

# Home Health Documentation

# Templates

Save 30  
Minutes  
a Day

**Physician Order Tracking**

| Physician Initials | POC/DOC Date | Physician Name | Order (Start of therapy, duration) | Last used by | Comments |
|--------------------|--------------|----------------|------------------------------------|--------------|----------|
|                    |              |                |                                    |              |          |
|                    |              |                |                                    |              |          |

**Goal Setting Template and Examples**

**Goal Setting Template:**  
The patient will \_\_\_\_\_ (state Summary) \_\_\_\_\_ (measure) \_\_\_\_\_ (frequency) \_\_\_\_\_ (time frame)

**Physician Verbal Order Examples & Script Templates**

**Initial Evaluation Summary Example (Eval, SOC, ROC)**

The initial evaluation summary examples below share a sample Subjective, Assessment, and Plan (Statement of Need) in a brief format similar to how your documentation may require. The objective measures you take are generally within separate tabs and are brought forward with respect to documenting vital signs, gait/balance, Tinetti score, etc.) Five included sub-headings to identify the subjective (assessment) plan within the summaries below. In your documentation, do not include the sub-headings ("Subjective") etc.

**Evaluation Summary Example 1**

**(Subjective)**  
Patient agrees to physical therapy evaluation (ROC). Patient was referred to PT home health due to muscle weakness and difficulty walking. She suffered a fall on 12/22/18 resulting in R femur fx and R shoulder dislocation. Patient has other medical hx of aff with cv, HTN, alcohol abuse, liver problems and depression.

**(Assessment)**  
Patient lives in an independent living facility and was independent/mod-independent with ADLs prior to her fall. Patient presents today with impaired balance and decreased coordination. Patient presents with independent transfers requiring SBM and WC for safe use of assistive device (cane). Patient has decreased/dynamic standing balance to fair with discontinuous steps when turning in a circle without hand support and increased postural sway when feet are together. Patient is able to ambulate 200 feet with PWB and SBM, but demonstrates poor coordination with turning. Her increased fall risk is evidenced by a Tinetti score of 1/208 and gait of 27.8 seconds. Patient does not report pain in R shoulder today and has limited use of R arm with reaching and ADLs.

**(Plan)**  
Skilled PT services are warranted to educate patient on HEAT, pain mgmt, adequate hydration, energy conservation and fall prevention strategies, strengthening both LE and UE, improving transfers, increasing standing balance and increasing gait and endurance while improving functional mobility to decrease fall.

**Evaluation Summary Example 2**

Plan for initial PT eval today with POC established. Patient is an 88 years old female. Home health due to muscle weakness and compression fracture. Patient has other hx of lumbar spine, anxiety, depression, urinary incontinence, osteoporosis, HTN, lung cancer.

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OVER  
30

Full Text  
Examples

# **Nursing Documentation For Home Health**

**Tina M. Marrelli**



# Nursing Documentation For Home Health

*Home Health Nursing* Karen E. Monks, 2002-10-22 This unique spiral bound handbook is compact portable and written with busy home health nurses in mind Organized by body system it offers instant advice on assessment and care planning for the disorders home health nurses are likely to encounter Providing assessment guides for all body systems the home environment and the client's psychological status it includes full care plans for over 50 illnesses and conditions most commonly encountered in the home Each plan lists nursing diagnoses short and long term expected outcomes nursing interventions and client caregiver interventions Care plans are organized by body systems to allow for quick retrieval of information Both short term and long term outcomes are included in the care plans to aid evaluation of the care provided Detailed assessment guidelines are provided for all body systems to facilitate complete and comprehensive client examinations Guidelines for environmental and safety assessments aid in the appraisal and improvement of clients living conditions Client and caregiver interventions are outlined in the care plans to promote active client participation in self care The convenient pocket size makes transportation and use convenient to home health nurses Appendices on documentation guidelines laboratory values medication administration home care resources and standard precautions provide quick access to useful home care information Related OASIS items are identified in the assessment section and ICD 9 diagnostic codes in the care plans section assist with proper home care documentation Visit frequency and duration schedules are suggested within each care plan to assist nurses in evaluating and planning care NANDA nursing diagnoses are consistent with the latest 2001 2002 nomenclature An increase in suggested therapy referrals within the care plans and in a new appendix helps nurses identify indicators for specialized services A fully updated Resources Appendix includes websites for easy access to home health service information

**Nursing Documentation Made Incredibly Easy** Kate Stout, 2018-06-05 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 NEW discussion 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 Doshier Memorial Hospital in Southport North Carolina

