

Reporting and Documenting Client Care



PEOPLECARE
HEALTH SERVICES

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Reporting and Documenting Client Care

There are a number of different environments in which you may work, such as a private residence, apartment complex or senior living facility. But no matter *what* environment, *you* are responsible for reporting and possibly documenting information about your clients on a daily basis, if needed. Depending on the nature of your client's condition, you may even need to document hourly or more frequently.

What is important to remember about client care documentation?

- Any written documentation regarding your client acts as a permanent legal record of the client's care
- You serve as the “eyes and ears” for the rest of the care team. Your observations help the team make the necessary changes in each client's care plan and provides updates on the condition
- The information you report—either by *calling the office* or by *writing it down*—affects the care your clients receive. Some issues will require both verbal and written documentation
- Supervisors check the quality of your documentation when completing reviews, so reporting about your clients, gives you a chance to demonstrate your professionalism
- All client care reports and documents must be kept confidential

Why Is Documentation Important?

- Allows members of the health care team to communicate with each other so that they can work together to keep clients safe and healthy
- Serves as legal evidence that you have performed your job as directed
- Provides a place to record changes in the client's care plan
- Helps care organizations meet the requirements for licensure and/or accreditation
- Keeps a record of the services provided to each client so that your workplace may receive payment

Remember your documentation may be read by a number of different people including: coworkers and supervisors, doctors and other medical providers, quality improvement personnel, Medicare, Medicaid and insurance company reviewers, lawyers, social workers, judges and family members just to name a few. Take time to write your notes neatly, specifically and completely.

What should be included in your notes?

Tasks or Services Completed
Observations (change in behavior, condition, medications, etc...)
Daily Measurements, if directed
Safety Issues & Concerns
Client Statements & Complaints
Unusual Events



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Tasks or Services Completed should be documented as directed and could include client log books, time-sheets, communication book, etc... Any changes, such as tasks or services no longer being performed or new tasks or services needed should be documented and reported to the office immediately as it requires a change in the client's care plan. Any refusal of care or "non-compliance" by the client should also be documented.

Observations are the facts and events that you notice as you go about your scheduled shift.

Daily Measurements: you may be asked to document certain information for your client. They may include helping the client weigh themselves, monitor food consumption or urine output.

Safety Issues include any concerns you have about possible fall risk factors or safety hazards in the client's environment. This includes measures you took to ensure a client's safety.

Client Statements & Complaints: Document and report!—in their *exact* words—any pertinent statements your clients make about how they are feeling or incidents that occurred. This may include statements about a recent fall, pain, change in appetite or emotions. Be sure to report complaints. (Again, use the client's exact words.) Complaints PCHS improve client care and/or find new ways to meet a client's needs.

Unusual Events: Report anything out of the ordinary that happens while you are with a client. For example, be sure to document if a client refuses care, if the heat in the client's home doesn't work or if something does not seem "right".

Notify the Agency office as soon as possible, even while you are still at the client's home. If it is information you think may upset your client, call from the car before you leave the client's home.



Remember, even if something goes wrong, such as a fall or an error on your part and you are tempted to hide it—don't. Call the office immediately!

You are not alone.....we are here to support you. Reporting and documenting any accident, error, change or concern is the best way to ensure your client's safety and fast action toward resolution.

The reporting done by caregivers, like yourself, is vital to client care and safety. You spend a lot of time with clients and may be the first person to notice changes in a client's condition. By reporting and documenting your observations, you help your clients receive the best care possible.

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Rule # 1:

Make Sure Your Documentation Is Complete

Complete documentation is thorough and follows your workplace policies. In general, your documentation will be **complete** if you include:

- The correct day of the week, date and time
- The client's correct name, both first and last
- The tasks or services you perform with each client and how the client responds to your care
- Mileage driven for the client and copies of receipts if applicable
- Any changes you notice in a client's condition
- Any care that was refused by the client
- Any phone calls or oral reports you made for the client, or about the client
- Your signature and job title
- Check with your agency about how to complete the specific forms used

Remember...all PCHS documents are legal documents! When you sign your name (or initials) to your documentation and timesheet, you become responsible for the accuracy of that information.

Not Reporting

Not reporting can cause a number of legal problems—especially if a client's file ends up in the hands of a lawyer.

Poor documentation can give the appearance of poor care or neglected orders if documentation is not accurate, detailed and complete.

Poor documentation can cause your workplace to be denied payment for the services you provided to your clients.

When in doubt? Call. Two minutes of clarification can save you and your co-worker hours of work later on if documentation is called into question.



