing Know-howNursing Interventions & Clinical Skills - E-BookNursing

DocumentationRestorative Care Nursing for Older Adults

Fast Facts for the Long-Term Care Nurse

The purpose of restorative care nursing is to take an active role in helping older adults maintain their highest level of function, thus preventing excess disability. This book was written to help formal and informal caregivers and administrators at all levels to understand the basic philosophy of restorative care, and be able to develop and implement successful restorative care programs. The book provides a complete 6-week education program in restorative care for caregivers, many suggestions for suitable activities, and practical strategies for motivating both older adults and caregivers to engage in restorative care. In addition, the book provides an overview of the requirements for restorative care across all settings, the necessary documentation, and ways in which to complete that documentation.

Improving the Quality of Long-Term Care

Documenting Medical Necessity: A Practical Guide for Home Health Heather Calhoun, RN, BSN, HCS-D, COS-C Initial patient assessment in home health can be tricky. If documentation does not adequately provide a reason for skilled nursing care in the home, you might not get reimbursed at all. In Documenting Medical Necessity: A Practical Guide for Home Health, author Heather Calhoun, RN, BSN, HCS-D, COS-C,

provides down-to-earth, conversational documentation tips with dozens of example scenarios to help nurses understand medical necessity and document in a manner that encourages proper and complete reimbursement. In addition to initial assessments for skilled services, continued skilled care must also be properly documented. This resource will help nurses provide skilled services based on critical thinking throughout the continuum of care. This book has: A grounded, conversational style that speaks directly to nurses who are responsible for the documentation Dozens of hypothetical examples that provide concrete learning opportunities Scenarios that are available electronically to provide handouts for ongoing and on-the-go learning Content that serves as a great resource for orientation and annual training TABLE OF CONTENTS Background of Medical Necessity Criteria Changes of 1997 Present-Day Payment Criteria Fundamentals of Medical Necessity Focus of Care - Mistakes that lead to rehospitalization Delivery of Care - Start of care narrative Frequency of Care Mutually Agreed-Upon Goals Documentation: Paint the Picture Observation and Assessment Teaching and Training Direct Skilled Care Management and Evaluation Psychiatric Nursing Therapy Initial Assessment Standardized Tools 30-Day Reevaluation Therapy Indications - Gait training - Range of motion - Use of modalities - Wound care - Occupational therapy - Speech therapy - Maintenance therapy

Home Health Assessment Criteria

Guide to Coding Compliance

In today's environment where healthcare costs are outpacing the economy, healthcare systems are shifting from fee-for-service to value-based payment to deliver high-quality care while reducing costs. This shift presents nurses with the opportunity to take the lead in transforming care delivery and achieve the Triple Aim goals: improving patient experience of care, improving health of populations, and reducing per capita healthcare costs. INSPIREd Healthcare follows author Billie Lynn Allard and her team of nurses as they successfully implement an accountable community of health in pursuit of the Triple Aim. The INSPIRE Model they follow provides an evidence-based blueprint for other healthcare systems hoping to solve the complicated problems surrounding care transitions and health promotion

Critical Thinking in Long-term Care Nursing

The only product on the market that includes documentation strategies for both nurses and therapists! Align resident documentation across multiple disciplines to improve quality of care and protect your organization from an audit. Proper documentation has never been more crucial under MDS 3.0, and this is the only product on the market that blends the perspectives of both a nurse and a therapist to ensure resident-centered care. Complete with downloadable tools and examples of documentation scenarios, you will create an

interdisciplinary team approach to your documentation processes. This book will help you: * Align with MDS 3.0 documentation requirements * Coordinate documentation between nurses and therapists to improve resident care * Gain insight into nursing and therapy skilled services to promote better collaboration, reduce your audit risk, and strengthen reimbursement claims with comprehensive documentation * Prove medical necessity and need for skilled care by practicing accurate documentation

