Documentation Guidelines

CMHA-CEI

Training Unit

Reviewed 09/2020

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Course Content

- Value of documentation
- Legal concerns of documentation
- Specific Types of Records
- What must be documented
- Effective Documentation
- How to Report an Incident
- Basic Do's & Don'ts

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Why document?

If it wasn't documented,

it *didn't happen!*

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- Documentation is a way to share information with others who are involved in the care and treatment of an individual.
- Documentation is an essential tool for planning such things as activities and various types of treatment programs.
- Documentation is a method of recording unusual events such as injuries, unusual behaviors, and changes in baseline health or general condition

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- Documentation helps identify if services and treatment plans are effective and if any changes are necessary
- Documentation provides a record of services provided for purposes of maintaining compliance with various regulatory bodies.
- Documentation provides a method of tracking a person's progress and condition over time.
- Documentation provides evidence that treatment is effective.

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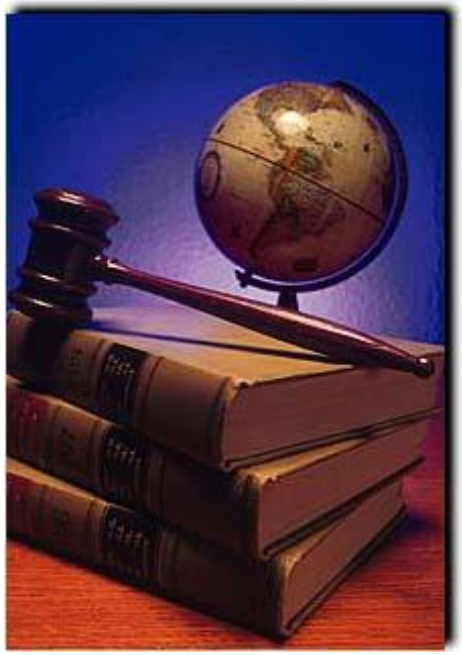
All Records are Legal Documents



- As a caregiver, you must document consumer care accurately.
- If questions arise about the care that was provided, the care and treatment of the consumer will be re-constructed from the record.
- Attorneys will review the record carefully in an attempt to discover any irregularities.
- Regulatory Bodies examine records during audits to determine if an organization is in compliance with their standards.

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List of Regulatory Bodies that audit CMHA-CEI's records

1. Commission on Accreditation of Rehabilitation Facilities (**CARF**)
2. Michigan Department of Community Health (**MDCH**)
3. Occupational Safety & Health Administration (**OSHA**)

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Statutory Mandates that we need to comply with

1. Balanced Budget Act **(BBA)**
2. Health Insurance Portability and Accountability Act **(HIPAA)**
3. Deficit Reduction Act **(DRA)**
4. Michigan Administrative Code **(MI ADMIN CODE)**
5. Code of Federal Regulations **(CFR)**

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Types of Documentation

- Individual Clinical Record
- Residential Record
- Day Program Record
- Medical Records
- Progress Notes
- Incident Report
- House Log

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Individual Clinical Record

- The Individual Clinical Record contains the most comprehensive information about the person receiving services.
- The Individual Clinical Record contains documentation from the person's past, previous placement and services provided.
- The Individual Clinical Record can provide historical data that can provide insights into the current needs of the person.

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Individual Clinical Record

Must include:

- Individual Service plan
  - Person Centered Plan
    - Goals – Things the individual wants in their future
    - Objectives – Time frames for achieving goals
  - Progress Notes
    - Method of communicating a person's preferences
  - Health Information
    - Illnesses
    - Doctor's Orders
    - Medication
  - Unusual Incidents

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Residential Record

- The Residential Record contains information that applies specifically to the residential setting.
- Staff who provide residential services can use the Residential Record to get information to better assist the person they are serving.
- Information contained in the Residential Record includes:
  - Incident Reports
  - Progress notes
  - Medical Records
  - Home Specific Treatment Plans
  - Health Care Information

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Day Program Records

- The Day Program Record contains information that applies specifically to the Day Program setting.
- Staff who provide Day Program services can use the Day Program Record to get information to better assist the person they are serving.
- Information contained in the Day Program Record includes:
  - Incident Reports
  - Progress notes
  - Medical Records
  - Program Specific Treatment Plans
  - Health Care Information

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Information contained in the Residential & Day Program Records can often overlap.

All documentation from the Residential and Day Program Records are merged into the Individual's Clinical Record.

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Medical Records

- The Purpose of Medical Records
  - Provide a variety of information about an individual's history of general health.
  - Help coordinate care across providers and staff
  - Manage chronic health conditions over time
  - Prevent Medication Errors
- Direct Care Staff will often refer to an individual's medical record for information regarding:
  - Current and past medications
  - Specific Health Care Issues
  - How to provide proper care for specific health issues.

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Progress Notes

- Writing progress notes is perhaps the most common documentation activity performed by direct service providers.
- There are two primary functions of a progress note.
  - Documenting Service Delivery
  - Documenting Progress of Treatment
- Both functions of the progress note are essential elements of evidence-based practices.