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Rule # 2:

Keep Your Documentation and/or Reporting Consistent

Documentation and reporting is *consistent* when it remains true to:

- The client's care plan and directions given to you by your supervisor
- Physician, nursing and other medical provider orders
- The observations that you and your coworkers have made about the same client
- Your workplace policies found in the Employee Handbook

Your documentation will be *consistent* if you:

- Use workplace-approved terms and abbreviations
- Perform your care according to each client's care plan. If you are unable to follow the care plan on a particular day, document the reason why
- Document in writing and tell your supervisor right away if you notice changes in a client's condition so that your observations can be shared with other members of the health care team

Rule # 3:

Check That Your Documentation Is Legible

Documentation is legible when it can be easily read. Your documentation will be *legible* if you:

- Keep in mind that one of the purposes of documentation is to communicate with coworkers and other agencies who may serve your client
- Do not abbreviate, except for commonly used abbreviations. If you are unsure if another person will know what you are trying to say, use the complete word or consider rephrasing it
- Use a black or blue ballpoint pens only. (The ink from felt tip pens tends to "bleed".) Do not use red ink or pencil
- Watch your handwriting...messy documentation could come back to haunt you. Messy or incorrect dates, times or documentation can affect things such as your paycheck, invoicing, coordination of care with other providers and client reimbursement from insurance. If no one but you can read your handwriting, your documentation will not communicate any information
- Remember that sloppy handwriting takes extra time to read and can lead to mistakes in client care



Tip: If your cursive handwriting tends to be hard to read, try printing instead.

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Rule # 4:

Make Sure Your Documentation Is Accurate and Specific

Documentation is accurate when it is true and complete. Your documentation will be *accurate* if you:

- Use appropriate terms and abbreviations that are commonly used
- Use correct spelling and proper English
- Double check that you've written down the correct full client name (both first and last name)
- Handle errors correctly by drawing one line through the mistake and writing the correct information. Never erase, white out or scribble through documented information
- Avoid adding information after the fact and if you need to, make sure to add the date the information was added to the previous note
- Record only the facts...*not* your opinions about those facts. For example, if your client seems dizzy and confused, don't write what you *guess* to be true, like "*Client acts like she's on drugs*". Instead, stick to the facts, like "*Client is unable to stand up without assistance and called me by her mother's name several times*"
- Record what a client tells you by quoting their exact words. For example: If your client says, "*I want my daughter to visit*", don't write their comments in your own words such as "*client misses his daughter*"

Rule # 5:

Finish Your Documentation On Time

Documenting on time means writing information down as it happens and turning in your timesheets or paperwork when it is due. Your documentation will be *on time* if you:

- Write information down immediately. Do not rely on your memory or wait until you have finished your care and leave the clients home. The longer you wait, the more likely you are to forget some of the details. What may not seem important now, can become very important later
- Be sure you make note of exact times on your documentation. Don't guess at the time or put a general time frame like "*Day Shift*"
- Note the time of your arrival and your departure from each client's home on the documentation log as well as your timesheet. Do not fill out your timesheet at the end of the week, but at each visit every time
- Be sure to complete your documentation notes at the time of each visit. Don't wait until the end of the day or week to fill out visit notes on all your clients
- Be sure to meet the deadlines for turning in your timesheets and documentation to the office

Remember: On time completion and submission of documentation and timesheets to the office helps you and PCHS get paid. It is your responsibility as an employee and part of your job description. Failure to complete and turn in documentation and timesheets on time regularly is grounds for disciplinary action and possible termination.

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How To Handle Errors

- If you left out important information, call your Agency as soon as possible. Follow the proper procedure for charting late information. (see rule #5 above)
- Never correct someone else's error. Instead, tell that person that you noticed a mistake in their documentation
- Never try to *erase* an error in your documentation. Using white out or scribbling over your notes is also not acceptable
- Follow the proper procedure for correcting an error in your charting by drawing one line through the error and initialing it. Write "*mistaken entry*" and your initials next to it. Documenting "mistaken entry" is better than writing "error" since someone might think you made an error in *care*—not just in documentation

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- You may be responsible for giving an oral report about a client to your coworkers or another provider. This report may be one-on one with another person or in a group setting such as a team meeting, client care conference or scheduled visit. Complete, accurate, detailed and specific documentation notes will make you more confident and professional when speaking about your client or referencing changes over a period of time
- Some health care organizations use tape recorders or voice mail systems for reporting client care. At this time, PCHS does not use these devices
- Oral reports should be given in a professional manner according to your workplace policy. For example, it's not appropriate to tell your supervisor about a client's problem as they dash off for an appointment. They might forget what you told them and client care could suffer. It is better to ask when it would be a good time to discuss your client's care or even schedule a meeting so the focus can be on you, and your client's needs

You've probably heard this old saying:

**If you didn't write it down,
you didn't do it!**

This is especially true for care workers. When medical records are reviewed—by supervisors, surveyors or attorneys—the only information that counts is what is written.

