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focuses on the communicatiion skills that are the key to good documentation 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 if these are your concerns i ll never get time to finish my nursing notes is it legal can i use white out can t they make a better form than this how can i record this family set up quickly weren t computers made for clerks not nurses there has to be something wrong with documenting for funding how do you record the pain level of someone who has a dementing illness who walks down critical pathways what happens if a home health record gets lost how can i document my client s spiritual concerns realistically will managed care affect what i write is there a culturally appropriate way to document what is charting by exception how did nurses document before nanda then this book is for you back cover 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 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 the fifth edition of nursing care plans and documentation provides nurses with a comprehensive guide to creating care plans and effectively documenting care this user friendly resource presents the most likely diagnoses and collaborative problems with step by step guidance on nursing action and rationales for interventions new chapters cover moral distress in nursing improving hospitalized patient outcomes and nursing diagnosis risk for compromised human dignity the book includes over 70 care plans that translate theory into clinical practice online tutoring powered by smarthinking free online tutoring powered by smarthinking gives students access to expert nursing and allied health science educators whose mission like yours is to achieve success students can access live tutoring support critiques of written work and other valuable tools nursing documentation is not an aim in itself it is a vital source of information for nursing staff and essential for the patient s safety and the quality of nursing care however there are indications that the quality of nursing documentation is often sub optimal how this quality can be improved was not clear this thesis aims to give a better understanding of the quality criteria and the views of nurses and patients on electronic nursing documentation a systematic review of systematic reviews focussed on what quality criteria nursing documentation should meet four of the eleven reviews indicate that alignment of the documentation with the phases of the nursing process is a criterion for high quality documentation furthermore seven reviews report that the use of standardized terminologies improves the quality of nursing documentation in addition three reviews show that electronic documentation is preferred and that the user friendliness of electronic health records is an important quality criterion a nationwide survey showed that nursing staff only feel moderately supported in their documentation by the use of electronic health records only half of these nursing staff used a standardized terminology the extent to which nursing staff felt supported in their documentation was not associated with the use of a standardized terminology nursing staff were less positive about whether the information in the electronic health records was accurate and whether the electronic health records were user friendly a mixed methods study showed that community nurses estimated that they spent twice as much time on clinical documentation of the care for patients as on organizational documentation concerning financial aspects the time spent on organizational documentation was related to nurses perceived workload while the time spent on clinical documentation was not organizational documentation in particular resulted in a high workload among nurses focusing on the legal implications in the us this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice clearly and concisely provides guidelines for appropriate and careful documentation of care accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources in addition it plays a large role in how third party payors make payment or denial decisions this new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment special attention focuses on the latest documentation issues specific to specialty settings such as acute care home care and long term care and a variety of clinical specialties such as obstetrics pediatrics and critical care amazon com armed with this portable handbook nurses in any practice setting will know exactly what to document in any situation featuring an a to z organization that makes finding information easy this reference offers a new learn by example approach to charting and delivers clear examples for documenting more than 270 patient care situations from common diseases to legal and ethical issues legal casebook spotlights real life court cases to help you avoid perilous charting completed accuchart sample forms such as oasis incident reports and fall prevention reports give readers the confidence to chart accurately at all times 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 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 charting an incredibly easy pocket guide provides time starved nurses with essential documentation guidelines in a streamlined bulleted format with illustrations logos and other incredibly easy features the book is conveniently pocket sized for quick reference anytime and anywhere the first section reviews the basics of charting including types of records dos and dont s and current hipaa and jcaho regulations the second section alphabetically organized presents hundreds of examples and guidelines for accurately charting everyday occurrences logos include help desk best practices tips form fitting completed forms that exemplify top notch documentation making a case documentation related court cases and memory jogger mnemonics pocket sized companion to documentation skills for quality patient care 2nd ed c1999 also by rhoda fay yocum provides a quick reference tool for on the job documentation tasks includes a list of common medical prefixes suffixes and roots glossary of terms and a spelling list of more than 9 000 words for