

Daily Skilled Documentation Guidelines

Hospital Medicine: Just The Facts
The Long-term Care Legal Desk Reference
Long-Term Care Clinical Assessment and Documentation Cheat Sheets
Clinical Documentation Strategies for Home Health
Legal Aspects of Documenting Patient Care for Rehabilitation Professionals
Improving the Quality of Long-Term Care
Handbook of Informatics for Nurses and Health Care Professionals
Acute & Chronic Wounds
Improving the Quality of Care in Nursing Homes
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Basics
Improving Nursing Documentation and Reducing Risk
Long-term Care Skilled Services
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Communicating Clinical Decision Making Through Documentation: Coding, Payment, and Patient Categorization

Hospital Medicine: Just The Facts

"Handbook of Informatics for Nurses & Health Care Professionals" is an introduction to the computer technology used by nurses & other health care professionals. Offering an overview of informatics, as well as practical information for day-to-day use, this book includes: Expanded coverage of mobile computing and PDAs. Web-based technology, search tools, and evaluation criteria for online material. Various forms of electronic communication and ways to use it more effectively. The role of strategic planning in information management and system design and implementation. The development and use of the Electronic Medical Record (EMR). Regulatory and accreditation requirements, such as HIPAA. Disaster planning and recovery chapter with specific measures for the protection and back-up of information. A definition of telehealth as well as some of its applications and related issues. Applications of computer-based education for professionals and consumers.

The Long-term Care Legal Desk Reference

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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.

Long-Term Care Clinical Assessment and Documentation Cheat Sheets

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

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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

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Telehealth and EHR in homecare Motivating yourself and others to document completely and accurately

Clinical Documentation Strategies for Home Health

cs.hlth_prof.gerontol

Legal Aspects of Documenting Patient Care for Rehabilitation Professionals

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.

Improving the Quality of Long-Term Care

Your shortcut to accurate assessment and compliant documentation The quick and easy way to document quality resident care! The "Long-Term Care Clinical Assessment and Documentation Cheat Sheets" is the ultimate blueprint for how to provide resident-

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centered care for any symptom or condition. Available on CD, this electronic-only resource provides nurses with a thorough list of what to check and what to document during every shift, based on the specific circumstances of a given resident. Best of all, the new electronic format of this content enables long-term care clinicians to easily search for the condition they need to treat and access the appropriate checklist within seconds. Each checklist can be downloaded and printed to fit directly into the resident's record to ensure thorough, focused, and regular assessments and documentation. "Long-Term Care Clinical Assessment and Documentation Cheat Sheets" is the most convenient way to guarantee your residents receive the proper care and your facility maintains compliant documentation."Long-Term Care Clinical Assessment and Documentation Cheat Sheets"will help you: Save time finding the correct guidelines for a resident's condition with the searchable, electronic checklists Maintain complete and accurate clinical records for each resident to authenticate that physician orders were followed and residents were provided with the highest quality of care Ensure consistency of care across each nurse's shift by including the relevant checklist in each resident record Assess and document resident status, including cardiovascular, hematologic, and neurological conditions with more than 190 guidelines, tools, and cheat sheets Avoid survey citations, lost reimbursement, and legal implications arising from improper documentation Minimize nurses' stress by providing them with reliable guidance and data for each resident, in an easy-to-use format that fits seamlessly in their everyday work

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flow What's New Electronic, searchable checklists, which enable you to upload the information to the resident's EHR or print to file in their paper record! Special chapter covering the most frequent diagnoses for hospital readmissions and strategies for how to prevent them.

Handbook of Informatics for Nurses and Health Care Professionals

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 practice, and JCAHO and Medicare guidelines for nursing documentation.

