Long Term Care Documentation Requirements

*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- 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 flow*

It is with great pride that the Psychologists in Long Term Care (PLTC) have sponsored The Professional Educational Long-Term Care Training Manual, and now its second iteration, Geropsychology and Long Term Care: A Practitioner's Guide. Education of psychologists working in long-term care settings is consistent with PLTC's mission to assure the provision of high-quality psychological services for a neglected sector of the population, i.e., residents in nursing homes and assisted-living communities. To this end, direct training of generalist psychologists in the nuances of psychological care delivery in long-term care settings has been a major priority. It is a tribute to the accelerating nature of research in long-term care settings that a revision is now necessary. After all, the Professional Educational Training Manual's initial publication date was only in 2001. However, in the intervening years, much progress has been made in addressing assessment and intervention strategies tailored to the needs of this frail but quite diverse population. It is so gratifying to be able to say that there is now a corpus of scientific knowledge to guide long-term care service delivery in long-term care settings.

Helps you quickly and easily find the standards and scoring information you need. This title puts the accreditation requirements, policies, and procedures at your fingertips and includes scoring information at every element of performance.

An Evidence-based Handbook for Nurses

Data Compendium

Applying Medicare's Rules to Clinical Practice

Complete Guide to Documentation

The CMS Hospital Conditions of Participation and Interpretive Guidelines

Home Health Assessment Criteria

"[The book] lists all the federal requirements that are evaluated by state surveyors during the annual survey visit to nursing homes and for complaint visits. The exhibit section contains forms used by surveyors to gather data during the survey visit. Visually, the format makes the regulations easy to read. If nursing home staff used the book to prepare for a survey, they would be well prepared." -Marcia Flesner, PhD, RN, MHCA University of Missouri-Columbia From Doody's Review Nursing homes are now the most highly regulated environ service of maximizing the quality of each resident's life. This user-friendly guide has been updated to provide all of the requisite information needed by nursing home staff to prepare for a visit from federal surveyors. It provides the most current federal guidelines and the procedures used by federal surveyors in certifying facilities for participation in Medicare and Medicaid funding. It describes every aspect and service of a nursing home that is subject to inspection and includes the nearly 20% of new requirements established during the p new Minimum Data Set 3.0. The guide not only presents federal requirements and explanatory guidelines but also explains how to best interpret these guidelines so nursing home staff can be optimally prepared for a survey visit. It reflects changes in regulations regarding end-of-life care, nasogastric tube regulations, and rights to establish advance directives. The guide also provides information straight from CMS's Internet-Only Manual. New Features of Eighth Edition: Describes how to best use the updated manual Focuses on Minim interpret the new requirements, 20% of which have been updated Presents new quality measures Includes new CMS forms Reflects changes in regulations regarding end-of-life care, nasogastric tube regulations, and rights to establish advance directives

This portable reference is a timesaving guide on how to enhance charting skills, avoid legal pitfalls, and ensure that a complete and accurate record is created every time. Reviews fundamental aspects of charting, nursing process, legal and professional requirements, guidelines for developing a solid plan of care, and the variety of charting forms currently in use, including computerized charting. Completed forms show exactly how to document assessment, intervention, and evaluation. Also addresses the specific requirements for chart care and rehabilitation. Appendices include NANDA Taxonomy II, as well as common abbreviations and symbols.

"Nurses play a vital role in improving the safety and quality of patient car -- 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 pa Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

Report (to Accompany H.R. 4040).

ICD-9-CM Official Guidelines for Coding and Reporting

A Pocket Guide

The Nurse Practitioner in Long-term Care

Improving the Quality of Care in Nursing Homes

Congressional Record

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-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 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.

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.

This manual offers a quality documentation system using nursing diagnosis developed specifically for long-term care. it provides practical quality tools to guide professional nurses and interdisciplinary staff members in meeting documentation requirements under OBRA '87.

Improving the Quality of Long-Term Care

Nursing Home Policy and Procedure Manual

Nursing Documentation Made Incredibly Easy

Nursing & Therapy Documentation in Long-Term Care

What Nursing Home and Assisted Living Nurses Need to Know in a Nutshell

Quality Documentation for Long-term Care

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.

