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Orientation to Home Care *Nursing* Mosby Orientation to Home Care Nursing

is a comprehensive reference text that covers all aspects of home health nursing. This text can be used as a primary text for home care and community nursing courses. Or it can be used concurrently with the agency's own materials to apply learned material to daily practice or with students who are learning about home care. This companion text to the Manual of Home Care Nursing Orientation, by the same authors, provides the nurse with an in-hand reference for orientation and beyond.

Handbook of Home Health Standards & Documentation Guidelines for Reimbursement Clinical Documentation Strategies for Home Health

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home health and hospice care 899.

Mosby's Guide to Nursing Diagnosis **Elsevier Health Sciences**

Complete your charting at your patient's home and stay organized. EASY and CONVENIENT to use. 6x9 Inhces with 120 pages and Matte Finish.

Home Health Nursing HC Pro, Inc.

"This text covers conceptual information, leadership skills and current issues and trends. It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care." --Cover.

Complete Guide to Documentation Springer Publishing Company

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

Fast Facts for the Long-Term Care Nurse F A Davis Company

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.

Handbook of Home Health Standards, Revised Reprint
Lippincott Williams & Wilkins
An all-inclusive guide to fundamentals and medical-surgical nursing for the LPN/LVN, Foundations and Adult Health Nursing, 7th Edition covers the skills you need for clinical practice, from anatomy and physiology to nursing interventions and maternity, neonatal, pediatric, geriatric, mental health, and community health care. Guidelines for patient care are presented within the framework of the five-step nursing process; Nursing Care Plans are described within a case-study format to help you develop skills in clinical decision-making. Written by Kim Cooper and Kelly Gosnell, this text includes all of the content from their Foundations of Nursing and Adult Health Nursing books, including review questions to help you prepare for the NCLEX-PN ® examination! Full-color, step-by-step instructions for over 100 skills show nursing techniques and procedures along with rationales for each. The 5-step Nursing Process connects specific disorders to patient care - with a summary at the end of each chapter. Nursing Care Plans emphasize patient goals and outcomes within a case-study format, and promotes clinical decision-making with critical thinking questions at the end of each care plan. Clear coverage of essential A&P is provided by an

Introduction to Anatomy and Physiology chapter along with an overview of A&P in all body systems chapters. Student-friendly features enhance the learning of nursing skills with summary boxes for Patient Teaching, Health Promotion Considerations, Complementary and Alternative Therapy, Cultural Considerations, Older Adult Considerations, Home Care Considerations, Safety Alert, and Prioritization, Assignment, and Supervision. UNIQUE! Mathematics review in Dosage Calculation and Medication Administration chapter covers basic arithmetic skills prior to the discussion of medication administration. A focus on preparing for the NCLEX examination includes review questions and Get Ready for the NCLEX Examination! sections with key points organized by NCLEX Client Needs Categories. Evidence-Based Practice boxes provide synopses of nursing research articles and other scientific articles applicable to nursing, along with nursing implications for the LPN/LVN. Nursing Diagnosis boxes summarize nursing diagnoses for specific disorders along with the appropriate nursing interventions. UNIQUE! Delegation Considerations boxes provide parameters for delegation to nurse assistants, patient care technicians, and unlicensed assistive personnel. Medication Therapy tables provide quick access to actions, dosages, precautions, and nursing considerations for commonly used drugs. NEW! Reorganized chapters make it easier to follow and understand the material. NEW! Icons in page margins indicate videos, audios, and animations on the Evolve companion website that may be accessed for enhanced learning. UDATED illustrations

include photographs of common nursing skills.

Nursing Documentation Handbook Mosby Incorporated Historically, community health nursing has responded to the changing health care needs of the community and continues to meet those needs in a variety of diverse roles and settings. Community Health Nursing: Caring for the Public's Health, Second Edition reflects this response and is representative of what communities signify in the United States--a unified society made up of many different populations and unique health perspectives. This text provides an emphasis on population-based nursing directed toward health promotion and primary prevention in the community. It is both community-based and community-focused, reflecting the current dynamics of the health care system. The Second Edition contains new chapters on disaster nursing and community collaborations during emergencies. The chapters covering Family health, ethics, mental health, and pediatric nursing have all been significantly revised and updated.