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Progress Notes

- **Documenting Service Delivery**
  - Progress notes are based on the original treatment plan and goals.
  - Activities are recorded that were planned in advance and linked to the treatment plan.
  - The Date, Time and location the activity took place
- **Documenting Progress of Treatment** requires a few clear statements about the expected goals of the activity.
  - Brief description of the goal
  - Brief description of the outcome
  - Brief description the next step
  - Schedule for next activity

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INCIDENT REPORTING

- What is an incident?
  - "an occurrence that disrupts or adversely affects the course of treatment or care of a consumer."

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Who should fill out an Incident Report?

- An Incident Report needs to be completed when staff either witness or are the first to become aware/informed of an incident involving a CMHA-CEI consumer who is **actively receiving services**.
- For the sake of reporting, a consumer is considered to be actively receiving services when any of the following occur:
  1. A face-to-face intake has occurred and the individual was deemed to be eligible for on-going service, or
  2. CEI has authorized the individual for ongoing service, either through a face-to-face assessment or a telephone screening, or
  3. The individual is currently receiving a screening service in Crisis Services.
  4. The individual has received a non-crisis, non-screening encounter.

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Some examples of incidents that need to be reported.

- **Arrest**
- **Behavioral Event**
  - an event by a consumer that results in serious aggression towards others, serious property damage or serious self-injury.
- **Choking**
- **Death**
- **Emergency Care**
  - For injury or illness which requires an intervention beyond first aid, i.e., urgent care, emergency room visit, or hospitalization.
- **Exposure to Blood / Body Fluids**

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Some examples of incidents that need to be reported.

- **Medication Error/Event:**
  - Any occurrence involving a medication that places a consumer at risk due to a variance in medication processes.
  - You will receive more detailed information in the Basic Health & Medications Class.
- **Missing Recipient**
- **Physical Intervention**
- **Search and Seizure**
  - Search of the person, the person's property or their living space and the removal of said person's belongings
- **Sentinel Event:**
  - An unexpected occurrence to a recipient of services involving death or serious physical or psychological injury, or the risk thereof.

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The House Log

- The House Log provides a means for staff to share helpful updates with each other about each consumer at the end of their shift.
- The House Log is an informal communication method that may include:
  - Activities the consumer engaged in throughout the shift
  - The "type of day" the consumer had
  - Items the incoming staff may need to follow up on for each consumer
  - Any issue the staff will need to be aware of to meet the consumers needs for the new shift.
- Because the House Log is informal, it is important for staff to remember to use good documentation skills and record their information in professional manner.

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SKILLS FOR EFFECTIVE DOCUMENTATION

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- Your documentation skills can have a major effect on the quality of services received by an individual.
- Keep the reader in mind when writing. This person is probably not familiar with the individual you are writing about. Always communicate in a manner that the reader will understand.
- Here are some basic skills that will increase the effectiveness of your documentation

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Be Prompt

- Complete the report as soon as possible. This will produce a more accurate and detailed report.
- According to the Incident Report Procedure, an incident report must be completed by the end of the workday.

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Be Accurate

- Only document what you personally observed.
- Do not document for another staff and sign *their* name.
- Do not document based on "Hear Say" from another staff.
- Use Quotes whenever possible.
- Examples:
  - Right
    - After dinner, Mary complained to me of a stomach ache. She said: "My stomach feels bloated".
  - Wrong
    - Sauerkraut doesn't agree with Mary

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Be Specific

- Avoid using general, vague or subjective terms.
- Use specific, objective, and complete statements in your documentation.
- "Paint" a complete picture for person reading your documentation.
- Examples:
  - Right
    - Before dinner Val set the table without being prompted by staff.
  - Wrong
    - Val likes to help.

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Be Objective

- Describe your observations in a non judgmental manner. Avoid personal opinions.
- Example
  - Right
    - Susan did not make her bed this morning. Her dirty clothes were left on the floor.
  - Wrong
    - Susan is a slob

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Use Measurements

- Avoid words like; “a lot”, “a few” “ a little bit”, etc.
- Instead use amounts that can be measured
- Examples
  - Jane cried for 15 minutes after getting her TB shot
  - Karla ate 12 brownies after dinner
  - Marcia watched TV for 5 hours

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Maintain Confidentiality

- Avoid using one consumer's name in another's report.
- If you must reference another consumer, refer to them by case number, or initials, etc.
- Do not leave physical documents where they are accessible by consumers or unauthorized personnel.

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Maintain Confidentiality

- Only those staff members involved in the care and treatment of the consumer, and/or staff who have a bonafide need to know the information, shall be allowed access to the clinical record.
- All clinical documents will be prepared using consumer case number on each page.
- The clinical record is the property of the facility, and shall not leave the premises, except as permitted by a defined agency procedure.

