HOME CARE BRIEFING®

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Home Care Documentation: A Checklist of Essentials

Comprehensive documentation is an essential risk management strategy for home health providers. A well-designed client care record performs a wide range of functions, including the following:

- **Conveying clients' medical histories,** individual care needs and personal healthcare experiences.
- **Facilitating communication and coordination of care** among caregivers, physicians and family members.
- **Verifying adherence to the standard of care** and organizational protocols.
- **Demonstrating regulatory compliance** during audits or in the event of litigation.
- **Documenting care and services provided,** thus supporting the reimbursement process and minimizing exposure to allegations of inadequate care and billing fraud.
- **Providing necessary data** for quality review and performance improvement efforts.

In short, a detailed and accurate care record chronicling client interactions, improvements and outcomes not only enhances continuity of care, it also serves as critical evidence of services rendered for payment and regulatory purposes. In the event of an untoward event and subsequent legal action, objective and contemporaneous documentation of assessment findings and care often serves as the primary means of defense. This edition of *Home Care Briefing®* offers a self-assessment checklist intended to assist home health providers improve their documentation practices and avoid common lapses and omissions. While some elements of the checklist are universal to all home care providers, the tool primarily addresses documentation requirements for providers who are licensed and certified to deliver skilled care, as opposed to personal care.

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DOCUMENTATION CHECKLIST

The following self-assessment tool is designed to help home healthcare organizations reduce risk and strengthen legal defensibility by ensuring that documentation clearly reflects caregivers' ongoing attention to client clinical needs, safety and well-being. The list can serve as the basis for proactive self-assessment, revealing potential documentation deficits that can be addressed prior to regulatory audits. (Of note, a review of documentation requirements needed to satisfy billing- and compliance-related regulations is beyond the scope of this checklist.)

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DOCUMENTATION ELEMENTS	PRESENT YES/NO	COMMENTS
CLIENT SCREENING *Does the client care record indicate …*		
Basic medical and non-medical needs, including skilled nursing care and assistance performing activities of daily living?		
Medical and cognitive status, including medical and psychological diagnoses, allergies, presence and stage of Alzheimer's disease/ dementia, behavioral patterns and incidents, recent surgeries/ hospitalizations, presence of indwelling devices, standing physician orders, ability to comprehend information and instructions, and existence and level of pain?		
Fall risk and history, including near falls and falls that did not result in injury?		
Physical limitations, including limits on activities of daily living; bladder and/or bowel incontinence; toileting assistance requirements; ambulation/transfer needs; assistive devices used; weaknesses in the extremities; and deficits to vision, hearing or speech?		
Medications, including current drug regimen, self-administration abilities and assistance needs, and requirements for medication monitoring?		
Skin integrity, including description of wounds or other skin-related issues, as well as notation of any specific wound care needs?		
Nutritional requirements, including prescribed or special diets, feeding abilities and assistance needs, presence of feeding tubes and associated care requirements, and meal planning and preparation directives?		
Home safety, including fire prevention and response, fall risk identification and action plans, and modifications made to enhance the safety of the client and/or caregiver?		
Medical instructions, including existence of durable power of attorney for healthcare, advance healthcare directive, physician's order for life-sustaining treatment and/or conservatorship papers?		
ASSESSMENTS AND REASSESSMENTS *Does the client care record indicate …*		
A face-to-face home visit, addressing both medical and non-medical needs?		
Verification of suitability for home care and/or personal care services?		
Home environment limitations and related concerns regarding safety and well-being?		
Imminent need for palliative/end of life care or other major changes in level of care, if applicable?		
Reassessment every six months, or when the client's condition or needs change?		
A dated, timed and signed reassessment by an approved provider?		
Risk for hospitalization and falls, as well as presence of …		
- Pressure sores or other wounds?		
- Chronic medical conditions?		
- Mental impairments?		
- Functional deficiencies, including incontinence?		

DOCUMENTATION ELEMENTS	PRESENT YES/NO	COMMENTS
INDIVIDUALIZED CARE PLANS *Does the client care record indicate …*		
Goals and objectives developed in collaboration with the client and family?		
Specific clinical interventions and services required to improve client's quality of life?		
Services to be provided to address medical and non-medical needs?		
Supplies and equipment required to support medical and non-medical needs?		
Client monitoring guidelines, including frequency of visits?		
Name and contact information for person designated by client to assist with healthcare decision making?		
Safety measures implemented to protect against injury?		
Start of care date, formally documented and verified by signature?		
Appropriate authentication of all entries by the provider, including date, time and signature?		
Diagnoses and medical status, as well as the following medical and care-related information:		
- Nutritional requirements?		
- Ongoing medications and treatments?		
- Therapy services scheduled?		
- Prognosis?		
- Potential for rehabilitation?		
- Functional limitations?		
CLIENT'S CLINICAL STATUS *Does the client care record indicate …*		
A documented evaluation at every visit, including any observed deficits or problems?		
A detailed description of the client's condition, medical and non-medical?		
Interventions performed and client response?		
Variations from expected outcomes of care and/or treatment, including medications, procedures and protocols?		
Reasons for the variations and actions implemented in response?		
Notification of physician and family of variations to medication regimen, procedures and protocols?		
COMMUNICATION WITH PHYSICIANS AND OTHER CARE PROVIDERS *Does the client care record indicate …*		
Notification of physician regarding any changes in condition?		
Receipt of physician orders and their implementation?		
Discussions with physical therapists and other care providers?		
Non-medical referrals, including social services referrals?		

DOCUMENTATION ELEMENTS	PRESENT YES/NO	COMMENTS
COMMUNICATION WITH CLIENT AND FAMILY *Does the client care record indicate …*		
Notification of client/family regarding any changes in condition?		
Instructions provided to client and family regarding procedures, medications, transfer techniques and safety procedures?		
Caregiver absences, detailing provisions made to cover care and client's response to or refusal of substitute caregiver?		
Overall success in meeting client needs and expectations, including steps taken to discharge or transfer clients who are dissatisfied or whose needs cannot be met by caregiver?		
REFUSAL OF CARE *In the event a client refuses required care or services, does the client care record indicate …*		
Objective documentation of refusal of care and subsequent actions taken to inform client and/or family of potential consequences of refusal?		
Notification of physician, as well as family?		
Documentation of discussions with client about potential ramifications of refusing care, medications and/or treatment?		
Monitoring for changes in condition related to the client's refusal of care?		
UNUSUAL OCCURRENCES OR INCIDENTS *In the event of adverse or unexpected events, does the client care record indicate …*		
Falls, skin breakdown or other serious incidents?		
Behavioral situations, including violence or aggression on the part of the client and/or a family member?		
Changes in client's normal schedule, behavior or demeanor?		
Refusal to take prescribed medications or follow indicated therapies?		

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