Acute & Chronic Wounds

Improving the Quality of Care in Nursing Homes

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

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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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Effective Documentation for Physical Therapy Professionals

Restorative Care Nursing for Older Adults

The Future of Nursing explores how nurses' roles,

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responsibilities, and education should change significantly to meet the increased demand for care that will be created by health care reform and to advance improvements in America's increasingly complex health system. At more than 3 million in number, nurses make up the single largest segment of the health care work force. They also spend the greatest amount of time in delivering patient care as a profession. Nurses therefore have valuable insights and unique abilities to contribute as partners with other health care professionals in improving the quality and safety of care as envisioned in the Affordable Care Act (ACA) enacted this year. Nurses should be fully engaged with other health professionals and assume leadership roles in redesigning care in the United States. To ensure its members are well-prepared, the profession should institute residency training for nurses, increase the percentage of nurses who attain a bachelor's degree to 80 percent by 2020, and double the number who pursue doctorates. Furthermore, regulatory and institutional obstacles -- including limits on nurses' scope of practice -- should be removed so that the health system can reap the full benefit of nurses' training, skills, and knowledge in patient care. In this book, the Institute of Medicine makes recommendations for an action-oriented blueprint for the future of nursing.

Complete Guide to Documentation

Publisher's Note: Products purchased from Third Party sellers are not guaranteed by the publisher for

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quality, authenticity, or access to any online entitlements included with the product. Clear, concise, and simple to follow—everything you need to master the documentation process quickly and easily. Communicating Clinical Decision Making Through Documentation is the top choice for professionals and students seeking complete coverage of the documentation process including billing and coding. It shows how to ensure every service rendered and billed is supported by showing what to document, how to do it, and why it is so important. This text includes a refreshing student-friendly approach to the topic. You will find an abundance of cases portraying real-life case scenarios and it delivers must-know information on writing patient/client care notes, incorporating document guidelines, documenting clinical decision making (includes evidence-based practice), and performing billing and coding tasks. With Communicating Clinical Decision Making Through Documentation, you'll effectively maintain and organize records, record appropriate information, and receive proper payment based on the documentation content. A to Z coverage of physical therapy documentation, including: Documentation Standards and Guidelines Medicare Home Health Electronic Medical Records (EMR) International Classification of Functioning (ICF) Model and Application Pediatrics Legal Issue Utilization Review & Management Skilled Nursing Facilities Sample Documentation Content Initial Examination and Evaluation Criteria Continuum of Care Content and Goal Writing Exercises Documentation Aspects of Supervising PTAs Abbreviations Payment ICD-10 and CPT Codes and Application Chapter Review Questions

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Content Principles

Case Management in Healthcare

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.

The Journal of Long Term Care Administration

Expertly manage the top diseases and conditions in hospital medicine! This concise yet comprehensive review is the perfect tool to prepare for certification, re-certification, CME-or for use a clinical refresher. Featuring expert insights, its highly efficient format conveniently condenses and simplifies only the most important content for maximum yield and minimum time. FEATURES: Ideal for both specialists and generalists who manage subspecialty care in the

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increasingly complex hospital environment Complete, A-to-Z overview of all diseases and disorders commonly seen by hospitalists Expert, up-to-date coverage of unique, need-to-know concepts in hospital medicine-including key clinical, organizational, and administrative issues Practical coverage of the top 50 diagnosis related groups (DRGs) in US hospitals An incisive look at patient safety that helps you ensure optimal care Logically organized, easy-to-follow chapters help focus your study and provide rapid access to specific subjects [McGraw-Hill Medical logo] www.mcgraw-hillmedical.com

The Future of Nursing

Hospitals and nursing homes are responding to changes in the health care system by modifying staffing levels and the mix of nursing personnel. But do these changes endanger the quality of patient care? Do nursing staff suffer increased rates of injury, illness, or stress because of changing workplace demands? These questions are addressed in *Nursing Staff in Hospitals and Nursing Homes*, a thorough and authoritative look at today's health care system that also takes a long-term view of staffing needs for nursing as the nation moves into the next century. The committee draws fundamental conclusions about the evolving role of nurses in hospitals and nursing homes and presents recommendations about staffing decisions, nursing training, measurement of quality, reimbursement, and other areas. The volume also discusses work-related injuries, violence toward and

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abuse of nursing staffs, and stress among nursing personnel--and examines whether these problems are related to staffing levels. Included is a readable overview of the underlying trends in health care that have given rise to urgent questions about nurse staffing: population changes, budget pressures, and the introduction of new technologies. *Nursing Staff in Hospitals and Nursing Homes* provides a straightforward examination of complex and sensitive issues surround the role and value of nursing on our health care system.

Mosby's Surefire Documentation

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.