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Use only Approved Acronyms

- Always use acronyms that have been approved by CMHA-CEI.
- A list of approved acronyms can be located on page 4 of Procedure # 3.2.13A, "Clinical Service Documentation – Physical File"
- This procedure can be found on the CMHA-CEI Intranet by clicking on the following path:
  1. Reference Material
  2. Policies, Procedures, Guidelines, Forms
  3. Procedures
  4. Clinical Procedures

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HOW TO FILE AN INCIDENT REPORT

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CMHA-CEI Incident Web Portal

- All CMHA-CEI staff can access the Incident Report Form through the CEI Incident Web Portal
- The following slides will guide you through this process.

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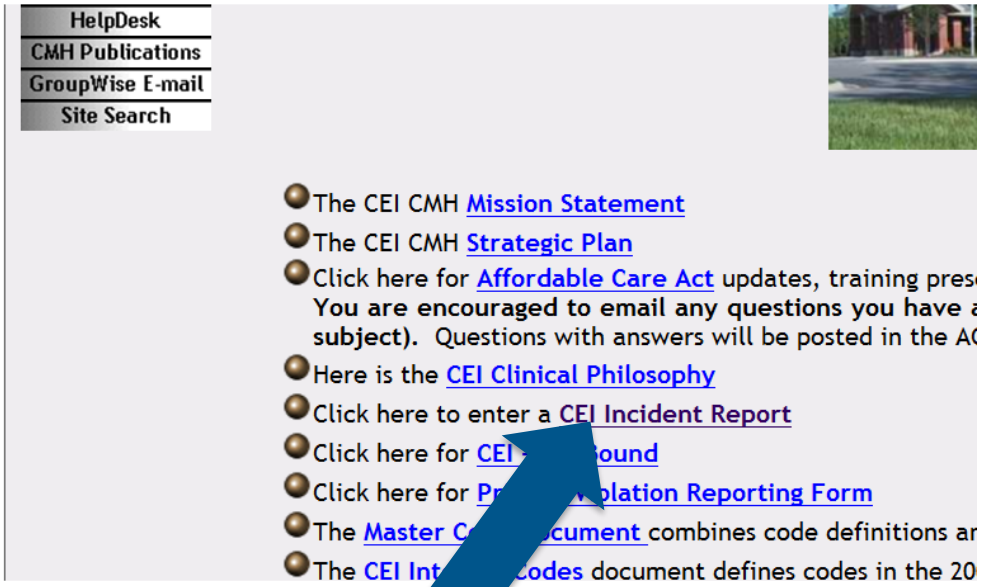
From the CMHA-CEI Intranet home page



- Click on CMHA-CEI Incident Report

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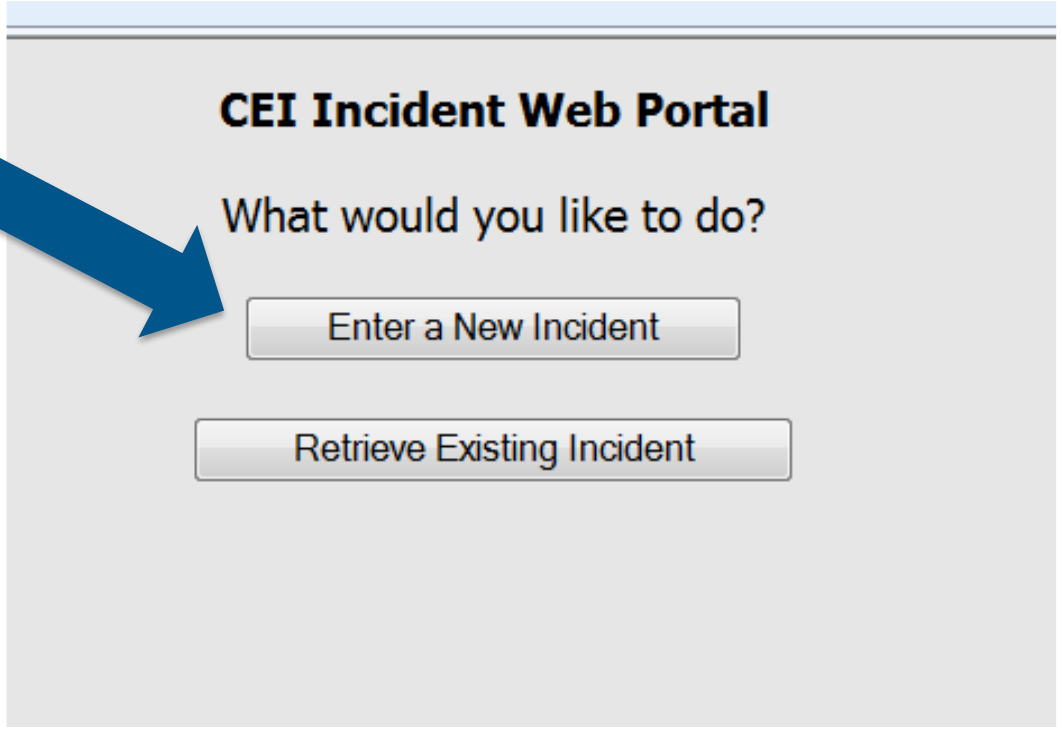
- Click on “Enter a New Incident”