**Home Health Assessment Criteria** Barbara Acello,Lynn Riddle Brown,2015 **Clinical Documentation Strategies for Home Health** Elizabeth I Gonzalez, RN, Bs,Elizabeth I. Gonzalez,2014-11-26 Clinical Documentation Strategies for Home HealthElizabeth 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 *Handbook of Home Health Care Administration* Marilyn D. Harris, 1997 Table of Contents Foreword Introduction Ch 1 Home health administration an overview 3 Ch 2 The home health agency 16 Ch 3 Medicare conditions of participation 27 Ch 4 The joint commission s home care accreditation program 63 Ch 5 CHAP accreditation standards of excellence for home care and community health organizations 71 Ch 6 Accreditation for home care aide and private duty services 81 Ch 7 ACHC accreditation for home care and alternate site health care services 86 Ch 8 Certificate of need and licensure 92 Ch 9 Credentialing organizational and personnel options for home care 101 Ch 10 The relationship of the home health agency to the state trade association 111 Ch 11 The national association for home care and hospice 115 Ch 12 The visiting nurse association of America 124 Ch 13 Self care systems in home health care nursing 131 Ch 14 Home health care documentation and record keeping 135 App 14 A COP standards pertaining to HHA clinical record policy 147 App 14 B Abington Memorial Hospital home care clinical records 150 Ch 15 Computerized clinical documentation 161 Ch 16 Home telehealth improving care and decreasing costs 176 Ch 17 Implementing a competency system in home care 185 Ch 18 Meeting the need for culturally and linguistically appropriate services 211 Ch 19 Classification an underutilized tool for prospective payment 224 Ch 20 Analysis and management of home health nursing caseloads and workloads 236 Ch 21 Home health care classification HHCC system an overview 247 Ch 22 Nursing diagnoses in home health nursing 261 Ch 23 Perinatal high risk home care 274 Ch 24 High technology home care services 279 Ch 25 Discharge of a ventilator assisted child from the hospital to home 291 Ch 26 Performance improvement 301 Ch 27 Evidence based practice basic strategies for success 310 Ch 28 Quality planning for quality patient care 315 Ch 29 Program Evaluation 320 App 29 A Formats for presenting program evaluation tools Ch 30 Effectiveness of a clinical feedback approach to improving patient outcomes 341 Ch 31 Implementing outcome based quality improvement into the home health agency 352 Ch 32 Benchmarking and home health care 383 Ch 33 Administrative policy and procedure manual 395 Ch 34 Discharge planning 399 Ch 35 Strategies to retain and attract quality staff 421 Ch 36 Evaluating productivity 436 Ch 37 Labor management relations 448 Ch 38 Human resource management 459 Ch 39 Staff development in a home health agency 474 Ch 40 Transitioning nurses to home care 484 Ch 41 Case management 495 Ch 42 Managed care 499 Ch 43 Community based long term care preparing for a new role 507 Ch 44 Understanding the exposures of home health care an insurance primer 519 Ch 45 Budgeting for home health agencies 527 Ch 46 Reimbursement 535 Ch 47 How to read interpret and understand financial statements 549 Ch 48 Management information systems 558 Ch 49 Legal issues of concern to home care providers 571 Ch 50 Understanding the basics of home health compliance 590 Ch 51 The HIPAA standards for privacy of individually identifiable health information 616 Ch 52 Ethical practice in the daily service to home care client their families and the community 666 Ch 53 Participating in the political process 675 Ch 54 Strategic planning 693 Ch 55 Marketing an overview 708 Ch 56 The internet in home health and hospice care 723 Ch 57 Disease management programs 736 Ch 58 The

process of visiting nurse association affiliation with a major teaching hospital 756 Ch 59 Grantsmanship in home health care seeking foundation support 771 Ch 60 Home care volunteer program 778 Ch 61 The manager as published author tips on writing for publication 796 Ch 62 Student placements in home health care agencies boost or barrier to quality patient care 810 Ch 63 A student program in one home health agency 818 Ch 64 The role of the physician in home care 834 Ch 65 Research in home health agencies 840 Ch 66 Hospice care pioneering the ultimate love connection about living not dying 850 App 66 A State of Connecticut physician assisted living PAL directive 863 App 66 B Summary guidelines for initiation of advanced care 864 Ch 67 Safe harbor a bereavement program for children teens and families 866 Ch 68 Planning implementing and managing a community based nursing center current challenges and future opportunities 872 Ch 69 Adult day services the next frontier 883 Ch 70 Partners in healing home care hospice and parish nurses 891 Ch 71 Meeting the present challenges and continuing to thrive in the future tips on how to be successful as an administrator in home health and hospice care 899

*Handbook of Home Health Standards E-Book* Tina M. Marrelli, 2008-09-03 Handbook of Home Health Standards Quality Documentation and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards This handbook offers detailed standards and documentation guidelines including ICD 9 CM diagnostic codes OASIS considerations service skills including the skills of the multidisciplinary health care team factors justifying homebound status interdisciplinary goals and outcomes reimbursement and resources for practice and education The fifth edition of this little red book has been updated to include new information from the most recently revised Federal Register Final Rule and up to date coding All information in this handbook has been thoroughly reviewed revised and updated Offers easy to access and easy to read format that guides users step by step through important home care standards and documentation guidelines Provides practical tips for effective documentation of diagnoses clinical conditions commonly treated in the home designed to positively influence reimbursement from third party payors Lists ICD 9 CM diagnostic codes needed for completing CMS billing forms in each body system section along with a complete alphabetical list of all codes included in the book in an appendix Incorporates hospice care and documentation standards so providers can create effective hospice documentation Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care Includes the most current NANDA approved nursing diagnoses so that providers have the most accurate and up to date information at their fingertips Identifies skilled services including services appropriate for the multidisciplinary team to perform Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient s needs Lists the crucial parts of all standards that specific members of the multidisciplinary team e g the nurse social worker must uphold to work effectively together to achieve optimum patient outcomes Resources for care and practice direct providers to useful sources to improve patient care and or enhance their professional practice Each set of guidelines includes patient family and

caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions Several useful sections make the handbook thorough and complete medicare guidelines home care definitions roles and abbreviations NANDA approved nursing diagnoses guidelines for home medial equipment and supplies Small size for convenient carrying in bag or pocket Provides the most up to date information about the newest and predominant reimbursement mechanisms in home care the Prospective Payment System PPS and Pay For Performance P4P Updated terminology definitions and language to reflect the federal agency change from Health Care Financing Administration HCFA to Centers for Medicare Medicaid Services CMS and other industry changes Includes the most recent NANDA diagnoses and OASIS form and documentation explanations New interdisciplinary roles have been added such as respiratory therapist and nutritionist LI

**Nursing Documentation** Jennifer Richmond,1997-01-01 If these are your concerns I ll never get time to finish my nursing notes Is it legal Can I use white out Can t they make a better form than this How can I record this family set up quickly Weren t computers made for clerks not nurses There has to be something wrong with documenting for funding How do you record the pain level of someone who has a dementing illness Who walks down critical pathways What happens if a home health record gets lost How can I document my client s spiritual concerns realistically Will managed care affect what I write Is there a culturally appropriate way to document What is charting by exception How did nurses document before NANDA then this book is for you Back cover

**Nursing Documentation** Ellen Thomas Egglund,Denise Skelly Heinemann,1994 Focuses on the communicatiion skills that are the key to good documentation

*Nursing Documentation* Patricia W. Iyer,Nancy Hand Camp,1995 Clearly and concisely provides guidelines for appropriate and careful documentation of care Accurate documentation shows managed care companies that patients receive adequate care and that health care providers are controlling costs and resources In addition it plays a large role in how third party payors make payment or denial decisions This new edition includes the latest changes and trends in nursing documentation as related to the newly restructured healthcare environment Special attention focuses on the latest documentation issues specific to specialty settings such as acute care home care and long term care and a variety of clinical specialties such as obstetrics pediatrics and critical care Amazon com

**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

**Documentation Skills for Quality Patient Care** Fay Yocum,1999      **Handbook of Home Health Standards** Tina M. Marrelli,2012 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      **Home Health Assessment Criteria** Barbara Acello,Lynn Riddle Brown,2015-05-28 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      **Handbook of Home Health Standards, Revised Reprint** Tina M. Marrelli,2011-08-11 Handbook of Home Health Standards Revised Reprint      **Home Health Nursing Manual** Sunny Sutton,1988 The whys and hows of charting for home health care      **Handbook of Home Health Standards and Documentation Guidelines for Reimbursement** T. M. Marrelli,1994 Topics new to this edition include Alzheimer s disease breast cancer and cystic fibrosis For each of the 60 clinical problems discussed the author provides standards and documentation guides including ICD 9 diagnostic codes and NANDA approved nursing diagnoses and service skills      **Mastering Documentation** Springhouse Corporation,1995 The complete guide for streamlining and improving nursing documentation for virtually every system Nurses will find instructions for virtually every common and not so common charting method From progress notes to protocols there is a wealth of easy to follow examples throughout the book Includes JCAHO approved nursing abbreviations ANA standards of practice and JCAHO and Medicare guidelines for nursing documentation      **Documenting Medical Necessity** Heather Calhoun,2015-08-21 Initial patient assessment in home health can be tricky If documentation does not adequately provide a reason for skilled nursing care in the home you might not get reimbursed at all In Documenting Medical Necessity A Practical Guide for Home Health author Heather Calhoun RN BSN HCS D COS C provides down to earth conversational documentation tips with dozens of example scenarios to help nurses understand medical necessity and document in a manner that encourages proper and complete reimbursement In addition to initial assessments for skilled services continued skilled care must also be properly documented This resource will help nurses provide skilled services based on critical thinking throughout the continuum of care This book has A grounded conversational style that speaks directly to nurses who are responsible for the documentation Dozens of hypothetical examples that provide concrete learning opportunities Scenarios that are available electronically to provide handouts for ongoing and on the go learning Content that serves as a great resource for orientation and annual training      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 Handbook of Home Health Standards & Documentation Guidelines for Reimbursement T. M. Marrelli,2001 Everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards is found in this handbook Offers detailed standards and documentation guidelines for each of more than 60 clinical problems including ICD 9 diagnostic codes service skills including the skills of the multidisciplinary health care team factors justifying homebound status and more

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