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Cpt 1999

Documenting Physical Therapy provides practitioners with the tools necessary to make documentation a successful and beneficial part of clinical practice. Using the reviewer's perspective, emphasis is placed on documenting components that are essential for coverage determinations. * Comprehensive overview of documentation in physical therapy for the purpose of justifying treatment strategies and avoiding claim denials * Case studies illustrate acceptable and unacceptable documentation practices * Provides suggestions to improve documentation

Ohio Monthly Record

Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice Avoid common mistakes that compromise compliance and payment Take the mystery out of skilled services and know when to skill a resident based on government regulations, Medicare updates, the MDS 3.0, and proven strategies. "Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice" illustrates the role played by nurses, therapists, and MDS coordinators in the application and documentation of resident care. Don't miss out on the benefits and reimbursement you deserve, as author Elizabeth Malzahn delivers clear, easy-to-understand examples and explanations of the right way to manage the skilled services process. This book will help you: Increase your skilled census and improve your facility's reputation with the support of your entire

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staff Avoid under- and overpayments from Medicare with easy-to-understand explanations of complex rules and regulations Provide necessary skilled services to each resident through a complete understanding of eligibility requirements Accurately document skilled services using proven, time-saving solutions Properly assess skilled services under the MDS 3.0 Improve communication to increase resident and family satisfaction Reduce audit risk and prove medical necessity through accurate documentation

Table of Contents Rules and Regulations Original law - Social Security and Medicare Act CMS publications Manuals Transmittals MLN matters National and local coverage determinations "RAI User's Manual " Hierarchy of oversight CMS-MAC/FI, OIG, GAO, etc. Technical Eligibility for Skilled Services in LTC Eligibility basics Verification of current benefits How enrollment in other programs impacts coverage under traditional Medicare Hospice HMO/managed care/Medicare Advantage Medicaid/Medi-Cal Hospital stay requirement 30-Day transfer rule for hospital or SNF Understanding benefit periods Care continuation related to hospitalization How does a denial of payment for new admissions impact Medicare SNF admissions? Meeting the Regulatory Guidelines For "Skilled" Services Skilled services defined Regulatory citations and references Clinical skilled services Therapy skilled services Physician certifications and recertification Presumption of coverage Understanding "practical matter" criteria for nursing home placement Impact of a leave of absence on eligibility MDS 3.0 - Assessments, Sections and Selection Oh My! Brief history of MDS 3.0 Types of MDS assessments The assessment schedule Items to consider Importance of

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timing Review of each care-related section of the MDS 3.0
Proper Communication During the Part A Stay
Medicare meeting Timinng Agenda What to discuss for each resident
Ending skilled services Notification requirements Discharging Other notification requirements and communication
Other Important Things to Know Medicare myths Consolidated billing
Medical review Audience Administrators, CFO/CEOs, directors of nursing, MDS coordinators, directors of rehab, therapy directors, PT/OT/ST, DONs.

Documentation for Physical Therapist Practice: A Clinical Decision Making Approach

Health Care Financing Administration Paperwork Burdens

Rules of state administrative agencies In full text, with tables and index including chart of proposed rules, with time and location of public hearings.

Nursing Documentation

"Nurses play a vital role in improving the safety and quality of patient care -- not only in the hospital or ambulatory treatment facility, but also of community-based care and the care performed by family members. Nurses need know what proven techniques and interventions they can use to enhance patient outcomes. To address this need, the Agency for Healthcare Research and Quality (AHRQ), with

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additional funding from the Robert Wood Johnson Foundation, has prepared this comprehensive, 1,400-page, handbook for nurses on patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, <http://www.ahrq.gov/qual/nursesshdbk>.

Mastering Documentation

This is the official CPT code book published by the American Medical Association. the 1999 CPT provides hundreds of new and revised CPT codes. Double columns on each page allow more codes to be viewed, plus an expanded index to aid in locating codes by procedure, service, organ, condition, synonym or eponym, and abbreviations

Provider

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.