It's too late to say, "*Oh, I forgot to write that down...but I did it!*" The only acceptable proof that you performed your client care as ordered is to document it as it is done.

Oral reports are not a substitute for writing information down.

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Incident Reports

An incident is an unexpected event that often involves an accident, (e.g., the client falls) or an injury, or other potentially dangerous event. This could be related to your client or yourself. When such events happen, an incident report is needed to document and verify the occurrence. An incident report is a special form on which you describe the event.

If your client has an incident:

- Let your Agency office or supervisor know about the incident as soon as possible. If an injury occurs, make sure the client is safe and free from further harm before calling the office or 911. Once the situation and client are secure, and you have notified your supervisor, complete the incident report, (e.g., some of the client's medications seem to be missing). Do not rely on your memory to fill out the report later
- By reporting incidents when they occur and in detail, it may help identify similar potential dangers to other clients that may be able to be prevented
- Notify your supervisor if there may be other potential related problems to the incident. If your supervisor knows all the details immediately when the incident occurs, they can notify the family and be proactive in identifying and implementing a solution
- Incident report should only be completed by people who actually *witness* an incident. If more than one person witness the incident, each person should complete a *separate* report. Only document the information you personally witnessed, not what other people heard or saw
- If a client is injured in your presence, be sure to document the facts about the situation in your regular daily documentation notes as well

A work related injury for an employee also constitutes an incident report. Immediate notification and an incident report must be filled out if you injure yourself on the job or witness a coworker injure themselves while they are on the job.

If you have an incident:

- Let your Agency office or supervisor know about the incident as soon as possible. If an injury occurs, make sure you or your coworker are safe and free from further harm before calling the office or 911. Once the situation and persons are secure, and you have notified your supervisor, immediately and completely fill out the incident report. Do not rely on your memory to fill out the report later
- By reporting incidents when they occur and in detail, it may help identify similar potential dangers to coworkers that may be able to be prevented
- Notify your supervisor if there may be other potential related problems to the incident. If your supervisor knows all the details immediately when the incident occurs, they can be prepared to cover your shift if you are not able to work and can be proactive in identifying and implementing a solution
- Incident report should only be completed by people who actually *experience or witness* an incident. If more than one person witness the incident, each person should complete a *separate* report. Only document the information you personally witnessed, not what other people heard or saw

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When Documenting, DO:

- Stick to the facts
- Remain brief and to the point. However, too much information is better than too little information
- Be specific and detailed
- Sign or initial all notes
- Avoid documenting the same information about a client day after day. Doing this makes it seem like you aren't really paying attention to your client and just going through the motions
- Observe each client carefully and document even small changes
- Include each client's full name in your documentation since there may be two clients with the same first or last name
- If you document a change in a client's condition, be sure to write what you did about it. For example, if you document "*Mr. Johnson fell yesterday, while he was alone*", you should also document that you notified your Agency office or supervisor. You might write "*Notified Lisa at the PCHS office by phone, about the fall. She said she will talk to the family and doctor and get back to me.*"
- If you leave a voicemail message for a supervisor or any person related to your client, document the time, date, person and telephone number you called. This proves that you did your part



When Documenting, DON'T:

- Criticize the care given by any of your coworkers or other providers. Avoid writing about workplace problems or frustrations. They should be reported to your supervisor
- Chart for someone else or write down what someone else tells you about a client
- Document a task that you did not do!
- Write with a pencil or red ink...always use black or blue ink
- Use two different colors of ink for the same entry. Someone might think you came back later to correct your initial charting
- Use language that sounds like you have negative feelings about a client. For example, instead of writing "*client is drunk*", stick to the facts by writing "*client's breath smells of alcohol and he is slurring his words*"
- Remove pages from a client's care plan book, unless instructed by your supervisor to do so. Under certain circumstances, you may need to fax or bring in documentation logs in order to have a copy placed in the client's office file. Documentation logs and care plans are permanent legal documents to remain in client's home
- Mention the name of one client in another client's chart. Keep all records confidential
- Document your client care ahead of time—even if it never seems to change from day to day

