Risk Management Considerations for Staff Communication & Documentation

When dealing with special needs clients, it is imperative that staff communicate and document on a regular basis. Open communication and accurate records can help mitigate the chance of high risk incidents and inappropriate behaviors going un-checked.

Example A:

Scenario: A client of a residential facility repeatedly drank in excess and then operated his scooter (which he uses to help with mobility). Various staff members witnessed the drinking and driving exercise, however, no one had documented it. Because it was not documented, each staff member thought they were seeing for the first time and decided to let it go rather than reprimand the client.

In one particular instance where the client had been drinking, he used his scooter to return to his room and ran into another client and broke her hip in the hallway.

The family of the injured client is pursuing a claim against the residential facility alleging that staff were well aware of the impaired driving and should have taken the proper steps to ensure it never happened again.

Example B:

Scenario: A disability support organization contracted some of their care services out to a third party company. One of the third party workers got a resident ready for her daily walk. It was not documented, nor communicated to the worker that the client was not allowed to walk around the grounds unsupervised.

During her walk alone, the woman fell on a trip ledge and was injured. It was alleged that the trauma experienced from the fall accelerated her Alzheimer's progression.

Communication and Documentation

It is important for all staff to document and communicate on patient status, progress and specifics on a regular basis. Documentation is not only effective in providing exceptional care and safety, it is key in any litigation.

Remember to Document:

1. The Date

- Use a consistent format
- This may seem irrelevant or petty until you try to decipher 01/02/06. What digits represent the month, date and year? What if another staff member documents their files differently?

2. Corrections

- Never destroy or use white out on corrections
- Initial all changes

3. Good Practices

- Always retain the original document
- Never document work that has not yet been done
- Never complete someone else's documentation

4. Time

- Use a consistent format - military or standard?

5. Abbreviations

- Use industry standards or avoid using them altogether
- The medical community is moving away from using abbreviations

6. Consistency

- Every staff member must use the same form and document in the same manner
- Consistency is crucial

7. Review

- Review staff documents to ensure they are following consistent standards and methods

intact public entities