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Client Name: DOB: WOUND ASSESSMENT PHN: OR ADDRESSOGRAPH/LABEL Year: & TREATMENT FLOW SHEET Wound Date of Onset_____ Page 1 of 2 Reference: Wound Assessment Guideline Decision Support Tool (DST).Adapted from VCHA Wound Care Assessment Tool (2009)

Focuses on the communication skills that are the key to good documentation.

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.

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: 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

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.

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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.

Now in its Ninth Edition, this comprehensive all-in-one textbook covers the basic LPN/LVN curriculum and all content areas of the NCLEX-PN®. Coverage includes anatomy and physiology, nursing process, growth and development, nursing skills, and pharmacology, as well as medical-surgical, maternal-neonatal, pediatric, and psychiatric-mental health nursing. The book is written in a student-friendly style and has an attractive full-color design, with numerous illustrations, tables, and boxes. Bound-in multimedia CD-ROMs include audio pronunciations, clinical simulations, videos, animations, and a simulated NCLEX-PN® exam. This edition's comprehensive ancillary package includes curriculum materials, PowerPoint slides, lesson plans, and a test generator of NCLEX-PN®-style questions.

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.

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