



Home Health Aide On-the-Go In-Service Lessons: Vol. 9, Issue 7: Documentation

HCPPro, Inc., Lu Post RN MN

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Effective documentation demonstrates that care was coordinated between team members involved in the plan of care, it supports the payment the agency receives for providing home health services to the patient, and it serves as legal proof that a visit was made. Poor documentation can result in costly survey citations and lost revenue for the agency. It can also lead to medical errors that can be life-threatening to patients and career-ending for clinicians. This lesson focuses on requirements and guidelines for accurate and complete electronic and handwritten home health aide documentation. **LESSON OBJECTIVES** After completion of this program, the home health aide will be able to: Identify five documentation flaws that could lead to legal or survey issues Distinguish between objective and subjective documentation Describe how to correct a documentation error in the medical record **Contents of this lesson:** A clearly written fact sheet A 10-question post-test to measure understanding of the subject matter An answer sheet with a place for the instructor's comments and signature An illustrative, homecare-specific case study Suggested supplemental learning activities An attendance log and certificate of completion

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