Nursing Notes Umentation

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Guilty Or Innocent?: Protecting Your License Through Proper Nursing Documentation Rosale Lobo 2012-05-01 With all the training and education nurses receive, there is little true explanation about the importance of documentation. Even in today's litigious culture and the backlash of services no longer reimbursable -- it is crucial we as nurses understand the rationale for our documentation practices. By creating specific systems to ensure license protection, we in turn provide more effective hand- off communication. Every nurse knows it's the law and that you don't want to lose your license, but do we really know why the methods of documentation are so vital to our livelihood? Has the electronic medical record made this approach additionally arduous? Do the questions on the EMR provide an accurate picture of the actual care provided? Often times, these reports are not clear or complete. Through fictional and non-fictional stories, Rosale Lobo reveals proper nursing documentation techniques providing clarity and important best practice concepts that can be applied immediately. Extraneous situations will arise in nursing, making it imperative to develop intentional methods of documentation. By putting together an effective system you will decrease your chances of being sued. For the future of nursing documentation, the EMR is not the answer, a personal system of accountabili is.

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.

Nursing Notes the Easy Way Karen Stuart Gelety 2010-11-01 Ever wonder what to put in a nursing note? This pocket sized guide provides you with over a hundred templates for written and verbal comminication in nursing to help you.

Documenting Care Frances Talaska Fischbach 1991 University of Wisconsin-Milwaukee School of Nursing's comprehensive charting and documentation manual for students and practitioners.

Legal, Ethical, and Practical Aspects of Patient Care Documentation Ronald W. Scott 2013 Fourth Edition, is the only text to integrate coverage of the legal responsibilities of rehabilitation professionals with basic, essential advice on how to effectively document patient care activities from intake through discharge. This resource thoroughly covers the basics of documentation and includes many exemplars, cases, and forms, as well as a sample abbreviations used in rehabilitation settings. This book covers all the bases from ethics, to practical aspects of patient care documentation, to relevant and salient legal implications and illustrative case examples that will help students excel in practice.

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.

Chart Smart 2011 Chart Smart: the A-to-Z Guide to Better Nursing Documentation tells nurses exactly what to document in virtually every type of situation they may encounter on the job, no matter where they practice--hospital, medical office, outpatient, rehabilitation facility, long-term care facility, or home. This portable handbook has nearly 300 entries that cover documentation required for common diseases, major emergencies, complex procedures, and difficult situations involving patients, families, other health care team members, and supervisors. In addition to patient care, this book also covers documenta

Medical Records for Attorneys Laurence M. Deutsch 2001

Nursing Care Plans & Documentation Lynda Juall Carpenito-Moyet 1999 his one-of-a-kind text covers every aspect of independent nursing care -- it's a must-have resource for every practicing and student nurse! Content includes nursing care plans for the care of all adults regardless of their clinical situation; detailed care plans for specific clinical problems; collaborative problems and nursing diagnoses; and a strong emphasis on documentation. It also includes research validated identification of frequently encountered nursing diagnoses and collaborative problems. This edition contains 15 new care paths for common diseases/disorders

Nursing Know-how 2009 Provides information on documentation issues, including electronic medical records, legal and ethical implications, and documentation in acute cases, along with a variety of charting examples.

Nursing Documentation in Aged Care Christine Crofton 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.

Notes on Nursing Florence Nightingale 1860 Outspoken writings by the founder of modern nursing record fundamentals in the needs of the sick that must be provided in all nursing. Covers such timeless topics as ventilation, noise, food, more.

Nursing Documentation Ellen Thomas Eggland 1994 Focuses on the communicatiion skills that are the key to good documentation.

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

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.

Documentation Erma Coty 2000-01 This book defines and explores the language of nursing. Encompassing even more than the mastery of medical jargon, it views communication as the cornerstone of good patient care. Chapter coverage includes managing bias in documentation, follow up questions for the beginner, systems and descriptors, medical and legal aspects of documentation, and practical use. For nursing professionals seeking to improve their communication in the combined world of medical personnel and patients.