Oregon Administrative Rules

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

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properly. This book will help you: Work directly with your staff to ensure accurate documentation Train nurses during orientation Educate your staff on the consequences of inaccurate documentation Create steps to share with your staff that will improve documentation Ensure complete comprehension of documentation issues through sample forms, auditing tools, and case studies Table of Contents Chapter 1: Contemporary Nursing Practice Includes Good Documentation Chapter 2: Contemporary Nursing Standards: Why it's Important for Nurses to Document Well Chapter 3: Reducing Professional Risk Through Documentation Chapter 4: Barriers to Good Nursing Documentation Chapter 5: 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

The How-to Manual for Rehab Documentation

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).

Code of Ethics for Nurses with

Interpretive Statements

The How-To Manual for Rehab Documentation, Third Edition A Complete Guide to Increasing Reimbursement and Reducing Denials Rick Gawenda, PT Up-to-speed with Medicare documentation requirements for 2009 and beyond? Increase cash flow and reduce Medicare claim denials by using strategies provided in the Third Edition of "The How-To Manual for Rehab Documentation. " Written by national consultant Rick Gawenda, PT. Since our last edition, there have been significant changes to the rules and regulations surrounding documentation in therapy settings. And now that the RACs are underway it is even more important to have accurate and thorough documentation. Mistakes can lead to delayed payments and denials, so how do ensure that you are in compliance with the current guidelines? Make it easy. Order your copy of "The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials." Written by author and national consultant Rick Gawenda, PT, of Gawenda Seminars, this book and CD-ROM set""focuses on the clinical aspects of documentation and offers proven methods to strengthen documentation and decrease the frequency of denials. Gawenda encourages b documentation methods that have worked for him and help you conquer potentially tough concepts such as maintenance therapy and CPT codes. What's new in the third edition? Clarification of certification and re-certification requirements regarding how long they are valid for and how soon they need to be signed

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Explanation of delayed certification
Tips to write function-based short- and long-term goals
Updated examples of well-written goals
Updated payer documentation guidelines for evaluations, progress reports, daily notes, discharge reports, and re-evaluations
"The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials"
outlines proper documentation strategies starting from the moment a patient registers and receives treatment to billing for time and services. Gawenda encourages b documentation methods that have worked for him and help you conquer potentially tough concepts such as maintenance therapy and CPT codes.
This comprehensive book and CD-ROM, helps you:
Improve therapy billing through better documentation
Prevent denials as a result of better documentation practices
Maintain quality assurance through proper documentation
Optimize your reimbursement from both Medicare and third-party payers
Avoid audits and targeted medical reviews
Document care in a more efficient way
Take the critical steps to verify therapy benefit coverage prior to a patient's initial visit
Support skilled therapy services with inclusion of required documentation
Understand Medicare certification and recertification time frames and requirements for all therapy settings
Understand and use the most commonly used CPT codes and modifiers in rehabilitation therapy
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Documentation Goals POC Documentation Creating a Solid Foundation Chapter 3: Certification and Recertification Physician Referrals Physician Referral Denials Outpatient Therapy Settings Certification and Recertification SNF Part A Therapy Services Reimbursed Under the Prospective Payment System (PPS) Home Health Agency Part A Therapy Services Chapter 4: Daily Documentation Daily Documentation Documentation Requirements Home Exercise Programs (HEPs) Plan Documentation Chapter 5: Progress Reports, Discharge Reports, and Reevaluations Progress Reports Discharges Reevaluations Chapter 6: Maintenance Therapy What is an FMP? Coverage Criteria Documentation Requirements Billing Cover All Your Bases Chapter 7: Wound Care Under Medicare Discharge Criteria Additional Pointers Appendix A: Navigating the CMS Web site Getting Started Final Word Make it easy to understand CMS' documentation guidelines No need to download and interpret the guidance from the CMS Web site yourself. Author Rick Gawenda, PT, has done the work for you. His documentation practices are sure to help you receive optimal compensation for the services you perform as a therapist. Nearly half of all rehab claim denials are STILL due to improper documentation. Ensure proper documentation for services provided and decrease the frequency of denials. Order "The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials" today!

Patient Safety and Quality

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Home Health Assessment Criteria

Focusing on a multidisciplinary approach, *Acute and Chronic Wounds: Nursing Management, 2e*, provides a resource for health care providers challenged with the care of acute surgical wounds and all types of chronic wounds.

Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations

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.

