Documentation of Client Files and Processes

As with any and all healthcare practice, through and complete documentation of files is a must! When a claim comes to the forefront, client files/documentation become a crucial factor and can plan a key part in the settlement and findings of any complaint/claim.

With any complete patient file the consent form should be the most specific form and always be part of a client's file. This form should be fully detailed to include items such as: treatment plan, assessment of the client, suggested visits/timeframe for recovery, recommendations and home treatment if required. This form should be discussed and reviewed with the client direct to ensure everyone is on the same page and in full understanding and agreement. It should include a legible signature/date by the client confirming accuracy and understanding of the overall program. Clients that sign should be of legal age and fluent in reading and writing English or the language of the form.

Updates to the patient file should be made after each visit/consultation and include responses of the treatment by the client. Notes should be legible and complete.

Files should always be properly and fully documented to ensure that if pulled in a claims scenario it can provide a full picture of the treatments and progress of each visit. Date and time stamps prove to be beneficial noted in file particularly when reference or complaints arise that are specific to times or treatments. When a claim occurs it is typically between the client and the provider and proper documentation can provide extensive insight to specific accusations of a claim and may clear or add crucial information to dismiss or discredit same.

Continual extensive documentation of files and a best practices standard maintained by an individual professional will prove supportive in any claims scenario. A constant regime of information filing, date stamping and consistent formatting of notes will assist a practitioner if a referral to a discipline committee is put forward.

In any claims situation, the ability to provide fully complete and well executed records detailing procedures and practices will prove favorable and assist in quicker and easier resolution.

Remember, your file documentation may prove to be the most important part of your defense. As a standard practice when documenting files for any reason treat your entry as if it will be used in the subject of a claim.