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documentation should be objective factual professional and use proper medical terminology grammar and spelling all types of documentation must include the date time and signature of the person documenting any type of documentation in the ehr is considered a legal document and must be completed in an accurate and timely manner

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documentation affects not only quality of care but also facilities costs and revenues redundant documentation wastes time and money while inadequate documentation negatively affects joint commission core measures and can result in license suspensions or legal action against a healthcare facility an expensive and often damaging outcome

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in this study on nursing documentation in long term care facilities a set of 9 delirium symptoms was used to evaluate the agreement between symptoms reported by nurses during monthly interviews and those documented in the nursing notes for the same 7 day observation period

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pmid 10624250 doi 10 1046 j 1365 2702 1999 00281 x abstract documentation of nursing care is an important source of reference and communication between nurses and other health care providers this article describes a study of the documentation practices of nurses in a long term care institution

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by following some it documentation best practices including using the right it documentation tools organizing information effectively and updating documentation regularly beginners can start creating effective it documentation and experience these benefits firsthand

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documentation in long term care has become increasingly complex as the resident s clinical needs and decision making have become more complex regulations and surveys more stringent documentation based payment systems implemented and litigation legal challenges have increased

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nursing documentation is an essential activity that attempts to effectively facilitate information exchange about care recipients health status and provide evidence of nursing care 1 2 accurate nursing documentation contributes to the continuity of care safety and well being of residents 1 during the previous decade the amount as well as

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thus their documentation should describe the nurses critical thinking process 1 assessment of a resident s conditions causative factors and or risk factors 2 analysis of potential outcomes or consequences 3 a plan of action and 4 evaluation of the resident s response to the plan

examples of documentation of skilled and unskilled care for Dec 04 2022

the following examples of skilled and unskilled documentation are used to illustrate medicare guidelines that state that all services must be medically necessary and be provided at a level of complexity and sophistication that requires a speech language pathologist to perform the tasks

documentation in the long term care setting pubmed Nov 03 2022

pmid 10608940 doi 10 1097 00005110 199912000 00010 abstract the challenge of delivering care in the long term care setting has been sharpened in recent years by the increasing diversity of the u s population the increase of the oldest elderly and the percentage of medicare patients with disabilities and dementia

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