Home Care Nursing Practice

Effective Documentation for Occupational Therapy

Director of Nursing Long Term Care

Thoroughly updated for its Second Edition, this

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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.

Caring

The influenza pandemic caused by the 2009 H1N1 virus underscores the immediate and critical need to prepare for a public health emergency in which thousands, tens of thousands, or even hundreds of thousands of people suddenly seek and require medical care in communities across the United States. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations* draws from a broad spectrum of expertise--including state and local public health, emergency medicine and response, primary care, nursing, palliative care, ethics, the law, behavioral health, and risk communication--to offer guidance toward establishing standards of care that should apply to disaster situations, both naturally occurring and man-made, under conditions in which

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resources are scarce. This book explores two case studies that illustrate the application of the guidance and principles laid out in the report. One scenario focuses on a gradual-onset pandemic flu. The other scenario focuses on an earthquake and the particular issues that would arise during a no-notice event. Outlining current concepts and offering guidance, this book will prove an asset to state and local public health officials, health care facilities, and professionals in the development of systematic and comprehensive policies and protocols for standards of care in disasters when resources are scarce. In addition, the extensive operations section of the book provides guidance to clinicians, health care institutions, and state and local public health officials for how crisis standards of care should be implemented in a disaster situation.

Nursing Staff in Hospitals and Nursing Homes

HOME CARE NURSING PRACTICE is a practical text and reference that provides guidelines for nurses managing complex patient care in a home environment. It addresses the basic concepts of home care nursing, common clinical conditions found in the home, patient education, and life span coverage packaged in a comprehensive, consistent format. Includes separate chapters on select clinical diagnoses, such as ventilator-dependent patients, patients with congestive heart failure, patients with AIDS, and patients receiving IV therapy Follows a consistent format in clinical chapters to describe

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pathophysiology, assessment guidelines, and related equipment, to aid the home care nurse in developing the plan of care. Describes the family role and nursing interventions for caring for families in crisis in a new chapter, Caring for Families in the Home Describes how the home environment may impact a patient's health in a new chapter, Managing Environmental Threats in the Home Provides an overview of holistic and alternative therapeutic practices that may be encountered in the home in a new chapter, Complementary Therapies and Home Care Nursing Practice

Documenting Physical Therapy

Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. Necessary for both students and clinicians, Documentation Basics: A Guide for the Physical Therapist Assistant will teach and explain physical therapy documentation from A to Z. Documentation Basics: A Guide for the Physical Therapist Assistant covers all of the fundamentals for prospective physical therapist assistants preparing to work in the clinic or clinicians looking to refine and update their skills. Mia Erickson and Becky McKnight have also integrated throughout the text the APTA's Guide to PT Practice to provide up-to-date information on the topics integral for proper documentation. What's Inside: Overview of documentation Types of documentation Guidelines for documenting Overview of the PTA's role in patient/client management, from the patient's point of entry to discharge How to write

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progress notes How to use the PT's initial examinations, evaluations, and plan of care when writing progress notes Legal matters related to documentation Reimbursement basics and documentation requirements The text also contains a section titled "SOAP Notes Across the Curriculum," or SNAC. This section provides sample scenarios and practice opportunities for PTA students that can be used in a variety of courses throughout a PTA program. These include: Goniometry Range of motion exercises Wound care Stroke Spinal cord injury Amputation Enter the physical therapy profession confidently with Documentation Basics: A Guide for the Physical Therapist Assistant by your side.

Documentation Basics

This hands-on manual covers the increasingly important area of case management in comprehensive, up-to-the-minute detail! It not only offers the field's most clinically focused coverage of the subject, but also provides practical details on a range of specific diagnoses. CASE MANAGEMENT IN HEALTHCARE focuses on the case management processes, interventions, and collaborations that are vital to guiding patients through the continuum of care. This book emphasizes the how-tos needed in specific clinical situations. It also prepares students to manage the pitfalls and barriers that are frequently encountered in practice.

Improving Nursing Documentation and Reducing Risk

Long-term Care Skilled Services

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

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saved to a computer whenever needed. By adding or deleting entries, the forms and care plans can be made resident specific.

Federal Register

Communicating Clinical Decision Making Through Documentation: Coding, Payment, and Patient Categorization

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.

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