

Clinical Documentation



Second Edition

Guide To Clinical Documentation 2nd Edition

Virginia Saba

Guide To Clinical Documentation 2nd Edition:

Guide to Clinical Documentation Debra D Sullivan, 2018-07-25 Understand the when why and how Here s your guide to developing the skills you need to master the increasing complex challenges of documenting patient care Step by step a straightforward how to approach teaches you how to write SOAP notes document patient care in office and hospital settings and write prescriptions You II find a wealth of examples exercises and instructions that make every point clear and easy to understand 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 ICAHO documentation standards and documenting outcomes and interventions for key nursing diagnoses

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assessment so you can assess patients effectively Case studies offer real life clinical scenarios challenging you to interpret data and make accurate patient assessments Assessment questions help you review by reflecting the learning objectives and the NBRC Exam format with answers including rationales for correct answer options Ask Yourself boxes list questions that you should ask patients e g coughing sputum shortness of breath or ask yourself e g lung sounds you are hearing blood pressure respiratory rate Simply Stated boxes highlight and promote understanding of important concepts Learning objectives chapter outlines chapter overviews and key terms lists begin each chapter preparing you for the key topics and content you will learn Key Point summaries at the end of each chapter emphasize the learning objectives and provide an overview of important material NEW Correlation of content to the NBRC combined CRT RRT exam matrices is provided on the Evolve companion website helping you prepare for these difficult exams by cross referencing material within the book to the NBRC exam matrices for the CRT and RRT credentialing exams NEW Emphasis on infection control includes expanded content on topics such as the prevention and treatment of VAP ventilator associated pneumonia and nosocomial infections in the hospital and home setting NEW or expanded coverage includes cardiopulmonary symptoms neurologic assessment blood gas interpretation and Electronic Medical Records EMR NEW Expert authors Albert Heuer and Craig Scanlan are well known recognized educators in the field of respiratory therapy NEW List of common abbreviations on the inside front cover offers quick and easy access to abbreviations and acronyms used in the text and throughout the profession Assessment in Respiratory Care 7 Albert J. Heuer, Craig L. Scanlan, 2013-01-01 The only respiratory care text devoted exclusively to patient assessment By performing a thorough patient assessment you ll be able to assist physicians in the decision making process regarding treatment in evaluating the treatment's effectiveness and in determining if changes in the treatment need to be made The book's comprehensive approach covers all of the most important aspects and topics of assessment This edition is streamlined to emphasize learning objectives And you can prepare for the CRT exam more effectively with the new NBRC Exam Matrix Correlation Guide A comprehensive approach covers all of the most important aspects of assessment so you can assess patients effectively Additional Questions to Ask About boxes list questions that you should ask patients e g coughing sputum shortness of breath or ask yourself e g lung sounds you are hearing blood pressure respiratory rate Learning objectives chapter outlines chapter overviews and key terms lists begin each chapter preparing you for the key topics and content you will learn Key Point summaries and assessment questions reflect and emphasize the key information identified in the learning objectives Answers to assessment questions help you review by including rationales and page references to the textbook by reflecting the NBRC format and by supporting learning objectives Enhanced Simply Stated boxes emphasize important concepts Additional case studies help you apply chapter content to clinical scenarios Content from the text is related to the NBRC exam matrix for the CRT exam on a companion Evolve website helping you better prepare for the difficult board exams A new Neurological Assessment chapter focuses on conscious sedation A

discussion of health literacy addresses the importance of determining the patient's level of understanding when conducting a patient assessment Discussions of the assessment of the obese patient prepare you for some of the unique challenges related to assessing obese patients e g the physical exam and chest x ray Key Point summaries in every chapter emphasize the learning objectives and provide an easy to find overview A list of abbreviations common to assessment is included on the inside of the cover for quick reference Procedure checklists for common assessment procedures are included in a new appendix with PDFs of the forms available on the Evolve website The Clinical Documentation Improvement Specialist's Handbook, Second Edition Heather Taillon, 2011-01-21 The Clinical Documentation Improvement Specialist's Handbook Second Edition Marion Kruse MBA RN Heather Taillon RHIA CCDS Get the guidance you need to make your CDI program the best there is The Clinical Documentation Improvement Specialist's Handbook Second Edition is an all inclusive reference to help readers implement a comprehensive clinical documentation improvement CDI program with in depth information on all the essential responsibilities of the CDI specialist This edition helps CDI professionals incorporate the latest industry guidance and professional best practices to enhance their programs Co authors Heather Taillon RHIA and Marion Kruse MBA RN combine their CDI and coding expertise to explain the intricacies of CDI program development and outline the structure of a comprehensive multi disciplinary program In this edition you will learn how to Adhere to the latest government and regulatory initiatives as they relate to documentation integrity Prepare for successful ICD 10 transition by analyzing your CDI program Step up physician buy in with the improved education techniques Incorporate the latest physician query guidance from the American Health Information Management Association AHIMA Table of Contents Chapter 1 Building the CDI Program Chapter 2 CDI and the healthcare system Chapter 3 Application of coding guidelines Chapter 4 Compliant physician queries Chapter 5 Providing physician education Chapter 6 Monitoring the CDI program What s new in the Second Edition Analysis of new industry guidance including AHIMA's Managing an Effective Query Process and Guidance for Clinical Documentation Improvement Programs CMS guidance from new IPPS regulations MLN Matters articles Quality Improvement Organizations and the Recovery Audit Contractor RAC program among others Strategies to help you incorporate the guidance into your CDI program Tools to help you interpret MAC initiatives and RAC focus areas to enhance your CDI program and help prevent audit takebacks New sample queries forms tools and industry survey data BONUS TOOLS This book also includes bonus online tools you can put to use immediately Sample guery forms Sample job descriptions for CDI managers and CDI specialists Sample evaluation form for CDI staff Sample pocket guide of common The Clinical Documentation Sourcebook Donald E. Wiger, 2010-02-02 All the forms handouts documentation standards and records mental health professionals need to meet documentation requirements fully revised and updated The paperwork required when providing mental health services continues to mount Keeping records for managed care reimbursement accreditation agencies protection in the event of lawsuits and to help streamline patient care in solo and group practices

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