nurses trim size 8 x 4 5 inches softcover 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 designed for rapid on the job reference documentation in action offers comprehensive authoritative practice oriented up to the minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties need to know information is presented in bulleted lists charts flow sheets sidebars and boxes with icons and illustrative filled in samples coverage includes documentation for care of patients with various diseases complications emergencies complex procedures and difficulties involving patients families and other health care professionals suggestions are given for avoiding legal pitfalls involving telephone orders medication reactions patients who refuse care and much more a section addresses computerized documentation hipaa confidentiality rules use of pdas nursing informatics and electronic innovations that will soon be universal 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 nurses are now commonly cited or implicated in medical malpractice cases enter the world of nursing care planning with confidence this informative guide is the perfect way to build your care planning and documentation skills practical and easy to read material covers each phase of care plan development and record keeping for both surgical and non surgical interventions 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 feeling unsure about documenting patient care learn to document with skill and ease with the freshly updated document smart 4th edition this unique easy to use resource is a must have for every student and new nurse offering more than 300 alpha organized topics that demonstrate the latest nursing medical and government best practices for documenting a wide variety of patient conditions and scenarios whether you are assessing data creating effective patient goals choosing optimal interventions or evaluating treatment this is your road map to documentation confidence and clarity the perfect guide to charting the popular davis s notes format makes sure that you always have the information you need close at hand to ensure your documentation is not only complete and thorough but also meets the highest ethical and legal standards you ll even find coverage of the nuances that are relevant to various specialties including pediatric ob gyn psychiatric and outpatient nursing now in its third edition chartsmart the a to z guide to better nursing documentation is completely updated with hundreds of practical examples that explain and show you at a glance how to chart safely and responsibly in all clinical settings hospitals outpatient and rehabilitation centers long term care facilities even right in the patient s home learn how to document routine nursing care as well as essential details you need to record for emergencies complex procedures and difficult situations involving patients families and other health care team members résumé de l éditeur provides information on documentation issues including electronic medical records legal and ethical implications and documentation in acute cases along with a variety of charting examples this practical guide to 50 frequently encountered problems their diagnosis and management includes documentation which will fulfill legal quality assurance and reimbursement requirements alphabetically organized the book helps identify interventions data and outcomes appropriate for specific patients as another volume in ausmed s guide to practice series of textbooks and audiobooks this is an essential text for all aged care nurses who wish to enhance their documentation skills and deliver higher quality care to the elderly audiobooks are ideal teaching tools 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 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 sold in packs of 25 the handbook includes a short post test and certificate of completion allowing nurses to evaluate their documentation understanding patient visit notes for hospice nurses this notebook will help you keep track of important patient visit info like temperature blood sugar level bp bmi height weight resp rate heart rate so2 o2 level pain level type of pain location of pain past medical history surgical history medications date of visit next visit date other notes etc features 8 5 x 11 inches 120 pages matte finish soft cover patient visit notes for hospice nurses keeping concise and accurate notes is crucial for correct patient care and legally required in the most situations although bedside charting is the generally preferred method of note taking for hospice nurses you quickly realise that it is not always practical given the hands on rapidly changing nature of hospice care this book is designed to simplify the process of patient note taking and contains all essential information for appropriate care it s also a great resource that helps to compile all your records into one convenient location which should be kept for a number of years should any legal situations arise it was designed with consultation and guidance from dr m smithe it is designed specifically for hospice and home care nurses and contains the following index page quick recap of which patient is on each page and the date of visit patient visit logs and notes for each patient 1 double page spread per visit blank notes pages at the end of the book each patient note spread contains the following date scheduled prn start and finish time patient name mileage start and finish for traveling hospice workers patient pain 1 10 and description temperature blood pressure respiratory rate heart rate so2 o2 lpm last bm left and right mac weight family facility updated yes no next visit date medication supply confirmed lined notes 3 4 page per patient visit notes for next visit 6 x blank input columns for personal notetaking unique to each hospice nurse book features 130 pages 6 x 9 inch very convenient size printed on white paper perfect bound softcover book this text covers standards of documentation principles of good written communication and general guidelines on documenting patient care in hospital and the community it also covers reports letter writing incident forms and legal issues

