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documentation in nursing practice  
workbook page 6 Workbook Activity #4  
his activity provides an opportunity for  
you to explore the characteristics of  
effective documentation by T examining  
three short scenarios. Scenario #1 Mr.  
Ron Brown is a 71 year old gentleman  
with Type 1 diabetes admitted to  
hospital for treatment of an ulcer on his

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## **Documentation in Nursing Practice Workbook**

3. Identify documentation practices that validate safe, effective, and high quality patient-centered care. 4. Identify documentation practices that create legal and professional risks. 5. Identify

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characteristics of nursing documentation that support a legal defense of nursing actions. 6.

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CNO Practice Standard on  
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Communication Documentation should

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be a complete record of nursing care - assessment, planning, intervention and evaluation Document objective and subjective data Ensure plan of care is clear, current, relevant and individualized to meet the client's needs and wishes

**R W BH - Speaking out for nursing.**

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## **Speaking out for health.**

Nursing Documentation and Reducing Risk  
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Improving Nursing Documentation and Reducing Risk  
Patricia A. Duclos-Miller, MSN, RN, NE-BC  
In the age of electronic health records and value-based purchasing, accurate and complete nursing documentation is

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crucial. Proper

## **Improving Nursing Documentation and Reducing Risk**

Documentation don'ts: Time blocks Do not chart time as a block (e.g., 7-3), especially for narrative notes. Narrative documentation should reflect the actual time the entry was made. For certain

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types of flow sheets, such as a treatment record, recording time as a block could be acceptable. For example, a treatment that can be delivered

## **Long-Term Care Pocket Guide to**

This Policy addresses the documentation standards for all Specialty Mental Health Services except Psychiatric Inpatient,

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PHF and Nursing Facility Services. Types of Providers: The type of provider contract determines the documentation standards and method of claiming for reimbursement of services. Each provider's contract specifies which

**Clinical Documentation Standards**  
Skilled care is nursing and therapy care

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that can only be safely and effectively performed by, or under the supervision of, professionals or technical personnel. It's health care given when you need skilled nursing or skilled therapy to treat, manage, and observe your condition, and evaluate your care.

**Skilled nursing facility (SNF) care -**

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NURSING DOCUMENTATION IN CLINICAL PRACTICE ORIGINAL PAPERS This thesis is based on the following papers, which will be referred to by their Roman numerals: I Development of an audit instrument for nursing care plans in the patient record. Björvell C, Thorell-Ekstrand I, Wredling R. Quality in Health

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## **Nursing Documentation in Clinical Practice**

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Principles of Documentation are merely  
guidance for surveyors and do not ...  
Effective CMS-2567L Documentation for  
Nursing Homes With an A level finding  
Principle #2 - Using Plain Language ... If  
either CMS or the entity is dissatisfied  
with an ALJ decision or dismissal, it may

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file a request for review to the ...

## **EXHIBIT 7A PRINCIPLES OF DOCUMENTATION NOTE: Principles of ...**

Proper and accurate documentation is essential to avoid types of nursing documentation errors, and for helping to avoid patient deaths or increased

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liability for the caregiving facility, physician, or nurse. This is where EMRs come in, and where effective EMR training of nursing students can play a vital role.

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Medical Supplies, and Nutritional  
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Obstetrics, and Family Planning Title XIX  
Services Handbook Home Health Nursing  
and Private Duty Nursing Services  
Handbook Inpatient and Outpatient  
Hospital Services ...

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