# DOCUMENTATION REVIEW

## Why Is Documentation Important?

## Documentation provides

An evaluation of the effectiveness of services

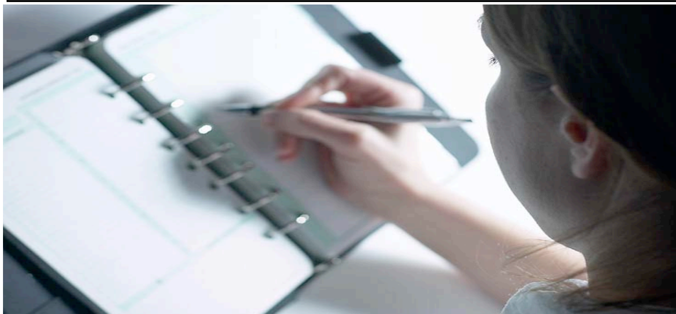
Notes document whether or not an individual is reaching his or her goals. Documentation helps to identify skills, needed resources, areas that need attention, etc.

Proof that services were actually delivered

Accurate and complete documentation is required for state and federal licensing and is required by funding sources. (How we get paid.)

A vehicle for communication of essential information

Vital information needs to pass from shift to shift, from provider to provider, from person to person – documentation



## What to Document

In general the types of things that should be documented include:

- **Goals**- Staff intervention and the person's responses
- **Support** you provide to them (shopping, help w/bathing, money ,ect)
- **Medications** - given/compliance
- **Maladaptive behaviors**
- **Signs and symptoms** of illness
- **Doctor's appointments** – if there are **medication changes** this must be documented in the Life plan progress notes, MAR's
and communication log
- **Sleeping/eating patterns**
- **Interactions** with staff and peers
- **Unusual incidents** (anything that leads to extra medical care or potential harm to the person)
- **Information** regarding the **progress or barriers** for their goals
- New area of **interest or achievement** for the person
- Areas where new **frustrations or problems** have emerged
- **Conversations** regarding the individual and his/her care with people outside of the staff in the home
- **Community events** with staff and family/friends

## How to Document Accurately

## Objectivity is Key!

The purpose of your documentation (daily doc, incident reports, ect) should be clear and the descriptions must be **objective. When** describing a situation, you should **assume that the person reading it does not know the person or the situation** and provide enough detail to clearly explain the following:

→ **who was involved**

→ **what was the sequence of events**

→ **what was said**

→ **what led up to the incident/condition**

→ **when it happened**

→ **what happened**

→ **where it happened**

→ **how it happened**

**Break it down step by step.**

## You *MUST* Make Time for Documentation

Avoiding documentation is easy. **Making time for documentation** is essential. Here are some tips:

**Jot notes during the shift** regarding events or situations that may be appropriate for documentation.

At the end of a long shift it can be tempting to document the most recent events rather than the most important events.

Note: **always document medications and medical treatment immediately** so that no errors in medications are made.

There is **no need to wait until the end of a shift** to begin documentation! While **you should never document an event before** it happens, you can choose to **document important events immediately** after they occur or during the next quiet period of your shift. This way you have time to document completely.

## SOME DEFINITIONS

Progress notes should reflect a **solid understanding of the individual's goals**, **objectives** and **staff interventions**.

**A Goal Is:**
A goal identifies a desired outcome.

**An Objective Is:**
An objective is an **action step** that is taken to reach a goal. Objectives are connected to a timeline and are observable and measurable.

**An Intervention Is:**
An intervention is a **specific action or statement** that a staff person takes to help an individual reach his/her goal(s).

**A Response is:**
What the person does or says in response to your intervention.

**A Progress Note Is:**
A progress note **documents a person's progress** or non-progress in reaching his/her goals. Also notes what you did to support the person.

## More Writing Do's and Don'ts

### Do's

**DO** reflect on the individual in a **positive** manner.
**DO** use **objective descriptions -what did you see and hear** of the individuals observed behavior.
**DO** be **specific** about how you **supported** the person.
**DO** comment on the individual's **level of participation**.
**DO** comment on the individual's **interest and response**.
**DO** be specific about the location including the street name of where the service is being provided.
**DO** document a day's worth of doc on one sheet.
**DO** provide an explanation why a goal was not ran.
**DO** document in all areas of progress notes

### Don'ts

**DON'T use symbols, slang/jargon or abbreviations**.
**DON'T** use notes such as "individual had a good day/month" **unless you include specific behavioral observations.**
**DON'T** use **opinionated remarks** such as "individual was being stubborn; individual is lazy."
**DON'T** write notes such as **"no contact" without explaining why**.

## Yikes, My Notes are Legal Documents!

Most forms of required documentation (like progress notes, incident reports, etc.) are considered a **legal document** and must be done in a manner that follows these **legal guidelines**:

- All entries must include a **date and time including year and am/pm.**
- All entries must be **signed** with a **FULL name** and **FULL title or title abbreviation**.
- **Do not leave blank lines or spaces** between entries in a log.
- **Stick to the facts.** Write what you see and observe, not what you feel or think. In other words, **be objective**.
- **Do not use white out**. If you make a mistake, **draw a single line** through the entry, write "error" and put your initials above or next to it.
- All entries must be **legible.**
- All entries must be in **blue or black ink.**

**Don't forget to keep information about individuals confidential.**