Complete and proper client record documentation is important because it permanently reflects that the interventions being provided meets professional standards by noting the progression of services, care, and monitoring provided to clients. In addition, it serves as a primary communication format to direct and coordinate services between the numerous professionals involved with the client’s care. An agency’s ability to adequately defend itself in the event of a lawsuit largely rests on the extent of the documentation regarding the incident in question.

During orientation, and as needed, provide staff with in-service training on the importance of the client’s record and the documentation standards they are expected to maintain.

Routinely complete random record reviews and audits to assure compliance.

Handle noted deficiencies through individual counseling and/or further staff training.

See that documentation about incidents involving clients consistently reflects clinical observations, staff interventions, client response to care, and appropriate periodic re-evaluation following the incident.

Never reference incident reports in a client’s record in order to limit discoverability by a plaintiff’s attorney and to retain its privileged internal status (depending upon jurisdiction).

Document in a timely manner all family and physician notification of any incidents, change in condition and/or alteration of treatments, as needed.

Document and keep all client appointments in the resident’s record.

If a client is refusing medication, hygiene, food, or other care, take measures ASAP to inform the client and/or the client’s power of attorney for healthcare decisions (if the client is unable to make his or her own decisions) of the risks involved with the refusal(s).

To protect the agency against liability, formally document the exchange of this information with a signature obtained from the client and/or the individual with power of attorney for healthcare decisions.