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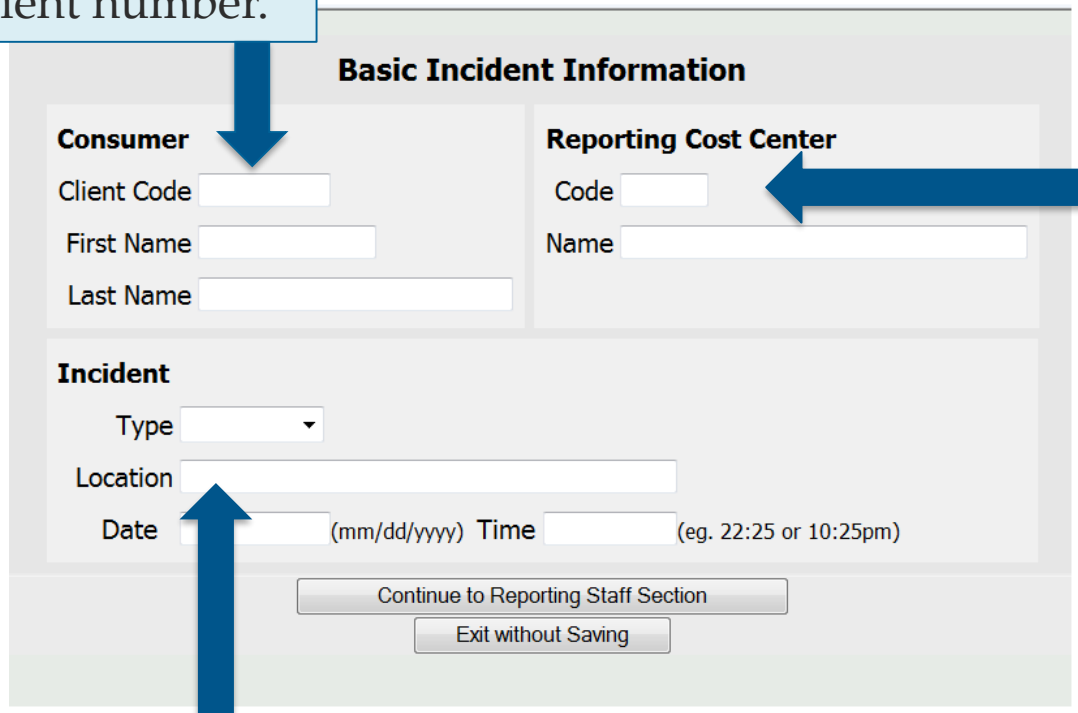
Basic Incident Screen

Captures information common to all incidents

The "**Client Code**" is the consumer's client number.



The "**Cost Center Code**" is the 5 digit code for your home. If you don't know the Cost Center Code for your home, please check with your Home Manager.

It is important to include the location where the event occurred and to note if the consumer was under the supervision of CEI staff at the time of the incident.

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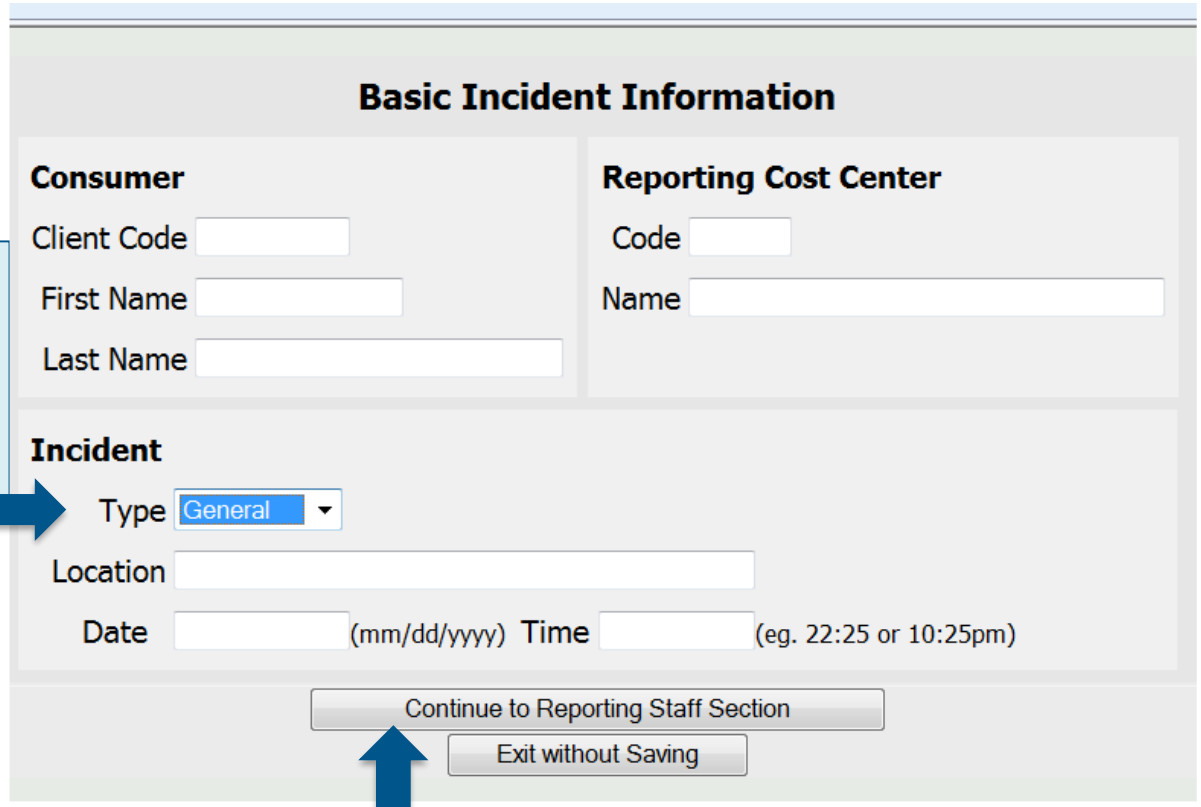
General Incident Report