Clinical Documentation Strategies for Home Health

Critical Thinking in Long-Term Care Nursing, Second Edition Shelley Cohen, RN, BS, CEN Resident outcomes have come under growing scrutiny, both through new quality measures and the overall star rating. Nurses are the frontline staff who engage with residents daily, and it's crucial for them to understand how to apply critical thinking. When caring for residents and creating documentation, critical thinking can improve facility and resident outcomes while reducing medical errors, which will ultimately lead to more accurate reimbursement. Raise the standard of professional nursing practice and teach clinical care providers how to function at a higher level by developing their critical thinking abilities.Critical Thinking in Long-Term Care Nursing, Second Edition, provides nurse managers and educators with accessible ways to teach these valuable skills to their staff. This easy-to-read resource explains the principles of critical thinking

and how to encourage nurses to use critical thinking methods. Author Shelley Cohen, RN, BS, CEN, provides guidance on how to lead classroom sessions for new graduates and experienced nurses to develop critical thinking skills, including classroom processes and learning strategies. The book includes handouts to supplement classroom training. Who should read this book? Nursing home administrators MDS coordinators Directors of nursing Charge nurses Frontline staff involved in care planning Other clinical managers This book will help you: Identify key aspects of critical thinking Explain how nurses develop competency in critical thinking Determine classroom strategies to teach, promote, and support the development of critical thinking Determine ways to evaluate nurses' progress in critical thinking throughout orientation Develop strategies for the development of critical thinking skills during the orientation process Discuss the role played by managers and educators in promoting environments that support critical thinking Analyze the challenges that both new and experienced nurses face when incorporating critical thinking skills in the practice setting Explain interventions to help new and experienced nurses meet their managers' and preceptors' expectations for critical thinking Understand the new quality measures and how nurses' actions and documentation affect a facility's star ratings Educate staff by developing a culture of critical thinking Coach new nurse graduates through bad resident outcomes by setting expectations Encourage experienced staff to continually apply critical thinking Apply critical thinking to nursing and documentation to improve resident outcomes This

book provides nurse managers and educators with easy ways to teach critical thinking to their staff, including customizable resources specific to long-term care, such as: Assessment tools Worksheets Sample questions Case studies What's New? Developing a culture of critical thinking in nursing is crucial in today's long-term care industry. Resident outcomes have come under growing scrutiny, both through surveys (new quality measures) and overall star ratings. Nurses are the frontline staff that engage with residents daily, and they need to understand how to apply critical thinking to nursing. Critical thinking during documentation can improve outcomes in their facility, which will ultimately lead to accurate reimbursement. This update will cover the new quality measures and discuss how nurses' actions and documentation affect the facility's star ratings.

Documentation

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.

Mastering Documentation

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.

Handbook of Home Health Standards

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.

Nursing Documentation Made Incredibly Easy

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

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Taking Action Against Clinician Burnout

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.

Infusion Nursing

Legal Aspects of Documenting Patient Care for Rehabilitation Professionals

Because Communication Among Healthcare Professionals Can Mean The Difference Between Patient Life And Death, Clear And Effective Patient Care Documentation Is As Important As The Delivery Of Care Itself. The Rehabilitation Professional Faces Formidable Documentation Responsibilities. Patient Care Documentation Created By The Rehabilitation Professional Must Be Accurate, Comprehensive, Concise, Objective, Timely, And Expeditiously Communicated To Other Professionals On The Health Care Team. Legal Aspects Of Documenting Patient Care For Rehabilitation Professionals, Third Edition, Provides A Comprehensive Overview Of Legal Issues Related To Everyday Patient Care Clinical Documentation. This Text Presents Extensive Coverage Of The Electronic Medical Record, The HIPAA Privacy Rule And Incident Reporting, Among Other Focused Topics.