Documentation in Action Lippincott Williams & Wilkins 2006 Designed for rapid on-the-job reference, Documentation in Action offers comprehensive, authoritative, practice-oriented, up-to-the-minute guidelines for documenting every situation in every nursing practice setting and important nursing specialties. Need-to-know information is presented in bulleted lists, charts, flow sheets, sidebars, and boxes, with icons and illustrative filled-in samples. Coverage includes documentation for care of patients with various diseases, complications, emergencies, complex procedures, and difficulties involving patients, families, and other health care professionals. Suggestions are given for avoiding legal pitfalls involving telephone orders, medication reactions, patients who refuse care, and much more. A section addresses computerized documentation, HIPAA confidentiality rules, use of PDAs, nursing informatics, and electronic innovations that will soon be universal.

Chart to Save Your RN License Lena Empyema 2021-08-11 You can be an excellent nurse in the clinical setting and still fail to prove that you are an excellent nurse if your documentation is inadequate. Having worked in a variety of inpatient and outpatient settings, I understand the obstacles nurses face. There's just not time, nor do nurses have the mental energy to meticulously document every little thing on top of the rest of their to-do list. That's part of why I became passionate about documentation education. It doesn't have to be an overwhelming, endless challenge to chart exhaustively in hopes that you enter enough data into the chart to defend yourself one day. Rather, leveraging the most critical data, knowing how to format notes and exactly what to say, and when to spend five minutes dumping information into the chart can be learned skills that make documentation faster, easier, and less stressful, while doing a better job of defending your actions. The Importance of Documentation & Overcoming Obstacles Purpose(s) of Documentation Defensive Charting Obstacles Impacting Quality of Medical Record Overcoming Obstacles Legal Responsibilities of the Nurse Duties of the Nurse Nurse Practice Acts Duties of the Hospital Hospital Policy vs. State Board of Nursing Regulations Reasonable Prudence Failure to Fulfill (Document) Responsibilities Fulfilling Responsibilities vs. Documenting Responsibilities What if Responsibilities Aren't Fulfilled? Mistakes Happen Professional Liability Insurance Malpractice Medical Negligence Acting with Malice

Fraud What Happens When a Nurse is Charged with Malpractice? What to Do if You Receive Notification of a Claim Common Charting Mistakes & How to Avoid Them The Most Common Errors Charting By Exception & Charting to Capture Minimal Data "But I've Always Charted This Way, and Nothing Bad Has Happened Yet..." What You Should Be Charting How and What to Chart Quick Glance Charting Checklists What is a Timely Manner? Documenting Assessments Sample Focused Assessment Criteria Sharing the Responsibility Modifying Electronic Data Abbreviations Standing Orders Early Warning Systems Scores & Scales Informed Consent Special Circumstances Paper Charting Writing an Incident Report Patient Leaving AMA Patient Threatening to Sue You Identifying Patient Belongings Another Member of the Team is Not Documenting Correctly Restraints Defective Equipment Suspected Abuse Patient Requesting to View Their EMR on Hospital Computer Narrative Notes When & How to Write Notes One Note or Severa Notes? Daily Narrative Notes Examples of Common Notes Written As-Needed How to Title Narrative Notes How to Format Notes Using Patient Names in Notes Length of Notes Create a Template Tips for Less Stress When Charting BONUS: How I Chart on a "Typical" Shift ABOUT THE AUTHOR: I'm Andrea, RN-MSN. Perfecting my own documentation and working to find concrete guidelines to share with my fellow nurses has become my passion. As I gained more knowledge and researched the dusty, forgotten corners of the internet for obscure evidence-based practice and case studies, becoming a subject matter expert on nursing documentation lit a spark because sharing this information helps empower nurses to understand exactly what should appear in their patient charts, where, when it should entered, and how it should be phrased.