For an incident that does not involve a medication, select "General" from the drop down menu.



After completing the basic information, select "Continue to Reporting Staff Section"

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General Incident Screen

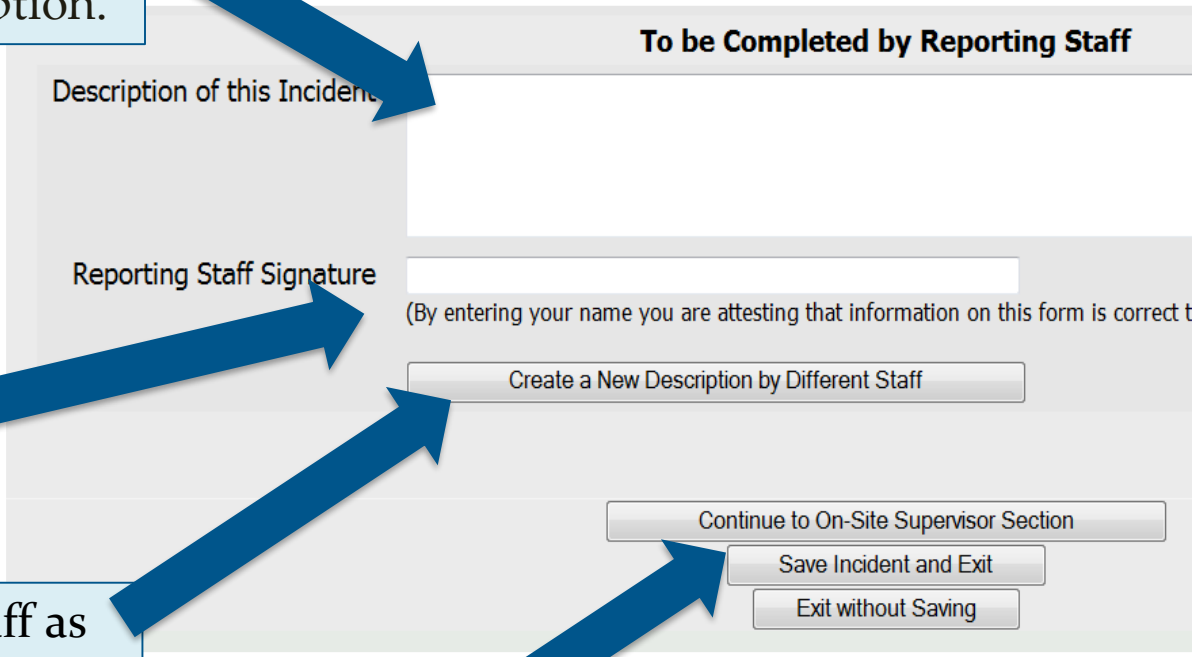
Shows the basic information for this incident and the correct form for a General Incident.

Reporting staff completes the required information and then "signs" the description.

The Reporting Staff signature only requires that a name is typed in the box.

Additional staff as needed can add their descriptions of the event and sign their name as well.