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.

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 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 requirement30-Day transfer rule for hospital or SNFUnderstanding benefit periodsCare continuation related to hospitalizationHow 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 recertificationPresumption of coverageUnderstanding "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 timing Review of each care-related section of the MDS 3.0Proper 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 communicationOther 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.

Long-term Care Pocket Guide to Nursing Documentation

Guidelines to Surveyors and Survey Protocols

Your Guide to Preparation and Implementation

Long-Term Care Medicine

Nursing Policies and Procedures for Long Term Care

Nursing Home Federal Requirements, 8th Edition

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 NEWdiscussion 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 Dosher Memorial Hospital in Southport, North Carolina.

"This resource will help you: Align with MDS 3.0 documentation requirements. Coordinate documentation between nurses and therapists to improve resident care. Gain the perspective of nursing or therapy to appreciate their specific approach to skilled services. Reduce your audit risk and strenthen reimbursement claims with comprehensive documentation. Prove medical necessity and need for skilled care by practicing accurate documentation"--P. [4] of cover.

This resource is the first to include documentation guidelines and their applications in long term care complete with the new RUG regulations and the MDS 2. In clear and concise terms a method of documenting nursing care is described using a self-care emphasis on all documentation. The book is organized to allow easy access to information. Sections include those focused on basic bodily processes: breathing, eating, drinking, activity, sleep, etc. The book also includes nursing diagnoses, nursing interventions classification, and nursing outcome terms.

Long-Term Care Clinical Assessment and Documentation Cheat Sheets

75 Checklists for Skilled Nursing Documentation

Proceedings and Debates of the ... Congress

Documentation And Reimbursement For Long-term Care

Long Term Care Health Information Practice and Documentation Guidelines

Critical Thinking in Long-term Care Nursing

Long-term Care Pocket Guide to Nursing DocumentationDocumentation And Reimbursement For Long-term CareAmer Health Information Management

This book addresses current issues surrounding hospital readmissions and the practice of post-acute and long-term care (LTC). Thoroughly updated, the Second Edition of this practical pocket guide presents new regulations governing these services and lessens the uncertainty involved in caring for patients in a long-term care facility. The book is divided into four sections that cover: types of care, which include community care, nursing facility care, and teamwork; clinical medicine, with suggested approaches to common conditions and wound care; psychosocial aspects of care, which include ethical and legal issues and caring for families; and special issues, with chapters on documentation, coding, and medication management. As community-based care is an area of rapid growth where the elderly are increasingly seeking their medical care, new chapters have also been added that describe these programs. Written by expert contributors, many of whom have worked within the American Medical Directors Association to create and disseminate a knowledge base for post-acute and LTC, this is a valuable resource for clinicians and educators seeking to maximize the care and living experience of residents in post-acute and long-term care settings.

This is an exceptionally well-organized, complete classroom textbook on non-acute care documentation requirements for students taking undergraduate courses in health information management (HIM) and health information technology (HIT) programs. The only text on documentation requirements for non-acute care facilities, the book contains chapters on ambulatory care, including hospital-based ambulatory care and physician offices, as well as ambulatory care in homes, hospices and correctional facilities. It covers documentation requirements for post acute (subacute) care, long-term care and behavioral health care. The text contains two chapters on documentation requirements for rehabilitation services: physical rehabilitation and chemical dependency rehabilitation. Author Barbara J. Manger, assistant professor in the Health Information Management Program at Kean University, also provides samples of forms used at different sites, information about applicable accreditation standards and their implications, references to official documents and accreditation manuals, a list of abbreviations, and an index.

