Home Health Documentation Examples

The rapid growth of home health care has raised many unsolved issues and will have consequences that are far too broad for any one group to analyze in their entirety. Yet a major influence on the safety, quality, and effectiveness of home health care will be the set of issues encompassed by the field of human factors research--the discipline of applying what is known about human capabilities and limitations to the design of products, processes, systems, and work environments. To address these challenges, the National Research Council began a multidisciplinary study to examine a diverse range of behavioral and human factors issues resulting from the increasing migration of medical devices, technologies, and care practices into the home. Its goal is to lay the groundwork for a thorough integration of human factors research with the design and implementation of home health care devices, technologies, and practices. On October 1 and 2, 2009, a group of human factors and other experts met to consider a diverse range of behavioral and human factors issues associated with the increasing migration of medical devices, technologies, and care practices into the home. This book is a summary of that workshop, representing the culmination of the first phase of the study.

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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. 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Here's the brand new third edition of the very popular Home Care Nursing Handbook -- considered by readers as a "beacon of excellence" in home care nursing. Now better than ever, this book that so many nurses have turned to for immediate, excellent advice, has been significantly expanded. It is reorganized for quicker access to expert guidance & devotes separate chapters to interventions for each impairment. Use this guide every day to assess situations quickly, develop efficient plans of care, provide accurate intervention strategies, document patient care quickly & precisely, promote quality patient outcomes--in the shortest number of contacts , & so much more. This book is a vital addition to critical pathways, point-of-care computer systems, & OASIS data collection.

Elizabeth I. Gonzalez, RN, BSN Are you looking for training assistance to help your homecare staff enhance their patient assessment documentation skills? Look no further than "Clinical Documentation Strategies for Home Health. " This go-to resource features home health clinical documentation strategies to help agencies provide quality patient care and easily achieve regulatory compliance by: Efficiently and effectively training staff to perform proper patient assessment documentation Helping nurses and clinicians understand the importance of accurate documentation to motivate improvement efforts Reducing reimbursement issues and liability risks to address financial and legal concerns

This comprehensive resource covers everything homecare providers need to know regarding documentation best practices, including education for staff training, guidance for implementing accurate patient assessment documentation, tips to minimize legal risks, steps to develop foolproof auditing and documentation systems, and assistance with quality assurance and performance improvement (QAPI) management. "Clinical Documentation Strategies for Home Health" provides: Forms that break down the functions and documentation requirements of the clinical record by "Conditions of Participation," Medicare, and PI activities Tips for coding OASIS Examples of legal issues such as negligence Case studies and advice for managing documentation risk (includes a checklist) Comprehensive documentation and auditing tools that can be downloaded and customized Table of Contents: Key aspects of documentation Defensive documentation: Reduce risk and culpability Contemporary nursing practice Clinical documentation Nursing negligence: Understanding your risks and culpability Improving your documentation Developing a foolproof documentation system Auditing your documentation system Telehealth and EHR in homecare Motivating yourself and others to document completely and accurately

Clinical Case Studies for the Family Nurse Practitioneris a key resource for advanced practice nurses and graduatestudents seeking to test their skills in assessing, diagnosing, andmanaging cases in family and primary care. Composed of morethan 70 cases ranging from common to unique, the book compilesyears of experience from experts in the field. It is organizedchronologically, presenting cases from neonatal to geriatric carein a standard approach built on the SOAP format. Thisincludes differential diagnosis and a series of critical thinkingquestions ideal for self-assessment or classroom use.

Better patient management starts with better documentation! Documentation for Rehabilitation: A Guide to Clinical Decision Making in Physical Therapy, 3rd Edition shows how to accurately document treatment progress and patient outcomes. Designed for use by rehabilitation professionals, documentation guidelines are easily adaptable to different practice settings and patient populations. Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned. Written by expert physical therapy educators Lori Quinn and James Gordon, this book will improve your skills in both documentation and clinical reasoning. A practical framework shows how to organize and structure PT records, making it easier to document functional outcomes in many practice settings, and is based on the International Classification for Functioning, Disability, and Health (ICF) model - the one adopted by the APTA. Coverage of practice settings includes documentation examples in acute care, rehabilitation, outpatient, home care, and nursing homes, as well as a separate chapter on documentation in pediatric settings. Guidelines to systematic documentation describe how to identify, record, measure, and evaluate treatment and therapies - especially important when insurance companies require evidence of functional progress in order to provide reimbursement. Workbook/textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts. NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations, re-evaluations, and discharge summaries. UPDATED content is based on data from current research, federal policies and APTA guidelines, including incorporation of new terminology from the Guide to Physical Therapist 3.0 and ICD-10 coding. EXPANDED number of case examples covers an even broader range of clinical practice areas.