Documentation Basics

Comprehensive manual for the new or experienced Director of Nursing. All the essential information on Staffing, Resident Care, Quality Assurance, MDS Essentials, Nursing Policy and Procedure, Long Term Care Regulations, Survey Protocols. Forms in the Director of Nursing book and on the CD for Nursing budget, Staffing, Scheduling, Employee records, Staff education, Quality assurance audits, Infection control. Includes 23 Skilled Charting Guidelines and 2019 MDS Assessment Scheduling Calendar. Current with all RAI Manual Updates, PDPM updates, Surveyor Guidelines and Federal Regulatory Changes. This Director of Nursing book aims to give all of the basic information a long term care Director of Nursing needs today. For the experienced Director of Nursing it provides a good reference for long term care regulations, standards, and laws. The forms included in the Director of Nursing book can greatly expedite job performance. Information is given on organizing the job, managing resident care, staffing, and quality assurance issues. For the new Director of Nursing, or the nurse aspiring to that position, the book outlines all of the major responsibilities of the job. Applicable federal regulations are quoted in each chapter, and forms are throughout the book. Forms and care plans have been updated to ensure compliance with the change to MDS 3.0 and with all of the federal regulations and guidelines updated during the past year. All of the forms and nursing care plans in the Director of Nursing book are included on the CD so they can be saved to a computer whenever needed. By adding or deleting entries, the forms and care plans can be made resident specific.

Successful Collaboration in Healthcare

ìBeaulieuís decades of social work practice illuminate every chapter, her years of networking with colleagues in Massachusetts and nationwide enhance every paragraph, and nuggets of insight earned through successfully establishing meaningful relationships with residents and families are reflected in every word. She knows her stuff and through this book shares it with others who are committed to enhancing the quality of life of nursing home residents through excellent social work services.î From the Foreword by Mercedes Bern-Klug, PhD, MSW, MA The University of Iowa School of Social Work "Beaulieu's book clearly articulates what on-the-ground nursing home social work practice involves These resources are useful as it is rare to be exposed to this type of information or detail during one's educational training Beaulieu reveals layer upon layer of social worker roles, responsibilities, and important tools. This is a comprehensive guide for social workers."--The Gerontologist This completely updated guide for nursing home social workers reflects the latest political, economic, and cultural trends and requirements for nursing home facilities and how they impact social workers. It is the most comprehensive guide to nursing home social work available and includes new chapters on changing expectations and new models for nursing home facilities (including the patient-centered facility), disaster planning, pain in older adults, and families and next of kin as legal representatives. Also included are policies that have been revised or added since the previous edition was

published, including information about the new Minimum Data Set (MDS 3.0) and the Health Insurance Portability and Accountability Act (HIPAA), and updated content on dementia, depression, elder abuse, and more. Key Features: Comprises the most comprehensive guide to nursing home social work available Includes new chapters on culture and diversity; spirituality; disaster planning; pain in older adults; new models for nursing homes; and families as legal representatives Provides new information about MDS 3.0 and HIPAA Contains helpful forms for assessments, screenings, transfer/discharge notes, new HIPAA forms, and many others

Nursing Policies and Procedures for Long Term Care

cs.hlth_prof.gerontol

Code of Ethics for Nurses with Interpretive Statements

Part of the Springhouse Incredibly Easy! Series(TM), this Second Edition provides current information about charting in a comprehensible, clear, fun and concise manner. Three sections cover Charting Basics, Charting in Contemporary Health Care, and Special Topics. New features include expanded coverage of computerized documentation and charting specific patient care procedures, plus current JCAHO standards both in the text and appendix, chapter summaries, and a new section with case study questions and answers. Amusing graphics and

cartoon characters call special attention to important information. Entertaining logos throughout the text alert the reader to critical information, Thought Pillows identify key features of documentation forms, and the glossary defines difficult or often-misunderstood terms.

