

Do's and Don'ts of Documentation

Dos	Don'ts
Use ink for all recorded entries.	Do not use pencil.
Record a client's reference to intent to cause bodily harm to self or another. Consult with your supervisor for guidelines on proceeding under the confidentiality policy.	Under the law, you are not required to record a client's reference to future criminal behavior that does not indicate bodily harm to a third party.
Be specific and objective in the way you record events and client responses. Document facts and concrete observations.	Do not document speculations, judgments, or characterizations of conduct or behavior.
Keep documentation current and complete enough so that another staff member can pick up your file and appropriately assist the client.	Avoid subjective words (i.e., house was dirty) when describing persons or situations. Try to use objective descriptive language.
Always give the source of information (e.g., was provided by client, a client's relative, other service providers, etc.) and attribute statement to the person who made them.	Do not make an informal diagnosis of a client's condition (i.e., client seems psychotic, client seems schizophrenic).
	Do not keep a second personal set of notes about a client. If you receive a subpoena, those personal notes will need to be produced.
	Never dispose of anything after a subpoena has been served or if you are aware that one might be served.
	Never alter or falsify records, add or change a record at a later date, re-write an old record, or change another person's records or notes.