GuideOne
Risk Resources for Health Care

DOCUMENTATION

Complete and proper medical record documentation is important because it permanently reflects that the nursing care being provided meets professional standards by noting the progression of services, care, and monitoring provided to residents. In addition, it serves as a primary communication format to direct and coordinate services between the numerous professionals involved with the resident's care. The assisted living facility'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 nurses with in-service training on the importance of the medical 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 residents consistently reflects clinical observations, nursing interventions, resident response to nursing care, and appropriate periodic re-evaluation following the incident.
Never reference incident reports in a resident's medical 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, alteration of treatments and/or roommate/room change regarding the resident.
Document and keep all resident appointments in the resident's record.
Send a physician consultation form with each resident to appointments in order to obtain recommended care and treatment information, based upon the physician's assessment.
When this form is returned with the resident, immediately transfer information to the resident's record and service plan, if indicated.

Immediately notify the resident's physician of any abnormal test results and the date, time, and to whom results were given. Document identification of the staff member relaying the results in the resident's record.
If a resident is refusing medication, hygiene, food, or other care, take measures ASAP to inform the resident and/or the resident's power of attorney for healthcare decisions (if the resident is unable to make his or her own decisions) of the risks involved with the refusal(s).
To protect the facility against liability, formally document the exchange of this information with a signature obtained from the resident and/or the individual with power of attorney for healthcare decisions.

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