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:

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NEW discussion of the necessary documentation process outside of charting—informed consent, advanced directives, medication reconciliation

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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, evaluationDocumenting the patient’s health history and physical examinationThe Joint Commission standards for assessmentPatient rights and safetyCare plan guidelinesEnhancing documentationAvoiding legal problemsDocumenting proceduresDocumentation practices in a variety of settings—acute care, home healthcare, and long-term careDocumenting special situations—release of patient information after death, nonreleasable information, searching for contraband, documenting inappropriate behavior

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That’s a wrap!—a review of the topics covered in that chapter