GENERAL DOCUMENATION (August)

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Guidelines for Documentation

Contact logs and progress notes are very important documentation. They record progress toward goals and are imperative for the consistency and continuity of the supports we provide. They also serve as a mechanism for the CCB to ensure that the services have been provided by the authorized service provider.

General Notes:

- Your notes must be readable. Handwritten notes are not an acceptable format.

- Your language must always be professional. Reflect how you would feel if you read about yourself what you are writing. In other words, Please be respectful.

- Use your progress notes to track behavioral information and service plan goals. Always write down your observations. This information should be descriptive and answer the questions: what? where? and how?. Remember, the person reading your notes wasn't there. You have to be their eyes and ears. For example, if you say someone had a "behavior" you know what that means to you, but who know what that means to the reader.

- Use descriptions that do just that... describe. An example: a new provider person starts working with someone. In his service plan, it says he likes "woodworking". What does that really mean? We owe it to those we serve not to put them in situation after situation where they have to continually repeat themselves to new team member.

When, Who, How to Document:

- Entries must be made for each contact related to a client's case the same day the contact takes place. Use the contact log in the client's digital file to record contact, sign document in order to create a permanent, unchangeable document with a date stamp.
    - Examples of client contact, emails to case managers, phone calls to client or family, communication between providers, etc.

- If you keep files outside of the Theranest digital file, do not use white out, or scribble out documentation. If an error has been made, use one line to mark through the error and initial it.

- Date each item of documentation, include month, date, and year. In Theranest make sure form dates are correct.

- Make sure to always digitally sign all Theranest documents. If sign documents outside of Theranest make sure to print your name next to your signature.

- Use only client ID numbers when including a client in another client's case file. For example, if I am writing and incident report for Bobby, and client Sue was a witness, instead of saying Sue was a witness, you would say client Su.ED.2456 was a witness. This is the same for any documentation, not just incident reports.

- Follow all time lines included in the contract and policy and procedures for documentation.

- Be descriptive and objective in your documentation of the facts rather the subjective or relaying your personal opinions.

- A progress notes needs to be completed after each session, see Theranest documentation for details

- Incident reports: see incident report training, MANE policy and procedure, MANE training, incident report policy and procedure