Nursing Documentation Patricia A. Duclos-Miller 2007 Improve your staff's documentation for less than $4 per person Documentation may be the least favorite part of a nurse's job--but it's also one of the most important aspects. Incomplete or improper documentation poses a huge financial and compliance threat, including citations from state, federal, and Joint Commission surveyors. Plus, nurse managers can legally be held accountable for their nurses' documentation.Now packages of 25 handbooks are only $89 Improve yo staffs' documentation with the handbook" Nursing Documentation: ""Reduce Your Risk of Liability, "Second Edition. Written specifically for staff nurses, this easy-to-read and affordable resource helps nurses understand the value of good documentation, and the consequences of not documenting accurately and in a timely fashion. The handbook's cas studies illustrate the legal threat nurses face from improper documentation, while the quick tips help them avoid common charting errors and improve their charting skills. The handbook includes a short post-test and certificate of completion, allowing nurses to evaluate their documentation understanding. With this handbook as their guide, your staff will be motivated to a level of excellence that will be reflected in the medical record, resulting in improved overall quality of care at their facility.Take a look at the table of contents: What is clinical documentation? The purpose of documentation Your potential liability risks Threat to licensure Civil litigation Case study 1: Documenting completely to avoid allegations of negligent careContemporary nursing standards Your state Nurse Practice Act The consequences of an incomplete medical recordCase study 2: Failing to record pertinent health informationEight common charting errors to avoidRisk management recommendationsTop 20 tips for improving your documentation Take a look at the companion book for nurse managers "Managing Documentation Risk: ""A Guide for Nurse Managers, "Second Edition provides nurse managers with strategies they can use to protect themselves, their staff, and their organization while continuing to offer the best quality of care. This resource guides nurse leaders through assessing their organization's risks and designing a system for auditing staff documentation. It features an accompanying CD-ROM, including all the customizable strategic forms and audit tools included in the book ready for immediate use in your facility.

Mosby's Surefire Documentation Mosby 2006-01 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.

Building Standard-based Nursing Information Systems Pan American Health Organization 2001 Building Standard-Based Nursing Information Systems is directed to practising and student nurses, health care professionals involved in the implementation of information systems, and information technology professionals working in the health sector. The objective of this book is to provide them with a basic source of facts related to the use and implementation of standards in nursing clinical and administrative documentation. Emphasis is placed on the importance of appropriately documenting nursing care, in order to facilitate analyses of nursing activities, the provision of quality and evidence-based direct patient care, and promotion of continuity of service. Standardized documentation is also required for communication of nursing concepts, interventions, and outcomes to other nurses and health professionals working in different settings and countries. The book focusses on key issues of modem nursing practice and illustrates how information technology support to the implementation and use of standard-based practice can improve clinical and management nursing functions [WHO website]

Nursing Documentation Handbook Tk M. Marrelli 2000 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 f 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 Administration Handbook Howard S. Rowland 1997 With the recent new and radical developments in the health care field that have been introduced at a breathless pace, nurse administrators must work to stay informed of the developments that affect their nursing departments both directly and indirectly. The Nursing Administration Handbook has a long track record, both as a textbook and as a hands-on tool for nurse executives seeking insight and step-by-step guidance in all aspects of administration. The fourth edition o this text surveys the entire field of nursing administration and incorporates the most significant new developments and current practices.

Skillmasters 2002-07-01 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 charting in acute care, home care, and long-term care and rehabilitation. Appendices include NANDA Taxonomy II, as well as common abbreviations and symbols.

Fachenglisch für Pflegekräfte Edith Kellnhauser 2003 Vorbereitung auf einen Auslandsaufenthalt. Das amerikanische Health Care System. Das Hospital. Die Pflegedienstleitung. Das Pflegeteam. Beschäftigungssituation. Pflegerische Ausbildung. Adressen und nützliche Hinweise. "Die Autorin führt mit diesem Werk den Leser in interessanter und ansprechender Weise durch das Gesundheitswesen in den USA. [...] Sie hat sich hierbei ganz deutlich auf die Organisationsstrukturen beschränkt und sich wenig mit medizinischer Fachtermini befasst. [...]. Allerdings ist das Buch für alle Studierenden oder professionell arbeitende Pflegende zu empfehlen, denn neben den Fachtermini wird die Funktionsweise des angloamerikanischen Gesundheitswesens sehr eingängig dargestellt. Damit erfüllt das Buch weitaus mehr als nur eine Vermittlung von englischen Fachtermini und kann uneingeschränkt jedem empfohlen werden, der sich mit dem Basiswissen über das angloamerikanische Gesundheitswesen auseinandersetzen möchte." www.pflegedialog.de.

