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Hospice Documentation Hospice providers must establish and maintain a clinical record for every individual receiving care and services. The record must be complete, promptly and accurately documented, readily accessible and systematically organized to facilitate retrieval.

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Incomplete or inaccurate patient documentation poses risks both to hospice patients and their providers. These errors can jeopardize patient safety, lead to delays in treatment and adversely impact payments to hospices from Medicare. Incorrect documentation also attracts regulatory scrutiny.

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~~Creating An Effective Hospice Plan of Care~~

Although it helps establish consistent documentation practices, it's still up to you to properly document your nursing assessments and patient care. Take care to follow these guidelines to prevent a plaintiff's attorney from raising questions about the quality of care you gave your patient.

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Hospice Nursing Documentation Ppt Documentation demonstrates the hospice aide provided personal care from 11:00 a.m. to 1:00 p.m. May document in narrative form or using charts or graphs The documentation needs to demonstrate the care provided and the time spent providing the care. Nursing Documentation-Supporting Terminal Prognosis

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Documentation of Beneficiary Election An individual (or his/her authorized representative) must elect hospice care to receive it. The initial election is for a 90-day period. An individual may elect to receive Medicare coverage for two 90-day periods and unlimited number of 60day periods.

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