

Documentation Guidelines : A summary of when to document what

Admission

- Complete Admission History in StarPanel within 24 hrs. of admission
- Assess ALL Care Categories, noting baseline status. If using WEL& OEL enter an annotation with supporting information.
- Document Care Contact & VUMC general & unit specific orientation in Education Tab

Beginning of Shift

- Assess Care Categories in **ALL CAPS** + others based on problems or risk for problems
- Denote Priority Problems for shift w/ **!!** & set goals for each priority problem.
- Document Interventions in real time or near real time through the shift.

Focused Re-assessment

- Document either "unchanged" or "unchanged except" & denote changes for OEL, problems, risk for problems or based on orders &/or nursing judgment. **DO NOT** document on those wnl.
- ICU – at least two more times during the shift
- Acute Care – at least once during the shift

Pre-Procedure or Transfer

- Focused reassessment, note new, resolved, or unchanged problems
- Summarize response to care focus on priority problems; Identify issues for f/u by receiving nurse; avoid duplication
- Enter interventions, vitals, I&O, & meds

End of shift

- Summarize response to care focus on priority problems; Identify issues for f/u by receiving nurse; avoid duplication
- Ensure all assessment, interventions, vitals, I&O, meds documentation is up-to-date

Discharge

- Summarize response to care, focus on unresolved problems and action plan post discharge; avoid duplication
- Ensure all assessments, interventions, vitals, I&O, meds documentation is up-to-date

Nursing Documentation Guidelines

Christine Crofton, Gaye Witney



Nursing Documentation Guidelines:

Nursing Documentation Made Incredibly Easy Kate Stout, 2018-06-05 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 NEW discussion 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 Doshier Memorial Hospital in Southport North Carolina [Chart Smart](#), 2011

Complete Guide to Documentation Lippincott Williams & Wilkins, 2008 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

Guidelines for School Nursing Documentation Nadine Schwab,1991 *Guidelines for School Nursing*

Documentation Nadine Schwab,Mari Jo Panettieri,Martha Dewey Bergren,1998 Illustrated Manual of Nursing Practice

,2002 Completely revised and updated this broad yet comprehensive edition contains twenty nine chapters on nursing issues and clinical practice Topics cover practice and process documentation legal issues health promotion physical assessment I V therapy surgical care and more Disorders are organized by body system and feature an overview of anatomy and physiology assessment diagnostic tests medication treatment and home care with coverage of care for maternal neonatal pediatric geriatric emergency and psychiatric patients Added features include grabbing nursing procedure graphics complementary therapies clinical pathways and cultural information Over 1 000 illustrations charts and graphs enhance the text with a new appendix relating Internet sites for nurses Document Smart Theresa Capriotti,2019-06-26 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 *ChartSmart* Lippincott Williams &

Wilkins,2007 This portable handbook shows nurses in all practice settings exactly what to document in any situation Nearly 300 alphabetically organized entries cover diseases emergencies procedures legal and ethical problems and difficult situations involving patients families and other health care professionals Legal Casebooks provide examples of legal implications of documentation AccuChart sample forms show how to accurately complete various forms Thoroughly updated to reflect current practice this Second Edition provides information on the electronic health record New entries cover situations such as surgical site verification patient glucose self testing cultural needs identification HIPAA and reporting critical test values A new appendix covers prohibited abbreviations Legal Issues in School Health Services Nadine

Schwab,2005-07 Legal Issues in School Health Services offers a legal resource never before available for education and health professionals and their legal advisors All professionals involved in the development implementation and evaluation of school health services will find this an exceptional tool This book addresses the spirit and letter of the laws the related standards the conflict between them and how they affect the delivery of school health services in regular and special education Special attention is given to pertinent issues for school administrators school attorneys and school nurses in order to foster school practices that are safe and effective Designed as a guide and reference work this book is written by 15 highly credentialed nurses attorneys and educators and offers detailed discussions of the legal challenges that exist in the 21st century KEY FEATURES School nursing practice standards and performance issues Risk management strategies for school

administrators school boards and attorneys Multi disciplinary approaches in ethico legal problem solving Collaborative approaches in promoting student learning and success Financial special education record confidentiality and future genetic challenges In depth legal references citations and research plus a comprehensive glossary and table of federal statutes and regulations Nursing Documentation Patricia W. Iyer,Nancy Hand Camp,1995 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 **Infusion Nursing** Infusion Nurses Society,Mary Alexander,Ann Corrigan,Lisa Gorski,Judy Hankins,Roxanne Perucca,2009-05-08 With a new focus on evidence based practice the 3rd edition of this authoritative reference covers every aspect of infusion therapy and can be applied to any clinical setting Completely updated content brings you the latest advances in equipment technology best practices guidelines and patient safety Other key topics include quality management ethical and legal issues patient education and financial considerations Ideal as a practical clinical reference this essential guide is also a perfect review tool for the CRNI examination Authored by the Infusion Nurses Society this highly respected reference sets the standard for infusion nursing practice Coverage of all 9 core areas of INS certification makes this a valuable review resource for the examination Material progresses from basic to advanced to help new practitioners build a solid foundation of knowledge before moving on to more advanced topics Each chapter focuses on a single topic and can serve as a stand alone reference for busy nursing professionals Expanded coverage of infusion therapy equipment product selection and evaluation help you provide safe effective care A separate chapter on infusion therapy across the continuum offers valuable guidance for treating patients with infusion therapy needs in outpatient long term and home care as well as hospice and ambulatory care centers Extensive information on specialties addresses key areas such as oncology pain management blood components and parenteral nutrition An evidence based approach and new Focus on Evidence boxes throughout the book emphasize the importance of research in achieving the best possible patient outcomes The user friendly design highlights essential information in handy boxes tables and lists for quick access Completely updated coverage ensures you are using the most current infusion therapy guidelines available *Fundamentals of Nursing - E-Book* Patricia A. Potter,Anne G. Perry,Patricia A. Stockert,Amy Hall,2021-12-22 Selected for Doody s Core Titles 2024 with Essential Purchase designation in Fundamentals Learn the concepts and skills and develop the clinical judgment you need to provide excellent nursing care Fundamentals of Nursing 11th Edition prepares you to succeed as a nurse by providing a solid foundation in critical thinking clinical judgment nursing

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Long-term Care Pocket Guide to Nursing

Documentation Elizabeth Peterson,2004-10-01 *Mosby's Surefire Documentation* Mosby,2006 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

Nursing Documentation

in Aged Care Christine Crofton,Gaye Witney,2004 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

Managing Documentation Risk

Patricia A. Duclos-Miller,2004 Nurses are now commonly cited or implicated in medical malpractice cases

Notes on Nursing

Documentation ,2022 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 Documentation in Aged Care Christine Crofton,Gaye Witney,2004 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

Standards College of Nurses of Ontario,1996

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