Conditions of Participation for Hospitals

A Nursing Diagnosis Approach

Patient Safety and Quality

Nursing and Therapy Documentation in Long-Term Care

Fast Facts for the Long-Term Care Nurse

Better Documentation

Today, more than 10 million people in the United States require some form of long-term care, a number that is rapidly increasing and will continue to do so for years to come. This concise and user-friendly resource contains the fundamental information long-term care nurses need to provide all aspects of safe and effective care to their patients in nursing homes and assisted living facilities. Written by a renowned and highly respected nurse leader in long-term care and gerontology, it presents key facts and core competencies related to the clinical and managerial responsibilities of nurses in these settings. Details on the specific skills required for this challenging specialty, as well as must-know information on regulatory standards, site visits, management and leadership, and dementia care, are presented in a concise format for quick access to information. The book embodies a holistic approach to nursing that recognizes the importance of quality of life in addition to quality of care. It provides an overview of the unique features of long-term care, addressing the operational differences between these settings and those of acute settings, the distinct responsibilities of long-term care nurses, special needs of the residents, and major clinical challenges. The text offers guidance on the use of evidence-based knowledge within the constraints of long-term care settings. Topics such as legal risks, documentation essentials, and the importance of self-care are covered, along with management and leadership issues relevant to the supervision of unlicensed personnel. The Fast Facts in a Nutshell feature assists readers in reinforcing and applying content, and a comprehensive resource list supplements the text. The book will also serve as a useful study tool for long-term nursing care certification. Key Features: Embodies the essential competencies for long-term care nursing practice Presents information in a concise easy-to-access format with bulleted facts and the Fast Facts in a Nutshell feature Addresses management and leadership issues germane to the long-term care setting Includes must-know information on regulatory standards, site visits, legal risks, documentation essentials, and more Guides nurses in using evidence-based knowledge in long-term care settings

2016 Third Edition. Also includes 23 Skilled Charting Guidelines. Current with all RAI Manual Updates, Surveyor Guidelines and Federal Regulatory Changes. Covers all nursing policies and procedures for long term care. Includes many policies for Medications, Falls, Restraints, Pressure Ulcers, and Pain Care. Current with all of the latest regulatory updates. The form at the top of each nursing policy for long term care has spaces for the date the policy and procedure was approved by the Director of Nursing and the date of any addendums or changes. Each nursing policy for long term care may also be used as teaching tools in an inservice or employee counseling session. Nursing policies and procedures 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.

