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Sommario/riassunto	Clinical Documentation Strategies for Home HealthElizabeth I. Gonzalez, RN, BSNAre 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 documentationHelping nurses and clinicians understand the importance of accurate documentation to motivate improvement effortsReducing reimbursement issues and liability risks to address financial and legal concernsThis 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 activitiesTips for coding OASISExamples of legal issues such as negligenceCase studies and

advice for managing documentation risk (includes a checklist) Comprehensive documentation and auditing tools that can be downloaded and customizedTable of Contents:Key aspects of documentationDefensive documentation: Reduce risk and culpabilityContemporary nursing practiceClinical documentationNursing negligence: Understanding your risks and culpabilityImproving your documentationDeveloping a foolproof documentation systemAuditing your documentation systemTelehealth and EHR in homecareMotivating yourself and others to document completely and accurately