2015 Third Edition. 205 pages. 136 Home Health Nursing Care Plans with 39 Medication Care Plans in the book and on the CD. 23 Skilled Charting Guidelines. The Home Health nursing care plans and plan of care forms in this book cover every nursing diagnosis and care plan problem that may be generated from the OASIS-C form for the nursing plan of care. Also includes Pain Care manual.Terminology is based on OASIS-C language and nursing diagnosis definitions and classifications as outlined by the North American Nursing Diagnosis Association (NANDA). The home health nursing care plan format follows the care plan standards from the American Nurses Association. The first section of the book covers regulations and standards for nursing care plans, Home Health Nursing care plan components, and Quality Measures and Outcome Measures. Because the terminology of the home health nursing care plan is based on OASIS-C language, it is very easy to see which care plans and plan of care forms are triggered by the OASIS-C entries. The home health nursing care plans can be used to supplement the nursing plan of care, and are also extremely useful for teaching patients and caregivers.

Better patient management starts with better documentation! Documentation for Rehabilitation: A Guide to Clinical Decision Making in Physical Therapy, 3rd Edition shows how to accurately document treatment progress and patient outcomes. Designed for use by rehabilitation professionals, documentation guidelines are easily adaptable to different practice settings and patient populations. Realistic examples and practice exercises reinforce concepts and encourage you to apply what you've learned. Written by expert physical therapy educators Lori Quinn and James Gordon, this book will improve your skills in both documentation and clinical reasoning. A practical framework shows how to organize and structure PT records, making it easier to document functional outcomes in many practice settings, and is based on the International Classification for Functioning, Disability, and Health (ICF) model — the one adopted by the APTA. Coverage of practice settings includes documentation examples in acute care, rehabilitation, outpatient, home care, and nursing homes, as well as a separate chapter on documentation in pediatric settings. Guidelines to systematic documentation describe how to identify, record, measure, and evaluate treatment and therapies — especially important when insurance companies require evidence of functional progress in order to provide reimbursement. Workbook/textbook format uses examples and exercises in each chapter to reinforce your understanding of concepts. NEW Standardized Outcome Measures chapter leads to better care and patient management by helping you select the right outcome measures for use in evaluations, re-evaluations, and discharge summaries. UPDATED content is based on data from current research, federal policies and APTA guidelines, including incorporation of new terminology from the Guide to Physical Therapist 3.0 and ICD-10 coding. EXPANDED number of case examples covers an even broader range of clinical practice areas.

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 for 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

This Protocol delineates the evidence for using devices for noninvasive patient monitoring of blood pressure, heart rhythms, pulse oximetry, end-tidal carbon dioxide, and respiratory waveforms. These protocols guide clinicians in the appropriate selection of patients for use of the device, application of the device, initial and ongoing monitoring, device removal, and selected aspects of quality control.

Individuals with disabilities, chronic conditions, and functional impairments need a range of services and supports to keep living independently. However, there often is not a strong link between medical care provided in the home and the necessary social services and supports for independent living. Home health agencies and others are rising to the challenges of meeting the needs and demands of these populations to stay at home by exploring alternative models of care and payment approaches, the best use of their workforces, and technologies that can enhance independent living. All of these challenges and opportunities lead to the consideration of how home health care fits into the future health care system overall. On September 30 and October 1, 2014, the Institute of Medicine and the National Research Council convened a public workshop on the future of home health care. The workshop brought together a spectrum of public and private stakeholders and thought leaders to improve understanding of the current role of Medicare home health care in supporting aging in place and in helping high-risk, chronically ill, and disabled Americans receive health care in their communities. Through presentations and discussion, participants explored the evolving role of Medicare home health care in caring for Americans in the future, including how to integrate Medicare home health care into new models for the delivery of care and the future health care marketplace. The workshop also considered the key policy reforms and investments in workforces, technologies, and research needed to leverage the value of home health care to support older Americans, and research priorities that can help clarify the value of home health care. This summary captures important points raised by the individual speakers and workshop participants.

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.

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.

In addition, with the updated HCFA home health agency manual coverage as well as coverage and documentation guidelines, forms may be completed with knowledge of the latest Medicare rules. Best of all, the OASIS-B form, which is hot off the press, is included in its entirety!

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.

Regional health care databases are being established around the country with the goal of providing timely and useful information to policymakers, physicians, and patients. But their emergence is raising important and sometimes controversial questions about the collection, quality, and appropriate use of health care data. Based on experience with databases now in operation and in development, Health Data in the Information Age provides a clear set of guidelines and principles for exploiting the potential benefits of aggregated health data--without jeopardizing confidentiality. A panel of experts identifies characteristics of emerging health database organizations (HDOs). The committee explores how HDOs can maintain the quality of their data, what policies and practices they should adopt, how they can prepare for linkages with computer-based patient records, and how diverse groups from researchers to health care administrators might use aggregated data. Health Data in the Information Age offers frank analysis and guidelines that will be invaluable to anyone interested in the operation of health care databases.

