GuideOne
Risk Resources for Health Care

TOP 10 TIPS FOR DEFENSIVE DOCUMENTATION

One of the biggest indicators for a facility to defend itself can be found in the level of its documentation. This is as true in a state survey situation as it is in a courtroom.

The term "defensive documentation" refers to a thoroughly accurate accounting of the circumstances surrounding a resident issue. It's documentation that's undertaken with the sensitivity that individuals on the outside may be reviewing the records looking for fault at a later date.

Here are 10 tips to assist your staff in documenting more defensively:

1. Have a purpose for your entry. (That is, think about what you want to say before you say it);
2. Be descriptive, concise, and precise;
3. Don't leave problems from a previous shift unaddressed;
4. Don't leave the reader in suspense and wondering what happened;
5. Describe resident responses and reactions to therapy and medication changes;
6. Avoid "labeling" terms (such as "difficult resident…problem behaviors…combative"); and describe behaviors instead;
7. Avoid vague terms (such as "will monitor…observe…follow-up"); and describe what you did instead;
8. Include your signature, date, and time on all entries so the reader understands the timing of the sequence of events;
9. Ensure that entries correspond with the resident's care plan as much as possible; and
10. Use legible handwriting, dark ink, and never skip lines.

Good documentation is worth its weight in gold. It means safer care for your residents and a sounder defense for you if a lawsuit or survey issue should arise.

Periodically, GuideOne conducts a two-hour "Defensive Documentation" seminar designed to enhance documentation skills. To find the dates and locations nearest you, or to inquire about how you can become a sponsor, please send an email to info@goriskresources.com.

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