Save and exit after all the information has been completed



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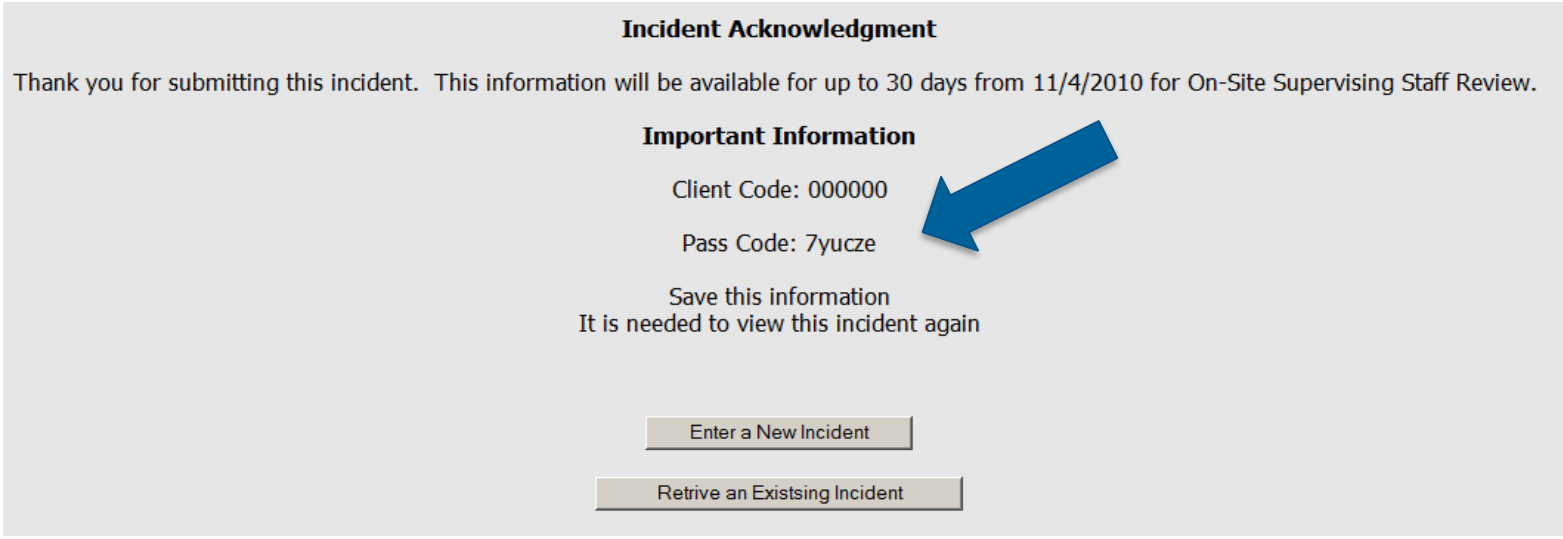
Incident Acknowledgment Screen

- Whenever a user exits from a "save incident", they are taken to a receipt page and the pass code for the incident is displayed.
- It is important to note the Pass Code.
- The One-Site Supervising Staff will need this information to move the Incident Report through the Incident Reporting System.



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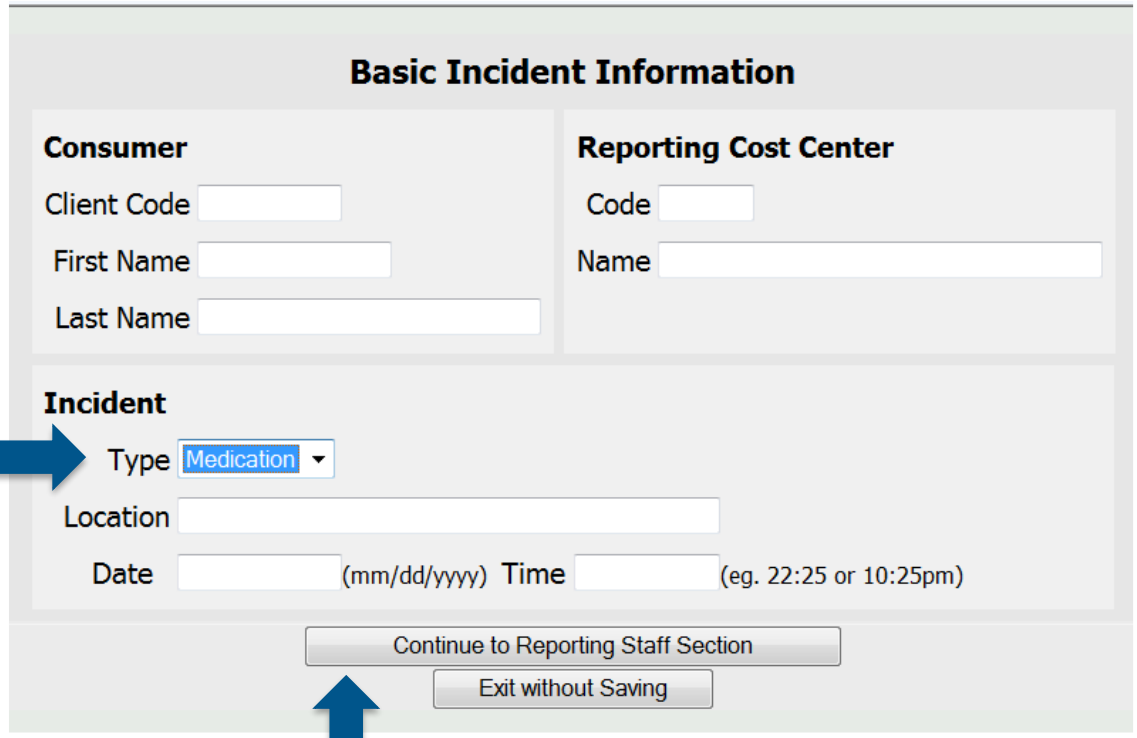
Medication Incident Report

For an incident involving a medication, select "Medication" from the drop down menu.