"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 patient safety and quality -- Patient Safety and Quality: An Evidence-Based Handbook for Nurses. (AHRQ Publication No. 08-0043)."--Online AHRQ blurb, http://www.ahrq.gov/qual/nurseshdbk.

Home Health nursing care plans for OASIS-C documentation

This practical resource provides the speech-language professional with an introduction to home care practice and offers detailed examples of new perspectives in meeting the diagnostic and treatment challenges e ncountered in this setting. Specific procedures and actual case studie s are included.

In the United States, health care devices, technologies, and practices are rapidly moving into the home. The factors driving this migration include the costs of health care, the growing numbers of older adults, the increasing prevalence of chronic conditions and diseases and improved survival rates for people with those conditions and diseases, and a wide range of technological innovations. The health care that results varies considerably in its safety, effectiveness, and efficiency, as well as in its quality and cost. Health Care Comes Home reviews the state of current knowledge and practice about many aspects of health care in residential settings and explores the short- and long-term effects of emerging trends and technologies. By evaluating existing systems, the book identifies design problems and imbalances between technological system demands and the capabilities of users. Health Care Comes Home recommends critical steps to improve health care in the home. The book's recommendations cover the regulation of health care technologies, proper training and preparation for people who provide in-home care, and how existing housing can be modified and new accessible housing can be better designed for residential health care. The book also identifies knowledge gaps in the field and how these can be addressed through research and development initiatives. Health Care Comes Home lays the foundation for the integration of human health factors with the design and implementation of home health care devices, technologies, and practices. The book describes ways in which the Agency for Healthcare Research and Quality (AHRQ), the U.S. Food and Drug Administration (FDA), and federal housing agencies can collaborate to improve the quality of health care at home. It is also a valuable resource for residential health care providers and caregivers.

Complete & accurate documentation is one of the essential skills for a physical therapist. This book covers all the fundamentals & includes practice exercises & case studies throughout.

Patient Visit Notes For Hospice Nurses Keeping concise and accurate notes is crucial for correct patient care, and legally required in the most situations. Although Bedside Charting is the generally preferred method of note taking for Hospice Nurses, you quickly realise that it is not always practical, given the hands-on, rapidly changing nature of Hospice Care. This book is designed to simplify the process of patient note taking, and contains all essential information for appropriate care. It's also a great resource that helps to compile all your records into one convenient location, which should be kept for a number of years should any legal situations arise. It was designed with consultation and guidance from Dr M. Smithe. It is designed specifically for Hospice and home care Nurses, and contains the following: Index page (Quick Recap of which patient is on each page and the date of visit. Patient Visit Logs, and Notes for each Patient (1 Double Page Spread per Visit) Blank Notes Pages at the end of the book Each Patient Note Spread Contains the following: Date Scheduled / PRN Start and Finish Time Patient Name Mileage start and finish (For traveling hospice workers) Patient Pain (1-10) and description Temperature Blood Pressure Respiratory rate Heart Rate SO2 O2 LPM Last BM Left and Right MAC Weight Family / Facility Updated (Yes / No) Next Visit Date Medication supply confirmed Lined notes (3?4 page per patient visit) Notes for next visit 6 x blank input columns for personal notetaking unique to each hospice nurse. Book Features: 130 Pages 6 x 9 inch - very convenient size Printed on white paper Perfect bound, softcover book

Home care clinicians everywhere depend on "the little red book" for essential, everyday information: detailed standards and documentation guidelines including ICD-9-CM diagnostic codes, current NANDA-I and OASIS information, factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement considerations, and evidence-based resources for practice and education. COmpletely revised and updated, this indispensable handbook now includes the most recently revised Federal Register Final Rule and up-to-date coding guidelines.

Improve your therapy documentation skills today! This best-selling book has been newly updated to improve therapy documentation immediately. This practical resource is the only product on the market that aids PTs, OTs, and SLPs in honing their documentation skills under OASIS-C and complying with the therapy requirements mandated in the home health PPS rules. Through clear examples, real-life scenarios, and the expertise of author Cindy Krafft, PT, MS, therapists will be able to integrate high-quality documentation processes into effective care management practices. This book will teach you how to: * Improve therapy documentation accuracy to ensure payment and compliance * Coordinate documentation between therapists and other members

of the clinical team to improve patient care * Prove medical necessity and need for skilled care by practicing accurate documentation * Align documentation with functional reassessment and OASIS-C requirements * Prevent missed payment and denials and reduce the risk of an audit

"The Postacute Care Guide to Maintenance Therapy "contains regulatory information, analysis, and advice for maintenance therapy care and documentation in postacute settings.