Nursing Documentation 1994

focuses on the communicatiion skills that are the key to good documentation

Nursing Notes the Easy Way *2004-08*

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 *2018-06-05*

if these are your concerns i ll never get time to finish my nursing notes is it legal can i use white out can t they make a better form than this how can i record this family set up quickly weren t computers made for clerks not nurses there has to be something wrong with documenting for funding how do you record the pain level of someone who has a dementing illness who walks down critical pathways what happens if a home health record gets lost how can i document my client s spiritual concerns realistically will managed care affect what i write is there a culturally appropriate way to document what is charting by exception how did nurses document before nanda then this book is for you back cover

Nursing Documentation 1997-01-01

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

Nursing Notes the Easy Way 2010-11-01

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

Documentation Skills for Quality Patient Care *1999*

the fifth edition of nursing care plans and documentation provides nurses with a comprehensive guide to creating care plans and effectively documenting care this user friendly resource presents the most likely diagnoses and collaborative problems with step by step guidance on nursing action and rationales for interventions new chapters cover moral distress in nursing improving hospitalized patient outcomes and nursing diagnosis risk for compromised human dignity the book includes over 70 care plans that translate theory into clinical practice online tutoring powered by smarthinking free online tutoring powered by smarthinking gives students access to expert nursing and allied health science educators whose mission like yours is to achieve success students can access live tutoring support critiques of written work and other valuable tools

Complete Guide to Documentation 2008

nursing documentation is not an aim in itself it is a vital source of information for nursing staff and essential for the patient s safety and the quality of nursing care however there are indications that the quality of nursing documentation is often sub optimal how this quality can be improved was not clear this thesis aims to give a better understanding of the quality criteria and the views of nurses and patients on electronic nursing documentation a systematic review of systematic reviews focussed on what quality criteria nursing documentation should meet four of the eleven reviews indicate that alignment of the documentation with the phases of the nursing process is a criterion for high quality documentation furthermore seven reviews report that the use of standardized terminologies improves the quality of nursing documentation in addition three reviews show that electronic documentation is preferred and that the user friendliness of electronic health records is an important quality criterion a nationwide survey showed that nursing staff only feel moderately supported in their documentation by the use of electronic health records only half of these nursing staff used a standardized terminology the extent to which nursing staff felt

supported in their documentation was not associated with the use of a standardized terminology nursing staff were less positive about whether the information in the electronic health records was accurate and whether the electronic health records were user friendly a mixed methods study showed that community nurses estimated that they spent twice as much time on clinical documentation of the care for patients as on organizational documentation concerning financial aspects the time spent on organizational documentation was related to nurses perceived workload while the time spent on clinical documentation was not organizational documentation in particular resulted in a high workload among nurses

Nursing Care Plans & Documentation *2009*

focusing on the legal implications in the us this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice

Nursing Documentation Handbook *2000*

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

Notes on Nursing Documentation *2022*

armed with this portable handbook nurses in any practice setting will know exactly what to document in any situation featuring an a to z organization that makes finding information easy this reference offers a new learn by example approach to charting and delivers clear examples for documenting more than 270 patient care situations from common diseases to legal and ethical issues legal casebook spotlights real life court cases to help you avoid perilous charting completed accuchart sample forms such as oasis incident reports and fall prevention reports give readers the confidence to chart accurately at all times

Nursing Documentation *1999-05-06*

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 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

Nursing Documentation Handbook *1992*

charting an incredibly easy pocket guide provides time starved nurses with essential documentation guidelines in a streamlined bulleted format with illustrations logos and other incredibly easy features the book is conveniently pocket sized for quick reference anytime and anywhere the first section reviews the basics of charting including types of records dos and dont s and current hipaa and jcaho regulations the second section alphabetically organized presents hundreds of examples and guidelines for accurately charting everyday occurrences logos include help desk best practices tips form fitting completed forms that exemplify top notch documentation making a case documentation related court cases and memory jogger mnemonics

Nursing Documentation *1995*

pocket sized companion to documentation skills for quality patient care 2nd ed c1999 also by rhoda fay yocum provides a quick reference tool for on the job documentation tasks includes a list of common medical prefixes suffixes and roots glossary of terms and a spelling list of more than 9 000 words for nurses trim size 8 x 4 5 inches softcover

ChartSmart *2001*

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

Chart to Save Your RN License *2021-08-11*

designed for rapid on the job reference documentation in action offers comprehensive authoritative practice oriented up to the minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties need to know information is presented in bulleted lists charts flow sheets sidebars and boxes with icons and illustrative filled in samples coverage includes documentation for care of patients with various diseases complications emergencies complex procedures and difficulties involving patients families and other health care professionals suggestions are given for avoiding legal pitfalls involving telephone orders medication reactions patients who refuse care and much more a section addresses computerized documentation hipaa confidentiality rules use of pdas nursing informatics and electronic innovations that will soon be universal