Click this button to move to the report details

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Medication Report Details

Provide information for each specific medication that applies to the incident

To be Completed by Reporting Staff

Indicate Medications Involved			
Medication(s) in event/error	Med classification *e.g., psycho-tropic, pain, etc.*	Prescribed # of does each day	# doses affected

Add more rows

Add more rows as needed to list all the medications necessary

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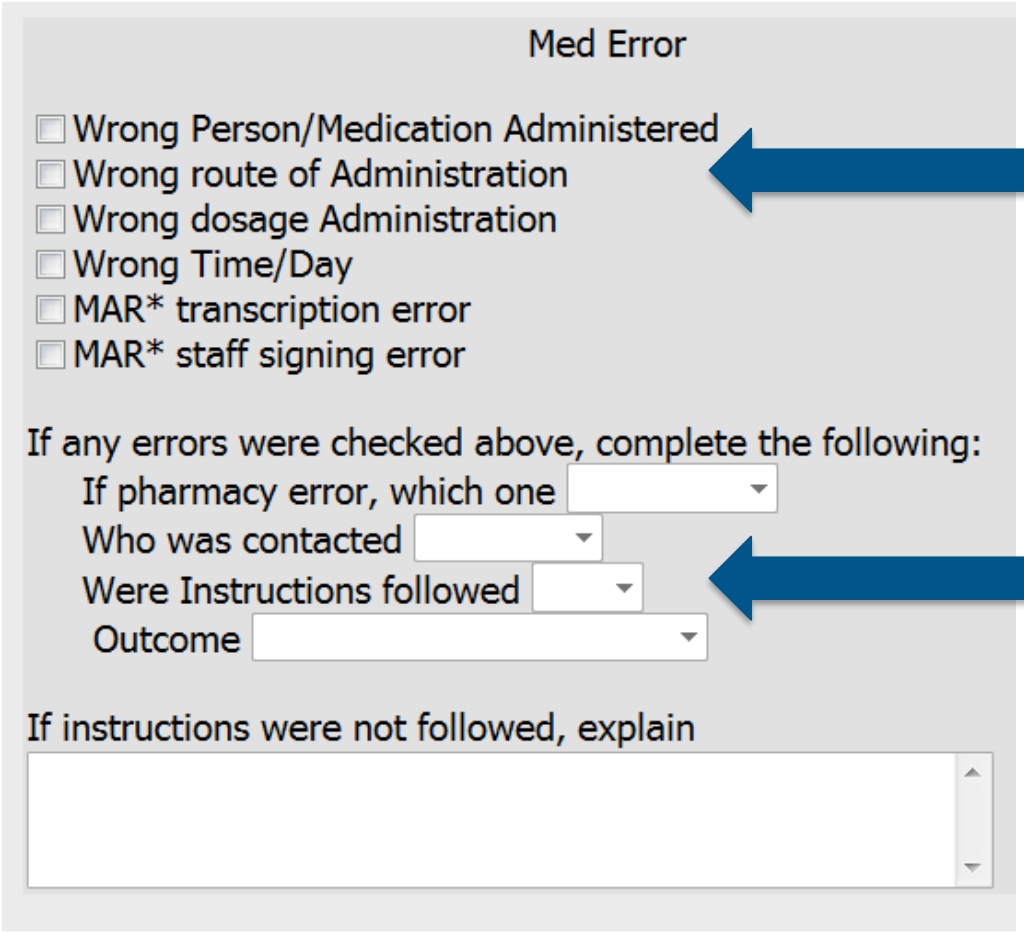
Medication Report Details
Med Errors