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 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 TABLE OF CONTENTS Section 1: Assessment Documentation Guidelines 1.1. Medicare Conditions of Participation 1.2. Determination of Coverage Guidelines 1.3. Summary of Assessment Documentation Requirements 1.4. Assessment Documentation for Admission to Agency 1.5. Case Management and Assessment Documentation 1.6. Assessment Documentation for Discharge Due to Safety or Noncompliance 1.7. Start of Care Documentation Guidelines 1.8. Routine Visit Documentation Guidelines 1.9. Significant Change in Condition Documentation Guidelines 1.10. Transfer Documentation Guidelines 1.11. Resumption of Care Documentation Guidelines 1.12. Recertification Documentation Guidelines 1.13. Discharge Documentation Guidelines Section 2: General Assessment Documentation 2.1. Vital Sign Assessment Documentation 2.2. Pain Assessment Documentation 2.3. Pain Etiology Assessment Documentation 2.4. Change in Condition Assessment Documentation 2.5. Sepsis Assessment Documentation 2.6. Palliative Care Assessment Documentation 2.7. Death of a Patient Assessment Documentation 2.8. Cancer Patient Assessment Documentation Section 3: Neurological Assessment Documentation 3.1. Neurological Assessment Documentation 3.2. Alzheimer's Disease/Dementia Assessment Documentation 3.3. Cerebrovascular Accident (CVA) Assessment Documentation 3.4. Paralysis Assessment Documentation 3.5. Seizure Assessment Documentation 3.6. Transient Ischemic Attack (TIA) Assessment Documentation Section 4: Respiratory Assessment Documentation 4.1. Respiratory Assessment Documentation 4.2. Chronic Obstructive Pulmonary Disease (COPD) Assessment Documentation 4.3. Pneumonia/Respiratory Infection Assessment Documentation Section 5: Cardiovascular Assessment Documentation 5.1. Cardiovascular Assessment Documentation 5.2. Angina Pectoris Assessment Documentation 5.3. Congestive Heart Failure (CHF) Assessment Documentation 5.4. Coronary Artery Bypass Graft Surgery (CABG) Assessment Documentation 5.5. Coronary Artery Disease (CAD) Assessment Documentation 5.6. Hypertension Assessment Documentation 5.7. Myocardial Infarction Assessment Documentation 5.8. Orthostatic Hypotension Assessment Documentation 5.9. Pacemaker and Defibrillator Assessment Documentation Section 6: Gastrointestinal Assessment Documentation 6.1. Gastrointestinal Assessment Documentation 6.2. Cirrhosis Assessment Documentation 6.3. Crohn's Disease Assessment Documentation 6.4. Hepatitis Assessment Documentation 6.5. Peritonitis, Suspected Assessment Documentation 6.6. Pseudomembranous Colitis Assessment Documentation 6.7. Ulcerative Colitis Assessment Documentation Section 7: Genitourinary Assessment Documentation 7.1. Genitourinary Assessment Documentation 7.2. Acute Renal Failure Assessment Documentation 7.3. Chronic Renal Failure Assessment Documentation 7.4. Urinary Tract Infection (UTI) Assessment Documentation Section 8: Integumentary Assessment Documentation 8.1. Integumentary Assessment Documentation 8.2. Skin Tear Assessment Documentation 8.3. Herpes Zoster Assessment Documentation 8.4. Leg Ulcer Assessment Documentation 8.5. Necrotizing Fasciitis (Streptococcus A) Assessment Documentation 8.6. Pressure Ulcer Assessment Documentation Section 9: Musculoskeletal Assessment Documentation 9.1. Musculoskeletal Assessment Documentation 9.2. Arthritis Assessment Documentation 9.3. Compartment Syndrome Assessment Documentation 9.4. Fall Assessment Documentation 9.5. Fracture Assessment Documentation Section 10: Endocrine Assessment Documentation 10.1. Endocrine Assessment Documentation 10.2. Diabetes Assessment Documentation Section 11: Eyes, Ears, Nose, Throat Assessment Documentation 11.1. Eyes, Ears, Nose, Throat Assessment Documentation 11.2. Dysphagia Assessment Documentation Section 12: Hematologic Assessment Documentation 12.1. Hematologic Assessment Documentation 12.2. Anticoagulant Drug Therapy Assessment Documentation 12.3. Deep Vein Thrombosis (DVT) Assessment Documentation 12.4. HIV Disease and AIDS Assessment Documentation Section 13: Nutritional Assessment Documentation 13.1. Nutritional Assessment Documentation 13.2. Dehydration Assessment Documentation 13.3. Electrolyte Imbalances Assessment Documentation 13.4. Weight Loss, Cachexia, and Malnutrition Assessment Documentation Section 14: Psychosocial Assessment Documentation 14.1. Psychosocial Assessment Documentation 14.2. Delirium Assessment Documentation 14.3. Psychotic Disorder Assessment Documentation 14.4. Restraint Assessment Documentation Section 15: Infusion Assessment Documentation 15.1. Implanted Infusion Pump Assessment Documentation 15.2. Infusion Therapy Assessment Documentation 15.3. Vascular Access Device (VAD) Assessment Documentation

Post-Acute and Long-Term Medicine

Documentation Requirements in Non-acute Care Facilities and Organizations

Understanding and Minimizing Risk for Nursing Home Managers

Long-Term Care Documentation

Guidelines for Clinical Practice

In addition to reprinting the text of the CMS CoPs and Interpretive Guidelines, we include key Survey and Certification memos that CMS has issued to announced changes to the emergency preparedness final rule, fire and smoke door annual testing requirements, survey team composition and investigation of complaints, infection control screenings, and legionella risk reduction.

