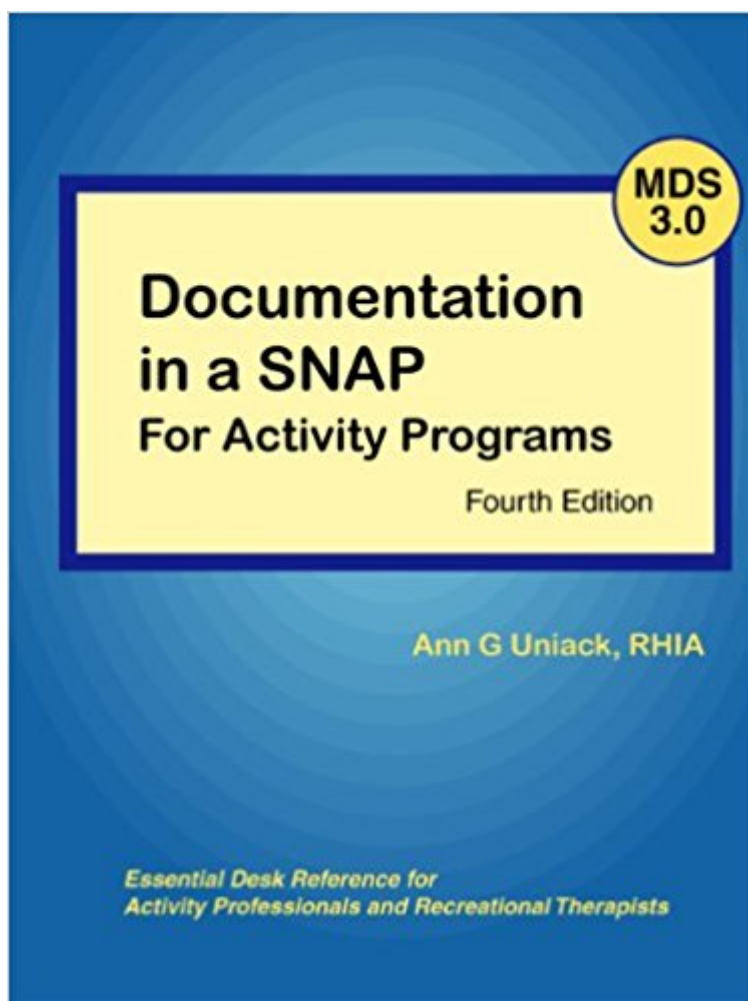


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# Documentation In A SNAP For Activity Programs



## Synopsis

The purpose of this book is to create a system of documentation that supports the delivery of resident care. The clinical record may be either handwritten or electronic, but its purpose is to provide the activity professional with information to:

- assess each resident's needs
- develop a plan of care
- establish goals to be achieved and outcomes expected
- document interventions
- evaluate the success or need for revision of the care plan

Throughout this book there are references specific to activity programs in nursing facilities and other situations that fall under OBRA guidelines. Federal regulations with interpretive guidelines and sections of the Resident Assessment Instrument (RAI) Version 3.0 Manual that describe documentation requirements are included.

## Book Information

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## Customer Reviews

Ann G Uniack is a registered health information administrator. Although now retired, she has specialized in clinical record systems for skilled nursing facilities for more than forty-five years. Originally from Portland, Oregon, she received her Bachelor of Science in Medical Records Science from Seattle University. Her professional activities have included election to Director of the California Health Information Association and President of the San Francisco Health Information Association. She has also served as a committee chair and member of various local, state, and national professional association committees. She has been honored by the California Health Information Association as their Distinguished Member in 1977 and received the Professional Achievement Award in 2009. Articles written by Ann G Uniack have been regularly published in the CHIA Journal.

She has been a speaker at many seminars on subjects such as documentation in the clinical record and ICD-9-CM coding.

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