Patient Safety and Quality Jones & Bartlett Publishers

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

Nursing Documentation Made Incredibly Easy Hcpro, a Division of Blr

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

Handbook of Home Health Care Administration Jones & Bartlett Learning

This pocket-size guide saves nurses precious time while ensuring that a complete patient record is created and that legal, quality assurance, and reimbursement requirements are met. This handbook provides specific verbiage for charting patient progress, change or tasks accomplished for approximately 50 common problems. The new third edition has been completely

updated to include Critical Assessment Findings, Subjective Findings for Documentation, Resources for Care and Practice, Legal Considerations, Time Saving Tips, and new Managed Care information. Plus, roughly 15 additional common problems and diagnoses have been added making this practical resource more valuable than ever. Diagnoses are in alphabetical order allowing for fast and easy access. Each patient problem or diagnosis found in this handbook includes specific documentation guidelines for the following aspects of nursing care: *Assessment of patient problem *Associated nursing diagnosis *Examples of objective findings for documentation *Examples of subjective findings for documentation *Examples of assessment of the data *Examples of potential medical problems for this patient *Examples of the documentation of potential nursing interventions/actions *Examples of the evaluations of the interventions/actions *Other services that may be indicated and their associated interventions and goals/outcomes *Nursing goals and outcomes *Potential discharge plans for this patient *Patient, family, caregiver educational needs *Resources for care and practice *Legal considerations for documentation, as appropriate Introductory chapters describe documentation, the medical record systems of nursing documentation, and current JCAHO and ANA standards related to documentation. Specialty sections provide important and specific

guidelines for hospice care and maternal-child care. Appendices provide the latest NANDA-approved nursing diagnoses, descriptions of services provided by other disciplines, abbreviations, and a listing of resources (i.e., directory of resources, clinical newsletters and journals, Internet resources, further reading). Includes Time Saving Tips boxes to help minimize the time needed for documentation responsibilities. Each diagnosis includes a Critical Assessment Components/Findings section to help nurses with their critical decision making and determine whether an assessment finding indicates immediate attention or patient follow up. The Goals/Outcomes section of each diagnosis now appears at the beginning so that nurses know the intended goals and outcomes up front before beginning the assessment. All documentation guidelines now include sections on Examples of Subjective Findings for Documentation and Resources for Care and Practice. Includes Legal Considerations for Documentation as appropriate to highlight important legal issues. Part One has been updated to reflect the current managed care environment, including new information required by the National Community of Quality Assurance [NCQA], so that nurses can incorporate and focus on these changes as they document

Nursing Care Plans Elsevier Health Sciences

Including all of the information necessary for safe, competent practice, this is a practical, hands-

on educational and training resource for nurses working in telephonic health care settings. It delivers the requisite tools and instruction for optimizing patient communication, performing assessments, and providing effective care of chronic conditions. Moving step-by-step from simple to complex information, the resource de-mystifies the process of telephonic nursing care and describes numerous tools such as learning outcomes, algorithms, exercises to reinforce learning, case studies, and critical thinking questions that help readers develop and hone telehealth nursing skills. The text instructs nurses on how to actively listen to the patient "between the lines" in the absence of an in-person examination and discern the right questions to ask and tone to adopt. Chapters provide enhanced communication techniques to perform comprehensive health assessments with only the sense of hearing and resources available through the telephone. Clinical pearls are scattered throughout the text from those who have been “ in the trenches ” and cared for a wide variety of patients using the telehealth nursing techniques illustrated in this book. Key Features: Helps nurses understand the keys to successful telehealth nursing Teaches enhanced, specialized communication techniques including "active listening" Guides nurses in assessing patients using only sense of hearing/active listening Includes case studies, algorithms, patient teaching resources and more Reviews body systems and disease processes with application exercises

Managing Documentation Risk Elsevier Health Sciences

In addition, with the updated HCFA home health agency

manual coverage as well as coverage and documentation guidelines, forms may be completed with knowledge of the latest Medicare rules. Best of all, the OASIS-B form, which is hot off the press, is included in its entirety!

Nursing Know-how Hcpro, a Division of Blr

This is a book that specifies the aspects required of Medicare to be included within an OASIS nursing narrative note in order for a skilled nursing visit to be deemed as approved by, and reimbursable by Medicare.