Effective Documentation for Physical Therapy Professionals

2016 Third Edition. Also includes 23 Skilled Charting Guidelines and 2019 MDS Assessment Scheduling Calendar. Current with all RAI Manual Updates, Surveyor Guidelines and Federal Regulatory Changes. Covers all nursing policies and procedures for long term care. Includes many policies for Medications, Falls, Restraints, Pressure Ulcers, and Pain Care. Current with all of the latest regulatory updates. The form at the top of each nursing policy for long term care has spaces for the date the policy and procedure was approved by the Director of Nursing and the date of any addendums or changes. Each nursing policy for long term care may also be used as teaching tools in an inservice or employee counseling session. Nursing policies and procedures have been updated to ensure compliance with the change to MDS 3.0 and with all of the federal regulations and guidelines updated during the past year. Each nursing policy for long term care in the book is also included on the CD which is located in the back of the manual, so they may be easily edited on a word processor for desired updates and changes.

Director of Nursing Long Term Care

The complete guide for streamlining and improving nursing documentation for virtually every system. Nurses will find instructions for virtually every common and not-so-common charting method. From progress notes to protocols, there is a wealth of easy-to-follow examples throughout the book. Includes JCAHO-approved nursing abbreviations, ANA standards of practive, and JCAHO and Medicare guidelines for nursing documentation.

Nursing Notes the Easy Way

This book is intended to meet the needs of students and clinicians in determining how they should be recording their practice and what the legal implications of these records may be. The authors first examine the realm of nursing documentation, including the legal implications of current methods of recording. In Part II the book presents the basis for liability in terms of nursing negligence and risk management. The third section explores documentation and its legal implications with respect to the delegation of patient care and across the range of in-patients and outpatient settings.

Home Health Nursing

Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and

current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal safeguards, and advice for special situations. Appendices include NANDA taxonomy, JCAHO documentation standards, and documenting outcomes and interventions for key nursing diagnoses.

Physical Therapy Documentation

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.

Snf Nursing and Therapy Collaboration

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach provides the framework for successful documentation. It is synchronous with Medicare standards as well as the American Physical Therapy Association's recommendations for defensible documentation. It identifies documentation basics which can be readily applied to a broad spectrum of documentation formats including paper-based and electronic systems. This key resource skillfully explains how to document the interpretation of examination findings

so that the medical record accurately reflects the evidence. In addition, the results of consultation with legal experts who specialize in physical therapy claims denials will be shared to provide current, meaningful documentation instruction.

INSPIREd Healthcare

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.

The Long-term Care Legal Desk Reference

Patient-centered, high-quality health care relies on the well-being, health, and safety of health care clinicians. However, alarmingly high rates of clinician burnout in the United States are detrimental to the quality of care being provided, harmful to individuals in the workforce, and costly. It is important to take a systemic approach to address burnout that focuses on the structure, organization, and culture of health care. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being builds upon two groundbreaking reports from the past twenty years, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century, which both called attention to the issues around patient safety and quality of care. This report explores the extent, consequences, and contributing factors of clinician burnout and provides a framework for a systems approach to clinician burnout and professional well-being, a research agenda to advance clinician well-being, and recommendations for the field.

Documenting Care

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

Complete Guide to Documentation

Master nursing skills with this guide from the respected Perry, Potter & Ostendorf author team! The concise coverage in Nursing Interventions & Clinical Skills, 6th Edition makes it easy to master the clinical skills required in everyday nursing practice. Clear guidelines address 159 basic, intermediate, and advanced skills — from measuring body temperature to insertion of a peripheral intravenous device — and step-by-step instructions emphasize the use of evidence-based concepts to improve patient safety and outcomes. Its friendly, easy-to-read writing style includes a streamlined format and an Evolve companion website with review questions and handy checklists for each skill. Coverage of 159 skills and interventions addresses basic, intermediate, and advanced skills you'll use every day in practice. UNIQUE! Using Evidence in Nursing Practice chapter provides the information needed to use evidence-based practice to solve clinical problems. Safe Patient Care Alerts highlight unusual risks in performing skills, so you can plan ahead at each step of nursing care. Delegation & Collaboration guidelines help you make decisions in whether to delegate a skill to unlicensed assistive personnel, and indicates what key information must be shared. Special Considerations indicate additional risks or accommodations you may

