Acute Care Documentation

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Acute Care Documentation
Chapter 16 discusses the need for clear, comprehensive, and accurate records of health interventions for patients in acute care, nurses' professional accountability in relation to their record keeping, and the legislative standards that apply to their practice, and discusses the purpose of documentation and health records, the principles of good documentation, including content and style of the health record, common deficiencies identified in health records, accountability and legal ...

Documentation in acute care - Oxford Medicine
Topics: Physician, Patient, Time Pages: 2 (444 words) Published: May 4, 2012. Documentation Requirements for the Acute Care Inpatient Record (AHIMA Practice Brief) The medical record is a tool for collecting, storing, and processing patient information. Records are being used daily for a multitude of purposes, including: • providing a means of communication between the physician and the other members of the healthcare team caring for the patient • providing a basis for evaluating the ...

Documentation Requirements for the Acute Care Inpatient ...
Medical record documentation has always been a critical component of the post-acute care environment, for nursing in particular. In skilled resident care, documentation is required to support MDS coding, reimbursement, and the need for skilled services on an inpatient basis.

The Importance of Documentation in Long-Term Care for ...
Specifically, documentation should describe each condition as acute, chronic, exacerbated, or resolved to clearly convey its current status and relationship to the current episode of care.

Practice Brief: Evolving Roles in Clinical Documentation ...
The Academy of Acute Care Physical Therapy is building a library of resources specifically tailored to acute care practice. These documents will provide information, references, and detail about commonly encountered practice and management issues in acute care.

Resource Guides - Academy of Acute Care Physical Therapy
Four of the Basic Components of an Acute Care Health Record Admission and Consent Records. The admission records contain all the pertinent information about the patient and include... History and Physical. The history and physical must be completed by the physician or his designee within a specific ...

Four of the Basic Components of an Acute Care Health ...
The nursing process can be applied to electronic documentation to avoid workarounds and close gaps in communication.

Nurse documentation and the electronic health record ...
The Academy of Acute Care Physical Therapy (AACPT) is composed of more than 3,000 physical therapists, physical therapist assistants, and physical therapy students who are members of the American Physical Therapy Association. The mission of the AACPT is to foster excellence in acute care practice, in all settings, in order to enhance the health ...

Academy of Acute Care Physical Therapy
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Acute Care Electronic System
The Healthcare Association of New York State (HANYS') homepage.

The Healthcare Association of New York State (HANYS) | HANYS
The standards focus on important patient, individual, or resident care and organization functions that are essential to providing safe, high quality care. The Joint Commission's state-of-the-art standards set expectations for organization performance that are reasonable, achievable and surveyable.

Standards Information | Joint Commission
Abstract Documentation burden is a well-documented problem within healthcare, and improvement requires understanding of the scope and depth of the problem across domains. In this study we quantified documentation burden within EHR flowsheets, which are primarily used by nurses to document assessments and interventions.

Quantifying and Visualizing Nursing Flowsheet ...
Congress and CMS have set in motion an ambitious plan to significantly reform post-acute care, which includes long-term care hospitals (LTCH), inpatient rehabilitation facilities (IRF), skilled nursing facilities SNF) and home health (HH) agencies.

Fact Sheet: Post-acute Care | AHA
Download a printable copy of this fact sheet here. Acute care is an inpatient hospital setting for individuals with a critical medical condition. These patients may have experienced a sudden decline in their medical and functional status due to a traumatic event, a worsening of a progressive disease, or the onset of a new condition. The primary goal of acute care is to stabilize the patient's medical status and address life-threatening issues.

Occupational Therapy in Acute Care - AOTA
Health Information Technology, Patient Safety, and Professional Nursing Care Documentation in Acute Care Settings The electronic health record (EHR) is a documentation tool that yields data useful in enhancing patient safety, evaluating care quality, maximizing efficiency, and measuring staffing needs.

Health Information Technology, Patient Safety, and ...
Documentation requirements vary by facility, but the SLP in an acute care hospital setting must be able to write concise reports or SOAP notes (Subjective, Objective, Assessment, Plan) that address only essential patient information for appropriate patient management.

Getting Started in Acute Care Hospitals
Attending Physician Documentation In the acute care inpatient setting, the attending physician is the central point for all documentation in the patient's record. It is the responsibility of the attending physician to determine the relevance and importance of all other documentation in the patient's record.

Documentation and Data Improvement Fundamentals
Because multidisciplinary communication and collaboration is so important in the care of patients/clients with acute health needs, the physical therapy documentation is the critical vehicle that will ensure that the goals and outcomes of the care that the PT or PTA gives is communicated among all disciplines working with the patient/client.