ACENDIO 2005 Association of Common European Nursing Diagnoses, Interventions and Outcomes. European Conference 2005

Nursing Documentation Sue E. Meiner 1999-05-06 Focusing on the legal implications in the US, this book is designed to meet the needs of professional and student nurses in determining how they should be recording their practice.

Focus Charting Susan Lampe 1997

Basic Nursing Leslie S Treas 2013-09-04 Thinking. Doing Caring. In every chapter, you'll first explore the theoretical knowledge behind the concepts, principles, and rationales. Then, you'll study the practical knowledge involved in the processes; and finally, you'll learn the skills and procedures. Student resources available at DavisPlus (davisplus.fadavis.com).

Documentation Skills for Quality Patient Care Fay Yocum 1999

Nursing Documentation and Its Communicability Beatrice Bella Johnson 2012-10-09

Nursing Documentation Made Incredibly Easy Lww 2018-08-04 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.

Nursing Interventions & Clinical Skills - E-Book Anne Griffin Perry 2015-01-08 Master nursing skills with this guide from the respected Perry, Potter & Ostendorf author team! The concise coverage in Nursing Interventions & Clinical Skills, 6th Edition makes it easy to master the clinical skills required in everyday nursing practice. Clear guidelines address 159 basic, intermediate, and advanced skills — from measuring body temperature to insertion of a peripheral intravenous device — and step-by-step instructions emphas the use of evidence-based concepts to improve patient safety and outcomes. Its friendly, easy-to-read writing style includes a streamlined format and an Evolve companion websi with review questions and handy checklists for each skill. Coverage of 159 skills and interventions addresses basic, intermediate, and advanced skills you'll use every day in practice. UNIQUE! Using Evidence in Nursing Practice chapter provides the information needed to use evidence-based practice to solve clinical problems. Safe Patient Care Alerts highlight unusual risks in performing skills, so you can plan ahead at each step of nursing care. Delegation & Collaboration guidelines help you make decisions in whether to delegate a skill to unlicensed assistive personnel, and indicates what key information must be shared. Special Considerations indicate additional risks or accommodations you may face when caring for pediatric or geriatric patients, and patients in home care settings. Documentation guidelines include samples of nurses' notes showing what should be reported and recorded after performing skills. A consistent format for nursing skills makes it easier to perform skills, always including Assessment, Planning, Implementation, and Evaluation. A Glove icon identifies procedures in which clean gloves should be worn or gloves should be changed in order to minimize the risk of infection. Media resources include skills performance checklists on the Evolve companion website and related lessons, videos, and interactive exercises on Nursing Skills Online. NEW coverage of evidence based techniques to improve patient safety and outcomes includes the concept of care bundles, structured practices that have been proven to improve the quality of care, and tea back, a new step that shows how you can evaluate your success in patient teaching. NEW! Coverage of HCAHPS (Hospital Care Quality Information from the Consumer Perspective) introduces a concept now widely used to evaluate hospitals across the country. NEW! Teach-Back step shows how to evaluate the success of patient teaching, so yo can be sure that the patient has mastered a task or consider trying additional teaching methods. NEW! Updated 2012 Infusion Nurses Society standards are incorporated for administering IVs, as well as other changes in evidence-based practice. NEW topics include communication with cognitively impaired patients, discharge planning and transitional care, and compassion fatigue for professional and family caregivers.

ChartSmart 2001 Armed with this portable handbook, nurses in any practice setting will know exactly what to document in any situation. Featuring an A-to-Z organization that makes finding information easy, this reference offers a new learn-by-example approach to charting and delivers clear examples for documenting more than 270 patient-care situations, from common diseases to legal and ethical issues. "Legal casebook" spotlights real-life court cases to help you avoid perilous charting. Completed "AccuChart" sample forms--such as OASIS, incident reports, and fall prevention reports--give readers the confidence to chart accurately at all times.

