

CareCertify LLC

Adult Day Services Training Series

ADS-10

Documentation & Reporting

Participant Guide

Adult Day Services Training Series · Audience: Direct-Contact Staff · Volunteers · Subcontractors · Aides · CE Hours: 1.0

Records Keep Participants Safe

Documentation is where care becomes visible and accountable. It keeps the team coordinated, demonstrates the care and supervision participants received, supports the center's compliance, and is a legal record. For practical and legal purposes, undocumented care didn't happen.

This guide covers what to document, how to write it well, incident reporting, and confidentiality. Combined with the observation skills from earlier lessons, good documentation is how your front-line work protects participants.

Learning Objectives — by the end of this module you will be able to:

- Explain why documentation matters
- Identify what to document in adult day services
- Distinguish objective from subjective information
- Complete incident and injury reports
- Protect confidentiality and communicate with the team

Section 1: Why Documentation Matters

Documentation coordinates the team and supports continuity of care, demonstrates the care and supervision participants received, supports the center's compliance with the rules, and is a legal record. For practical and legal purposes, care that isn't documented didn't happen — which is why doing it accurately matters.

Section 2: What to Document in Adult Day Services

Document the things that keep participants safe and the center accountable: attendance (arrival and departure, who is present — important for emergencies), care and assistance given (including medications and meals), activities and participation, changes and observations about a participant's condition or behavior, and incidents. Follow your center's documentation requirements and forms.

Section 3: Objective vs. Subjective Information

Objective information is what you directly observe — a limp, half a meal eaten, a reddened area. Subjective information is what the participant reports — pain, nausea, sadness. Both matter; when documenting subjective information, attribute it ('participant states...'). Keep records factual and avoid opinions, labels, or guesses.

Section 4: Incident and Injury Reporting

Document and report incidents — falls, injuries, behavioral events, and near-misses — per your center's policy, even when they seem minor. Describe objectively what happened, the participant's condition, and what you did. Notify the nurse or supervisor and complete required incident reports. Remember that suspected maltreatment is reported to MAARC (ADS-02). Incident reports protect participants and help prevent the next event.

Even minor incidents matter

A 'minor' stumble can reveal a fall risk. Reporting and documenting incidents, including near-misses, helps the team prevent the next one.

Section 5: Writing Good Documentation

Good documentation is accurate, objective, timely, complete, legible, and signed. Record what actually happened promptly rather than from memory later, be specific, and attribute the participant's words. Never chart care before it happens or document something you didn't do. Correct errors the proper way per policy — never erase, backdate, or falsify.

Section 6: Confidentiality of Records

Participant records and information are private. Share only with those who need it for care and per center policy, protect documents and devices, and never discuss participants in public or on social media. Confidentiality is part of participants' rights and your professional duty, and it applies to the records you create as well as to conversations.

Section 7: Records as Legal Documents

Adult day services records are legal documents that can be reviewed by the team, DHS licensors, families, and courts. Accuracy and honesty protect participants, you, and the center. The center must maintain required records to comply with the rules, and your documentation is part of that compliance — which is why it's done carefully, not as an afterthought.

Section 8: Communicating With the Team and Families

Documentation works best paired with good communication. Report changes and concerns to the nurse or supervisor promptly, hand off clearly at the end of the day, and communicate appropriately with families within confidentiality rules. When your accurate records and clear communication reach the right person at the right time, your observations turn into action that keeps participants safe.

Key Terms

Term	What it means
Objective information	What you directly observe.
Subjective information	What the participant reports (pain, nausea, mood).
Incident report	A record of a fall, injury, behavioral event, or near-miss.

Near-miss	An event that could have caused harm; reporting helps prevent harm.
Confidentiality	Keeping participant information private and shared only as needed.
Legal document	A record that can be reviewed by licensors, families, or courts.

Check Your Understanding

1. Name three things you should document in adult day services.
2. What is the difference between objective and subjective information?
3. Why report even minor incidents and near-misses?
4. How should documentation errors be corrected?
5. Why are participant records considered legal documents?

What's Next

Looking ahead

This completes the Adult Day Services course. Keep each lesson's completion record on file, and pair these with your center's required drills and competency checks.