Outline

The Components of Documentation
- Guidelines
- Interpretation
- Mistakes
- Education
- Social Networking
- Indirect Care

Electronic Nursing Documentation
- American Recovery and Reinvestment Act
- Meaningful Use
- Health Insurance Portability and Accountability Act (HIPPA)
- Risky electronic documentation practices
- Dangers of email, social networking, and texting

Electronic Medical Records (EMR) Strategies
- Time Management
- Liability
- Software Knowledge
- Meaningful Use

Reimbursement and Documentation
- Medicare/Medicaid Changes
- Incentives and meaningful use criteria
- EMR Timelines
- Hospital Acquired Conditions

Documentation When Things Go Wrong
- Compliance
- Regulations
- CMC
- Incident Reports
- Adverse Events
- Risk Factors

Ethical Issues
- Truth Tellers
- Standards
- Deviations
- Errors
- Omissions
- Communicating
- Corrections

Avoiding Risky Documentation
- Credible evidence
- Avoiding Ambiguity
- Recording events objectively
- Late Entries
- Correcting Errors

What if the Worst Happens?
- Duty /Breach of Duty
- Nurse Practice Act
- State Board of Nursing
- Depositions

Examples and Case Studies of Documentation

Speaker

Brenda Elliff, RN, MPA, ONC, CCM, LNCC, established Elliff Medical-Legal Services in 1996. As a legal nurse consultant, she assists on both plaintiff and defense cases. She performs record reviews, develops strategies and provides expert witness preparation. Her work involves Medical Malpractice, Worker's Compensation, Personal Injury and a variety of legal cases. Previously, Brenda worked as a Health Care Coordinator for a large law firm and taught a Legal Nurse Consultation review course. Initially she began working with attorneys on legal cases in California and has now expanded her scope throughout the Pacific NW.

Her clinical nursing experiences are vast and span 40 years. Brenda has worked as a staff nurse, as a nurse manager at major teaching facilities, as nurse case manager and as an adjunct nursing professor. Nurses who have attended Brenda's past programs have appreciated the dynamic and fun way in which she can deliver excellent clinical and legal information. She has been a sought-after speaker at national, state and local levels, on a variety of topics that draw from her areas of expertise.

When not practicing nursing, Brenda enjoys participating with a local performing group. The group has performed at the LA Christmas Parade, 75th Anniversary of Pearl Harbor Parade in Honolulu, and the Washington DC Cherry Blossom Parade.

Financial: Brenda Elliff maintains a private practice. She receives a speaking honorarium from PESI, Inc.

Non-financial: Brenda Elliff has no relevant non-financial relationships to disclose.

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- Dangers in Social Media and Electronic Communication
- Case Studies of Correct and Incorrect Documentation Practices

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Nursing Documentation

Proven Strategies to Keep Your Patients and Your License Safe

Join expert and legal nurse consultant, Brenda Elliff, RN, MPA, ONC, CCM, LNCC, to learn how to develop a systematic approach to documentation that will keep you, your patients and your license safe. You will learn how to identify and avoid risky documentation as well as how to correctly utilize electronic documentation and the correct technique for meaningful use. Brenda will show you step by step, how to overcome your most complex documentation questions and challenges.

This dynamic one-day program will include tools to safeguard your documentation including:

- Time saving tips for electronic documentation and EMR use
- Documenting compliance, incident reports, and adverse events
- Sample strategy worksheets for ease of data collection
- Federal government requests for charting based on meaningful use criteria
- Dangers with social media, email, and texting
- Examples and case studies of correct and incorrect documentation

Objectives

1. Identify a strategic nursing documentation system.
2. Describe how documentation is used to decide if you are guilty or innocent in a lawsuit.
3. Recognize the meaningful use criteria to meet reimbursement needs.
4. List how to best use features in computerized records to ensure reimbursement.
5. Identify how to prevent risky behavior when using social media and other forms of electronic communication.
6. Define how to use best practice and standard of care for documenting incident reports and adverse events.
7. Integrate the correct practices into your documentation to keep your license unblemished.
8. Summarize the common documentation mistakes and how to avoid and/or correct them.

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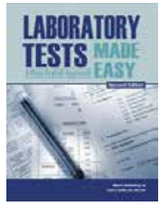

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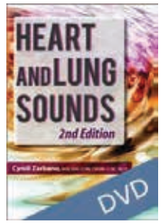
A Plain English Approach, Second Edition

By Mikel Rothenberg, MD
& Sean G. Smith, RN, BSN, NREMT-P, C-NPT, CCRN, CMC, CEN, CFRN, FP-C, CPEN

This best-selling reference book provides both the "need to know" information, as well as the "nice to know" details relevant to your patient's lab results. In this second edition you will find plain English summaries, pertinent case studies, and easy to read diagrams and tables. (2014)



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By Cyndi Zarbano, RN, BSN, CCRN, CMSRN, CLNC, NLCP

Achieving excellence in the care we give is a goal for every healthcare provider. In order to do so, we must ensure that we have the tools to allow for critical thinking to occur. One of the most fundamental tools for success in the medical arena is to have an understanding of the clues we find in our assessments. Cyndi Zarbano discusses pearls of wisdom for excellent assessment skills and be able to explain the: who, what, why, and where's of extra heart and lung sound clues. (2016)

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