DocuNotes Cherie Rebar 2009 A Daviss Notes Book. The perfect pocket guide for charting; ensures that documentation is not only complete and thorough, but also meets the highest ethical and legal standards. Covers nuances that are relevant to various specialties, including pediatric, OB/GYN, psychiatric and outpatient nursing. Reviews terminology essential to communicate effectively in writing with doctors, other health care professionals, and staff. Includes how-tos for template, electronic and other forms of charting.

Nursing Care Plans & Documentation Lynda Juall Carpenito-Moyet 2009 The Fifth Edition of Nursing Care Plans and Documentation provides nurses with a comprehensive guide to creating care plans and effectively documenting care. This user-friendly resource presents the most likely diagnoses and collaborative problems with step-by-step guidance on nursing action, and rationales for interventions. New chapters cover moral distress in nursing, improving hospitalized patient outcomes, and nursing diagnosis risk for compromised human dignity. The book includes over 70 care plans that translate theory into clinical practice.Online Tutoring powered by Smarthinking--Free online tutoring, powered by Smarthinking, gives students access to expert nursing and allied health science educators whose mission, like yours, is to achieve success. Students can access live tutoring support, critiques of written work, and other valuable tools.

Nursing Documentation Patricia W. Iyer 1999 Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources. This book clearly and concisely provides guidelines for appropriate and careful documentation of care. This new edition includes the latest changes and trends in nursing documentation as they relate to the newly restructured healthcare environment.

Clinical Care Classification (CCC) System Manual Virginia Saba, EdD, RN, FAAN 2006-10-09 Designated a Doody's Core Title! The Preeminent Nursing Terminology Classification System "The Clinical Care Classification (CCC) System described in this manual is the only standard coded nursing terminology that is based on sound research using the nursing process model framework and that meets the Patient Medical Record Information (PMRI) comparability requirement. The CCC System allows patient care data generated by nurses to be incorporated into the PMRI database, and enables nurses' contributions to patient outcomes to be studied and acknowledged." -- From the Foreword by Sheryl L. Taylor, BSN, RN, Senior Consultant, Farrell Associates TESTIMONIES: "ABC Coding Solutions-Alternative Link developed ABC codes for nursing in collaboration with Dr. Virginia Saba, developer of the CCC system. Approximately two hundred ABC codes were developed from the CCC System of Nursing Interventions to accurately document nursing and integrative health care processes, classify and track clinical care, and develop evidence-based practice models, thus filling significant gaps in older medical code sets." --Connie Koshewa, Practitioner Relations Director, ABC Coding Solutions-Alternative Link "The International Classification for Nursing Practice (ICNPÆ) is a program of the International Council of Nurses (ICN). One of the first steps in the development of the ICNPÆ was to collect and compare all the nursing concepts in existing nursing terminologies, including the CCC. To facilitate the goal of ICNPÆ as a unified nursing language system, a project is under way to map the CCC to the ICNPÆ Version 1.0. This work will facilitate evaluation and ongoing development of both terminologies and allow ICN to compare data using CCC codes with data from other standard nursing terminologies." --Amy Coenen, PhD, RN, FAAN, Director, ICNPÆ Program, International Council of Nurses

Surefire Documentation 1999 This informative title provides nurses with specific, practical advice on documenting a wide range of situations from caring for a patient with a myocardial infarction to witnessing a patient sign his will. In clear, concise language, the book gives detailed explanations of how, what, and when to document in nearly 100 of the most common, most important situations nurses face in practice. Each entry tells exactly what to consider and what to document so that the nurse can ensure quality patient care, continuity of care, and legal protection for the nurse and the institution. * Covers nearly 100 important nursing situations. * Provides clinically and legally sound advice. * Explains exactly what to do--and what not to do--for maximum protection for yourself and your institution.

Liability Issues in Perinatal Nursing 1999 Inside this comprehensive reference, you'll find in-depth coverage of the liability risks common to obstetric and neonatal settings. From the basics of healthcare law and its relation to clinical practice, to detailed discussions aimed at specific liability challenges, this resource prepares you for the professional and legal responsibilities of today's perinatal nursing.