face when caring for pediatric or geriatric patients, and patients in home care settings. Documentation guidelines include samples of nurses' notes showing what should be reported and recorded after performing skills. A consistent format for nursing skills makes it easier to perform skills, always including Assessment, Planning, Implementation, and Evaluation. A Glove icon identifies procedures in which clean gloves should be worn or gloves should be changed in order to minimize the risk of infection. Media resources include skills performance checklists on the Evolve companion website and related lessons, videos, and interactive exercises on Nursing Skills Online. NEW coverage of evidence-based techniques to improve patient safety and outcomes includes the concept of care bundles, structured practices that have been proven to improve the quality of care, and teach-back, a new step that shows how you can evaluate your success in patient teaching. NEW! Coverage of HCAHPS (Hospital Care Quality Information from the Consumer Perspective) introduces a concept now widely used to evaluate hospitals across the country. NEW! Teach-Back step shows how to evaluate the success of patient teaching, so you can be sure that the patient has mastered a task or consider trying additional teaching methods. NEW! Updated 2012 Infusion Nurses Society standards are incorporated for administering IVs, as well as other changes in evidence-based practice. NEW topics include communication with cognitively impaired patients, discharge planning and transitional care, and compassion fatigue for professional and family caregivers.

A Guide for Nursing Home Social Workers, Second Edition

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

Documenting Medical Necessity

This is a comprehensive textbook for the documentation course required in all Physical Therapy programs. The textbook incorporates current APTA terminology and covers every aspect of documentation including reimbursement and billing, coding, legal issues, PT and PTA communication, as well as utilization review and quality assurance. (Midwest).

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

University of Wisconsin-Milwaukee School of Nursing's comprehensive charting and documentation manual for students and practitioners.

Notes on Nursing

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.

Nursing Documentation

Home care clinicians everywhere depend on "the little red book" for essential, everyday information: detailed standards and documentation guidelines including ICD-9-CM diagnostic codes, current NANDA-I and OASIS information, factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement considerations, and evidence-based resources for practice and education. COmpletely revised and updated, this indispensable handbook now includes the most recently revised Federal Register Final Rule and up-to-date coding guidelines.

Charting Made Incredibly Easy!

This unique, spiral-bound handbook is compact, portable, and written with busy home health nurses in mind! Organized by body system, it offers instant advice on assessment and care planning for the disorders home health nurses are likely to encounter. Providing assessment guides for all body systems, the home environment, and the client's psychological status, it includes full care plans for over 50 illnesses and conditions most commonly encountered in the home. Each plan lists nursing diagnoses, short- and long-term expected outcomes, nursing interventions, and client caregiver interventions. Care plans are organized by body systems to allow for quick retrieval of information. Both short-term and long-term outcomes are included in the care plans to aid evaluation of the care provided. Detailed assessment guidelines are provided for all body systems to

facilitate complete and comprehensive client examinations. Guidelines for environmental and safety assessments aid in the appraisal and improvement of clients' living conditions. Client and caregiver interventions are outlined in the care plans to promote active client participation in self-care. The convenient pocket size makes transportation and use convenient to home health nurses. Appendices on documentation guidelines, laboratory values, medication administration, home care resources, and standard precautions provide quick access to useful home care information. Related OASIS items are identified in the assessment section, and ICD-9 diagnostic codes in the care plans section assist with proper home care documentation. Visit frequency and duration schedules are suggested within each care plan to assist nurses in evaluating and planning care. NANDA nursing diagnoses are consistent with the latest 2001-2002 nomenclature. An increase in suggested therapy referrals within the care plans and in a new appendix helps nurses identify indicators for specialized services. A fully updated Resources Appendix includes websites for easy access to home health service information.

