

Dialysis Assess/ Documentation on Return	Falls	Nutritional Status
<ul style="list-style-type: none"> <li>• Date/Time</li> <li>• Observation of Shunt</li> <li>• Skin Assessment</li> <li>• Edema</li> <li>• Ask about lunch consumption/ fluid intake</li> <li>• Review Dialysis notes: Document weight, amt. fluid pulled off, how resident tolerated dialysis, any other pertinent information from dialysis notes</li> </ul>	<ul style="list-style-type: none"> <li>• Date/Time</li> <li>• Incident specifics (What is observed.)</li> <li>• Vital signs (lying and standing B/P)</li> <li>• If diabetic, blood sugar</li> <li>• If respiratory diagnosis – O<sub>2</sub> sat level</li> <li>• Injury?               <ul style="list-style-type: none"> <li>– What resident was trying to do</li> <li>– Interventions tried</li> <li>– Resident response to interventions (Add intervention to Care Plan if effective.)</li> </ul> </li> <li>• MD and family notified?</li> </ul>	<ul style="list-style-type: none"> <li>• Swallowing disorders: i.e. choking, holding food in mouth, pain when swallowing</li> <li>• Oral and dental status</li> <li>• Complaints of poor appetite</li> <li>• % of p.o. intake</li> <li>• Amount of parenteral or tube feeding</li> <li>• Weight loss</li> <li>• Interventions and response to them</li> <li>• RD requested</li> </ul>
Pain (Routine) Assessment/Documentation	Pain (PRN) Assessment/Documentation	Restorative Nursing Services
<ul style="list-style-type: none"> <li>• Date/Time</li> <li>• Location of pain</li> <li>• Description of pain and score on pain scale 0-10</li> <li>• If pain noted: On scale of 1-10, what is resident's goal for pain relief?</li> <li>• Does pain limit ADL function during day?</li> <li>• Does pain interfere with sleep?</li> <li>• Is resident's pain goal met?</li> <li>• Was physician notified if Tx not effective?</li> </ul>	<ul style="list-style-type: none"> <li>• Date/Time</li> <li>• Location of pain</li> <li>• Description of Pain – burning, sharp, etc.</li> <li>• On scale of 0-10, how severe is pain?</li> <li>• On scale of 0-10 what is resident's goal for pain relief?</li> <li>• Does pain limit ADL function during day?</li> <li>• Does pain affect sleep?</li> <li>• Indicate PRN med given/document on scale of 0-10 pain level 30 min. to 1 hr post med</li> <li>• Did resident meet pain goal?</li> </ul>	<ul style="list-style-type: none"> <li>• Chart reason for and effect of service of the following:               <ul style="list-style-type: none"> <li>– Urinary and/or bowel toileting program</li> <li>– Passive and/or active ROM</li> <li>– Splint or brace assistance</li> <li>– Bed mobility and/or walking training</li> <li>– Transfer training</li> <li>– Dressing and/or grooming training</li> <li>– Eating and/or swallowing training</li> <li>– Amputation/prosthesis care</li> <li>– Communication training</li> </ul> </li> </ul>
Special Treatments, Procedures and Programs	<p style="text-align: center;"> <b>Documentation is a matter of good clinical practice and is an expectation of trained and licensed health care professionals.</b> </p> <p style="text-align: center;">  </p>	
<ul style="list-style-type: none"> <li>• Chart date, time and effect if receives any of the following:               <ul style="list-style-type: none"> <li>– Chemotherapy</li> <li>– Radiation</li> <li>– Oxygen therapy</li> <li>– Suctioning</li> <li>– Tracheostomy care</li> <li>– Ventilator or respirator</li> <li>– BIPAP/CPAP</li> <li>– IV medications</li> <li>– Transfusions</li> <li>– Dialysis</li> <li>– Hospice Care</li> <li>– Respite Care</li> <li>– Isolation</li> <li>– Vaccinations</li> </ul> </li> </ul>		

# Home Health Care Nursing Documentation

**K. Saranto, P. Flatley Brennan, H.-A.  
Park**



## **Home Health Care Nursing Documentation:**

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**Home Care Nursing Practice** Robyn Rice, 2006-01-01 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](#) 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

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**Documentation**, 2007 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

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**Personalized Digital Health and Patient-centric Services** Maria Hägglund, Hanife Rexhepi, Bridget T. Kane, Åsa Cajander, 2022-03-28 **Patient Safety and Quality: section 6, Tools for improvement**, 2008 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 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/nursesdbk> **Handbook of Home Health Care Administration** Marilyn D. Harris, 1997 Table of Contents Foreword Introduction Ch 1 Home health administration an overview 3 Ch 2 The home health agency 16 Ch 3 Medicare conditions of participation 27 Ch 4 The joint commission's home care accreditation program 63 Ch 5 CHAP accreditation standards of excellence for home care and community health organizations 71 Ch 6 Accreditation for home care aide and private duty services 81 Ch 7 ACHC accreditation for home care and alternate site health care services 86 Ch 8 Certificate of need and licensure 92 Ch 9 Credentialing organizational and personnel options for home care 101 Ch 10 The relationship of the home health agency to the state trade association 111 Ch 11 The national association for home care and hospice 115 Ch 12 The visiting nurse association of America 124 Ch 13 Self care systems in home health care nursing 131 Ch 14 Home health care documentation and record keeping 135 App 14 A COP standards pertaining to HHA clinical record policy 147 App 14 B Abington Memorial Hospital home care clinical records 150 Ch 15 Computerized clinical documentation 161 Ch 16 Home telehealth improving care and decreasing costs 176 Ch 17 Implementing a competency system in home care 185 Ch 18 Meeting the need for culturally and linguistically appropriate services 211 Ch 19 Classification an underutilized tool for prospective payment 224 Ch 20 Analysis and management of home health nursing caseloads and workloads 236 Ch 21 Home health care classification HHCC system an overview 247 Ch 22 Nursing diagnoses in home health nursing 261 Ch 23 Perinatal high risk home care 274 Ch 24 High technology home care services 279 Ch 25 Discharge of a ventilator assisted child from the hospital to home 291 Ch 26 Performance improvement 301 Ch 27 Evidence

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