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Sommario/riassunto	<p>Clinical Documentation Strategies for Home Health Elizabeth 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</p>

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