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach

A Guide For Nursing Home Social Workers

A Guide to Coding Compliance provides guidelines on performing coding compliance reviews and developing a coding compliance program. Practical and fundamental discussions on the differences between coding and billing, medical necessity, reviewing techniques, educational guides and coding compliance strategies, along with case studies based upon real experiences offer both the experienced coder and the student, with the tools necessary for handling a range of coding compliance issues. Special attention is also given to Medicare guidelines and the importance of official coding guidelines, as well as implementation of electronic health record systems and automated coding systems. For the coding and billing managers the text serves as a practical guide in answering some of the most common coding and compliance issues faced today. For students the text lays a foundation for understanding the legal requirements, payer specific instructions and the importance of quality coding. Important Notice: Media content referenced within the product description or the product text may not be available in the ebook version.

Mosby's Surefire Documentation

Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. The new Second Edition of Documentation Basics: A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z. Mia Erickson and Rebecca McKnight have

updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever-evolving profession. Updated inside Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition: * The discussion on integrating disablement into documentation * The discussion on how a PTA can show medical necessity and need for skilled care * The discussion on using documentation to communicate with other providers * Writing the assessment and plan to coincide with the initial documentation * Sample notes completed on forms * More examples and practice, including physical agents, school-based services, pediatrics, traumatic brain injury, spinal cord injury, and interventions consistent with the Guide to Physical Therapist Practice * Medicare reimbursement in different settings * The importance of consistent, reliable, and valid measurements * How to improve communication and consistency between documentation by the PT & the PTA The discussion on disablement has also been updated, shifting away from the Nagi Model toward the International Classification of Functioning, Disability, and Health (ICF). In addition, the PTA Normative Model has been integrated throughout to include more information on clinical decision making. New inside Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition: * Navigating the PT plan of careA step-by-step model for PTAs to use as they navigate the initial PT documentation and plan of care * How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem-oriented

medical record into electronic documentation * Sample notes and discussion of documentation in school-based settings, early intervention, skilled nursing settings, in-patient rehabilitation, and direct access * Medicare Parts C and D * Cash-based services and pro bono services Instructors in educational settings can visit www.efacultylounge.com for additional material to be used for teaching in the classroom. Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation.

Nursing Know-how

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

Nursing Interventions & Clinical Skills - E-Book

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.

Nursing Documentation

This full-color handbook is a quick-reference guide to all aspects of documentation for every nursing care situation. It covers current documentation systems and formats, including computerized documentation, and features scores of sample filled-in forms and in-text narrative notes illustrating everything from everyday occurrences to emergency situations. Coverage includes timesaving strategies for admission-to-discharge documentation in acute, outpatient, rehabilitation, long-term, and home care environments and special documentation practices for selected clinical specialties: critical care, emergency, perioperative, maternal-neonatal, and psychiatric. The book includes advice on legal safeguards, dangerous abbreviations, and compliance with HIPAA guidelines and JCAHO requirements.

Restorative Care Nursing for Older Adults

Among the issues confronting America is long-term care for frail, older persons and others with chronic conditions and functional limitations that limit their ability to care for themselves. Improving the Quality of Long-Term Care takes a comprehensive look at the

quality of care and quality of life in long-term care, including nursing homes, home health agencies, residential care facilities, family members and a variety of others. This book describes the current state of long-term care, identifying problem areas and offering recommendations for federal and state policymakers. Who uses long-term care? How have the characteristics of this population changed over time? What paths do people follow in long term care? The committee provides the latest information on these and other key questions. This book explores strengths and limitations of available data and research literature especially for settings other than nursing homes, on methods to measure, oversee, and improve the quality of long-term care. The committee makes recommendations on setting and enforcing standards of care, strengthening the caregiving workforce, reimbursement issues, and expanding the knowledge base to guide organizational and individual caregivers in improving the quality of care.

ROMANCE ACTION & ADVENTURE MYSTERY & THRILLER BIOGRAPHIES & HISTORY CHILDREN'S YOUNG ADULT FANTASY HISTORICAL FICTION HORROR LITERARY FICTION NON-FICTION SCIENCE FICTION