Community Health Nursing Jones & Bartlett Learning

Handbook of Home Health Standards: Quality, Documentation, and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards. This handbook offers detailed standards and documentation guidelines including ICD-9-CM (diagnostic) codes, OASIS considerations, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement, and resources for practice and education. The fifth edition of this "little red book" has been updated to include new information from the most recently revised Federal Register Final Rule and up-to-date coding. All information in this handbook has been thoroughly reviewed, revised, and updated. Offers easy-to-access and easy-to-read format that guides users step by step through important home care standards and documentation guidelines Provides practical tips for effective documentation of diagnoses/clinical conditions commonly treated in the home, designed to positively influence reimbursement from third party payors. Lists ICD-9-CM diagnostic codes, needed for completing CMS billing forms, in each body system section, along with a complete alphabetical list of all codes

included in the book in an appendix. Incorporates hospice care and documentation standards so providers can create effective hospice documentation. Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care. Includes the most current NANDA-approved nursing diagnoses so that providers have the most accurate and up-to-date information at their fingertips. Identifies skilled services, including services appropriate for the multidisciplinary team to perform. Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient's needs. Lists the crucial parts of all standards that specific members of the multidisciplinary team (e.g., the nurse, social worker) must uphold to work effectively together to achieve optimum patient outcomes. Resources for care and practice direct providers to useful sources to improve patient care and/or enhance their professional practice. Each set of guidelines includes patient, family, and caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns. Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions. Several useful sections make the handbook thorough and complete: medicare guidelines; home care definitions, roles, and abbreviations; NANDA-approved nursing diagnoses; guidelines for home medial equipment and supplies. Small size for convenient carrying in bag or pocket! Provides the most up-to-date information about the newest and predominant reimbursement mechanisms in home care: the Prospective Payment System (PPS) and Pay For Performance (P4P). Updated terminology, definitions, and language to reflect the federal agency change from Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS) and

other industry changes. Includes the most recent NANDA diagnoses and OASIS form and documentation explanations. New interdisciplinary roles have been added, such as respiratory therapist and nutritionist.,/LI>
Springer Publishing Company
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.

Home Health Assessment Criteria
SAGE Publications
This 6th edition of this comprehensive handbook provides practical information about complex Medicare and other "rules" in home care. Areas include OASIS considerations, possible patient goals/outcomes, skills based on the assessed patient needs, comfort consideration, and caregiver considerations. All you need to know about care planning. Other areas include tips for supporting medical necessity, quality and reimbursement and more! The Medicare Benefit Policy Manual Chapter 7, Home Health Services is reprinted for easy reference and use.

Nursing Interventions Classification (NIC) - E-Book
Lippincott Williams & Wilkins
Everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards is found in this handbook. Offers detailed standards and

documentation guidelines for each of more than 60 clinical problems, including ICD-9 (diagnostic) codes, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, and more.

Clinical Documentation Strategies for Home Health Elsevier Health Sciences

Important Notice: The digital edition of this book is missing some of the images or content found in the physical edition. Handbook of Home Health Care, Fifth Edition has been completely revised and updated to provide up-to-date, specific, authoritative guidance for the successful administration and management of home health care agencies. An excellent, comprehensive text, this Handbook addresses detailed legal and legislative issues, case management processes, and state-of-the-art technology.

Patient Visit Notes Lippincott Williams & Wilkins

Covering the full range of nursing interventions, Nursing Interventions Classification (NIC), 6th Edition provides a research-based clinical tool to help in selecting appropriate interventions. It standardizes and defines the knowledge base for nursing practice while effectively communicating the nature of nursing. More than 550 nursing interventions are provided — including 23 NEW labels. As the only comprehensive taxonomy of nursing-sensitive interventions available, this book is ideal for practicing nurses, nursing students, nursing administrators, and faculty seeking to enhance nursing curricula and improve nursing care. More than 550 research-based nursing intervention

labels with nearly 13,000 specific activities Definition, list of activities, publication facts line, and background readings provided for each intervention. NIC Interventions Linked to 2012-2014 NANDA-I Diagnoses promotes clinical decision-making. New! Two-color design provides easy readability. 554 research-based nursing intervention labels with nearly 13,000 specific activities. NEW! 23 additional interventions include: Central Venous Access Device Management, Commendation, Healing Touch, Dementia Management: Wandering, Life Skills Enhancement, Diet Staging: Weight Loss Surgery, Stem Cell Infusion and many more. NEW! 133 revised interventions are provided for 49 specialties, including five new specialty core interventions. NEW! Updated list of estimated time and educational level has been expanded to cover every intervention included in the text.