Focus Charting *1997*

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

Charting 2006-11-01

nurses are now commonly cited or implicated in medical malpractice cases

Notes on Nursing Notes *1999-01-01*

enter the world of nursing care planning with confidence this informative guide is the perfect way to build your care planning and documentation skills practical and easy to read material covers each phase of care plan development and record keeping for both surgical and non surgical interventions

Mastering Documentation *1995*

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

Documentation in Action *2006*

feeling unsure about documenting patient care learn to document with skill and ease with the freshly updated document smart 4th edition this unique easy to use resource is a must have for every student and new nurse offering more than 300 alpha organized topics that demonstrate the latest nursing medical and government best practices for documenting a wide variety of patient conditions and scenarios whether you are assessing data creating effective patient goals choosing optimal interventions or evaluating treatment this is your road map to documentation confidence and clarity

Mosby's Surefire Documentation *2006*

the perfect guide to charting the popular davis s notes format makes sure that you always have the information you need close at hand to ensure your documentation is not only complete and thorough but also meets the highest ethical and legal standards you ll even find coverage of the nuances that are relevant to various specialties including pediatric ob gyn psychiatric and outpatient nursing

Managing Documentation Risk *2004*

now in its third edition chartsmart the a to z guide to better nursing documentation is completely updated with hundreds of practical examples that explain and show you at a glance how to chart safely and responsibly in all clinical settings hospitals outpatient and rehabilitation centers long term care facilities even right in the patient s home learn how to document routine nursing care as well as essential details you need to record for emergencies complex procedures and difficult situations involving patients families and other health care team members résumé de l éditeur

Nurse to Nurse *1995*

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

Nursing Care Plans and Documentation *2005-11-01*

this practical guide to 50 frequently encountered problems their diagnosis and management includes documentation which will fulfill legal quality assurance and reimbursement requirements alphabetically organized the book helps identify interventions data and outcomes appropriate for specific patients

Nursing Narrative Note Examples to Save Your License *2020-01-06*

as another volume in ausmed s guide to practice series of textbooks and audiobooks this is an essential text for all aged care nurses who wish to enhance their documentation skills and deliver higher quality care to the elderly audiobooks are ideal teaching tools

Document Smart *2019-06-26*

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

DocuNotes 2009-04-10

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 sold in packs of 25 the handbook includes a short post test and certificate of completion allowing nurses to evaluate their documentation understanding

Chart Smart *2011*

patient visit notes for hospice nurses this notebook will help you keep track of important patient visit info like temperature blood sugar level bp bmi height weight resp rate heart rate so2 o2 level pain level type of pain location of pain past medical history surgical history medications date of visit next visit date other notes etc features 8 5 x 11 inches 120 pages matte finish soft cover

Charting 1992

patient visit notes for hospice nurses keeping concise and accurate notes is crucial for correct patient care and legally required in the most situations although bedside charting is the generally preferred method of note taking for hospice nurses you quickly realise that it is not always practical given the hands on rapidly changing nature of hospice care this book is designed to simplify the process of patient note taking and contains all essential information for appropriate care it s also a great resource that helps to compile all your records into one convenient location which should be kept for a number of years should any legal situations arise it was designed with consultation and guidance from dr m smithe it is designed specifically for hospice and home care nurses and contains the following index page quick recap of which patient is on each page and the date of visit patient visit logs and notes for each patient 1 double page spread per visit blank notes pages at the end of the book each patient note spread contains the following date scheduled prn start and finish time patient name mileage start and finish for traveling hospice workers patient pain 1 10 and description temperature blood pressure respiratory rate heart rate so2 o2 lpm last bm left and right mac weight family facility updated yes no next visit date medication supply confirmed lined notes 3 4 page per patient visit notes for next visit 6 x blank input columns for personal notetaking unique to each hospice nurse book features 130 pages 6 x 9 inch very convenient size printed on white paper perfect bound softcover book

Nursing Know-how *2009*

this text covers standards of documentation principles of good written communication and general guidelines on documenting patient care in hospital and the community it also covers reports letter writing incident forms and legal issues

Nursing Documentation Handbook *1992*

Charting by Exception 1989-09-01

Nursing Care Plans and Documentation *1991*

Nursing Documentation in Aged Care 2004

Documentation *2007*

Nursing Documentation *2007*

Nursing Know-How 2008

Patient Visit Notes for Hospice Nurses 2021-06-23

Hospice Nurse Patient Visit Notes ***2020-10-15***

Writing, Documentation and Communication for Nurses ***1998***

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