Nursing can be nuts. On a twelve-hour shift, the last thing most nurses want to do is sit down and draft a lengthy note describing the craziness that occurred. Written by a nurse, for nurses, this book is chock full of narrative note examples describing hypothetical situations to help you describe the, well, the indescribable. Some shifts are just like that!

It is my hope that this text, when properly used will be of great benefit to the individual aide or aide intraining in mastering the required skills that would make the individual a good home health aide. The book has been specially tailored as a teaching tool for home health aides.The book has two sections, the tutorial section one and the practical hands on section two. The second section is a good aide or good training tool for practical demonstartion purposes. For the purpose of understanding only, a home health aide does not have to be a Certified Nurses Aide. As a result this book can be used to train and prepare an individual to function in the capacity of a home health aide. The agency must prepare a set of standardized tests for the aides to ensure that the individual have fully internalized the reaching and traning that they have been put through. This book further addresses the rule and regulation (federal and State) that the home health aide must be familiar with. This book is an excellent tool for the home health aide. I strongly encourage all individual who practice and plans to practice as an aide in the home health field to read this book.

Complete your charting at your patient's home and stay organized. EASY and CONVENIENT to use. 6x9 Inhces with 120 pages and Matte Finish.

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.

Orientation to Home Care Nursing is a comprehensive reference text that covers all aspects of home health nursing. This text can be used as a primary text for home care and community nursing courses. Or it can be used concurrently with the agency's own materials to apply learned material to daily practice or with students who are learning about home care. This companion text to the Manual of Home Care Nursing Orientation, by the same authors, provides the nurse with an in-hand reference for orientation and beyond.

THE #1 Drug Guide for nurses & other clinicians...always dependable, always up to date! Look for these outstanding features: Completely updated nursing-focused drug monographs featuring 3,500 generic, brand-name, and combination drugs in an easy A-to-Z format NEW 32 brand-new FDA-approved drugs in this edition, including the COVID-19 drug remdesivir—tabbed and conveniently grouped in a handy “NEW DRUGS” section for easy retrieval NEW Thousands of clinical updates—new dosages and indications, Black Box warnings, genetic-related information, adverse reactions, nursing considerations, clinical alerts, and patient teaching information Special focus on U.S. and Canadian drug safety issues and concerns Photoguide insert with images of 439 commonly prescribed tablets and capsules

“This 5th edition is an important achievement; it is a symbol of commitment to the field of palliative nursing, where we have been and where we are going.” - Betty Rolling Ferrell, PhD, MA, FAAN, FPCN, CHPN From the Foreword The aging population has only grown since the first edition of this comprehensive and seminal publication nearly 20 years ago. Based on the need to humanize rather than medicalize the illness experience for patients, this text delves into palliative care beyond the specific diseases affecting the patient. Instead, content focuses on the whole person and family. Palliative patients struggle with chronic, debilitating, and painful conditions, and grapple with the fact that life as they knew it has already passed away. Families and friends reciprocally suffer, not knowing how to help and therefore become the secondary victims of the disease. This is not the challenge of a lone nurse, or a single physician, therapist, or social worker. Rather, palliative and hospice care requires the expertise and unique roles of an interprofessional team to help the patient and family strengthen their resilience, continue to find meaning and purpose in life, and cure what can be cured. Palliative Care Nursing, Fifth Edition, delivers advanced empirical, aesthetic, ethical and personal knowledge. This new edition brings an increased focus on outcomes, benchmarking progress, and goals of care. It expounds upon the importance of the cross-disciplinary collaboration introduced in the previous edition. Every chapter in Sections I, II, and III includes content written by a non-nursing member of the interprofessional team. Based on best-evidence and clinical practice guidelines, this text presents comprehensive, targeted interventions responsive to the needs of palliative and hospice patients and family. Each chapter contains compassionate, timely, appropriate, and cost-effective care for diverse populations across the illness trajectory. Key Features The expanded new edition offers current, comprehensive, one-stop source of highly-relevant clinical information on palliative care Life-span approach: age-appropriate nursing considerations (e.g. geriatric, pediatric and family) Includes disease-specific and symptom-specific nursing management chapters Promotes a holistic and interdisciplinary approach to palliative care Offers important legal, ethical and cultural considerations related to death and dying Case Studies with Case Study Conclusion in each clinical chapter New to The Fifth Edition: An expanded chapter on Palliative Care incorporates most up to date scope and standards, information on Basic and Advanced HPNA certification, self-reflection and self-care for nurses. A chapter on Interprofessional Collaboration Instructor Resources: Power points and Test bank

Handbook of Home Health Standards, Revised Reprint

"This text covers conceptual information, leadership skills and current issues and trends. It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care." --Cover.