Long-Term Care Medicine: A Pocket Guide lessens the uncertainty involved in caring for patients in a long-term care facility. This practical pocket guide is divided into four sections: Introduction, Common Clinical Conditions, Psychosocial Aspects, and Special Issues in Long-Term Care. The chapters address all the varied components of the LTC system as well as how to take care of the patients and residents living within it. The contributors to this easy-to-read guide are passionate about LTC and many have worked within the American Medical Directors Association to create and disseminate a knowledge base for practitioners. Long-Term Care Medicine: A Pocket Guide is an invaluable resource for clinicians, practitioners, and educators who are seeking to optimize the care and living experience of residents in LTC by providing resident-centered care as well as resident choice, well-being, dignity, and an improved quality of life.

An excellent resource for new or seasoned NPs and PAs! The Nurse Practitioner in Long-Term Care addresses the growing trend to utilize the nurse practitioner in the skilled nursing facility (SNF) to manage patients in long-term care and serves as a practical resource for managing those conditions commonly encountered in the geriatric patient. It includes an introduction to nursing homes, medication management, practical health promotion/disease prevention, and management of common clinical conditions specific to the skilled and long term care nursing home settings. It will also address important topics such as elder abuse, legal issues, reimbursement, and regulatory issues. Subjects covered are pertinent to everyday practice and this text is useful in graduate programs for nurse practitioners and clinical nurse specialists as well as for physician's assistant (PA) students.

Documentation of Resident Care Requirements by Nurses and Nursing Assistants in Long-term Care

The Long-term Care Legal Desk Reference

Health Care Facilities Code Handbook

Reporting Requirements and Documentation

Standards for Long Term Care 2012

Leading Change, Advancing Health

Resident outcomes have come under growing scrutiny, both through new quality measures and the overall star rating. Nurses are the frontline staff who engage with residents daily, and it's crucial for them to understand how to apply critical thinking. When caring for residents and creating documentation, critical thinking can improve facility and resident outcomes while reducing medical errors, which will ultimately lead to more accurate reimbursement. Raise the standard of professional nursing practice and teach clinical care providers how to function at a higher level by developing their critical thinking abilities.Critical Thinkin in Long-Term Care Nursing, Second Edition, provides nurse managers and educators with accessible ways to teach these valuable skills to their staff. This easy-to-read resource explains the principles of critical thinking and how to encourage nurses to use critical thinking methods. Author Shelley Cohen, RN, BS, CEN, provides guidance on how to lead classroom sessions for new graduates and experienced nurses to develop critical thinking skills, including classroom processes and learning strategies. The book includes handouts to supplement classroom training.

Your road map to ICD-10 implementation If ICD-10 implementation is not on your radar, it should be. To remain profitable and compliant under the new coding system, your facility must prepare now for the transition. Author Karen Fabrizio provides you with a three-step plan that takes you from understanding the differences between ICD-9 and ICD-10 to full- scale ICD-10 readiness at your facility with ICD-10 Essentials for Long-Term Care: Your Guide to Preparation and Implementation. You will learn the fundamentals of ICD-10 coding, what you can do today to manage the transition to ICD-10, and how to prepare for the impact on your daily operations. Complete with a chronological, step-by-step ICD-10 implementation action plan for your entire facility, this book is the perfect primer to get you where you need to be in order to survive and thrive under ICD-10. ICD-10 Essentials for Long-Term Care will help you: * Implement simple procedural changes immediately to ease the burden of the transition in future months * Familiarize your coders with the ICD-10 format to ensure a smooth transition during implementation * Develop timelines to train clinicians in new documentation requirements * Achieve leadership buy-in for the necessary budge policy changes, and infrastructure upgrade to accommodate ICD-10 requirements * Execute a step-by-step action plan throughout your facility to ensure timely ICD-10 readiness

"Written for long-term care administrators, nursing directors, health information managers, privacy and security managers and educators, this book provides a comprehensive overview and explains specific medicare and medicail reporting requirements related to long-term care."

Long-term Care Insurance Uniform Data Set

Long-Term Care Security Act

The Future of Nursing

A Practitioner's Guide

Geropsychology and Long Term Care

Documentation Guidelines for Evaluation and Management Services

The Future of Nursing explores how nurses' roles, 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.

Long-term Care Skilled Services

Skillmasters

Skills for Collaboration and Compliance

ICD-10 Essentials for Long-Term Care