If the incident was a Medication Error, check the appropriate box

Use drop down arrows to provide the information that applies

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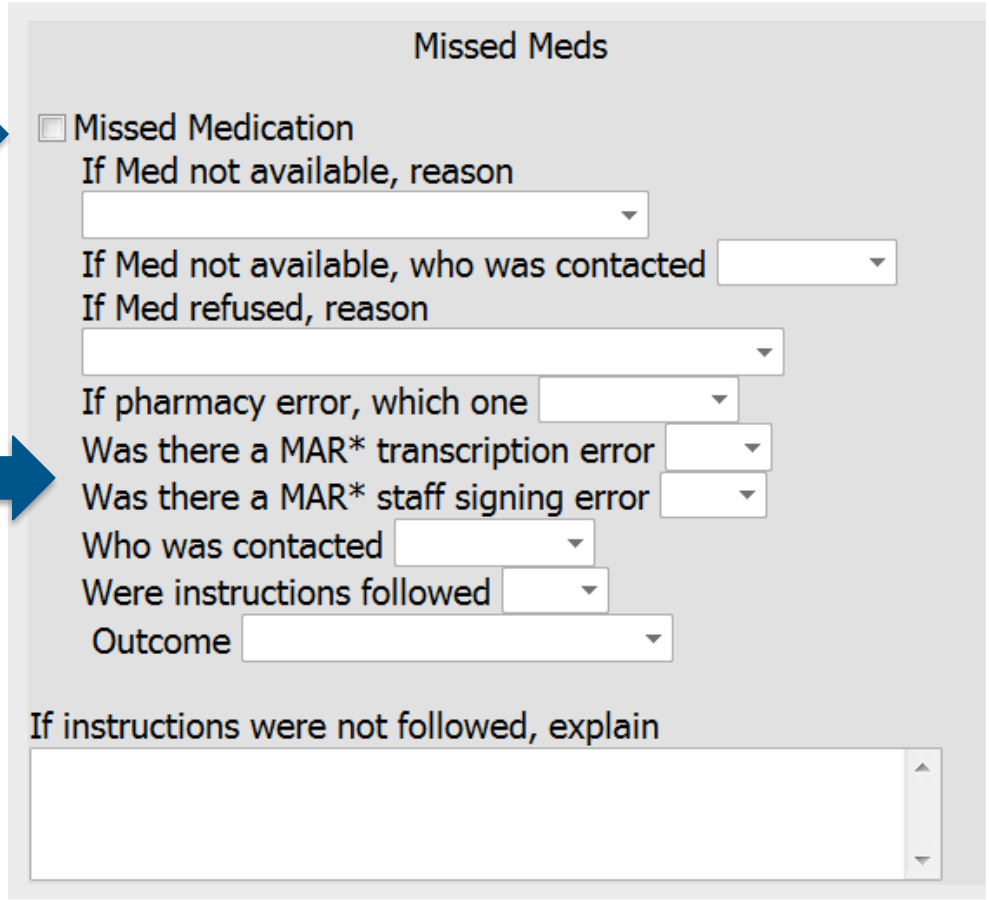
Medication Report Details
Missed Medication

In the case of a Missed Medication, check the box

Use drop down arrows to provide the information that applies



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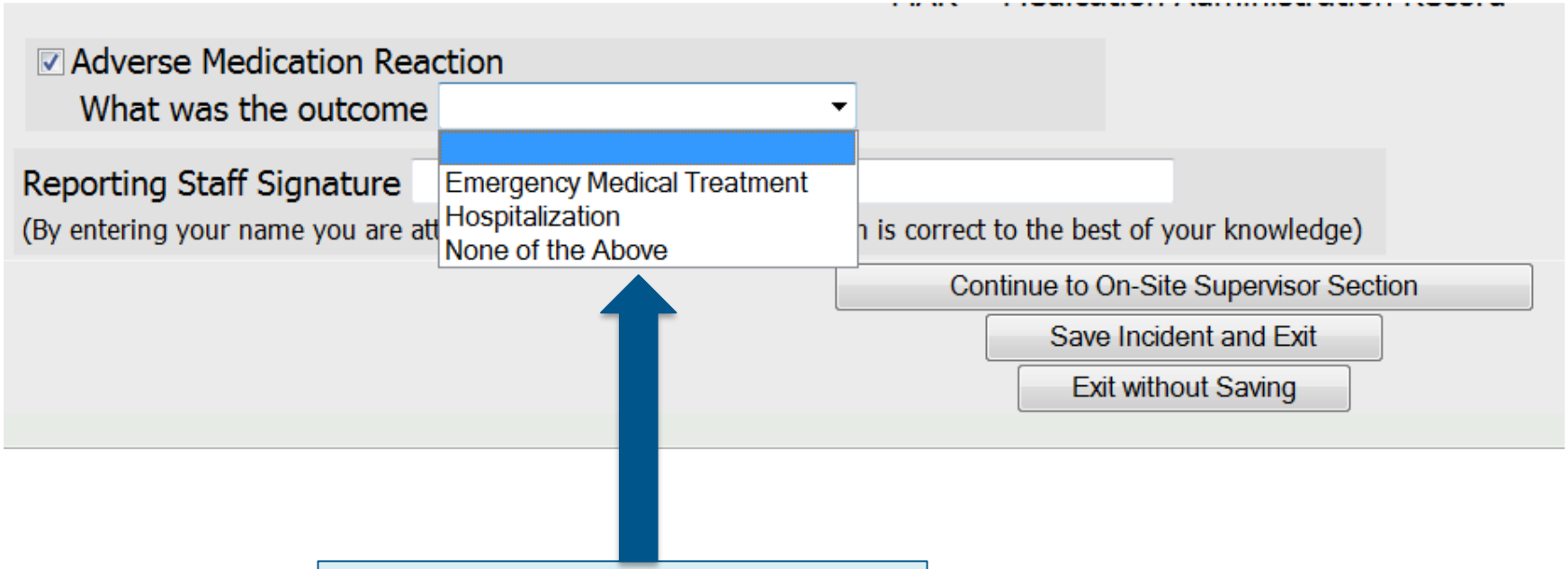
Medication Report Details
Adverse Reaction



If the incident resulted in an Adverse Medication Reaction, use the drop down arrow to indicate the outcome

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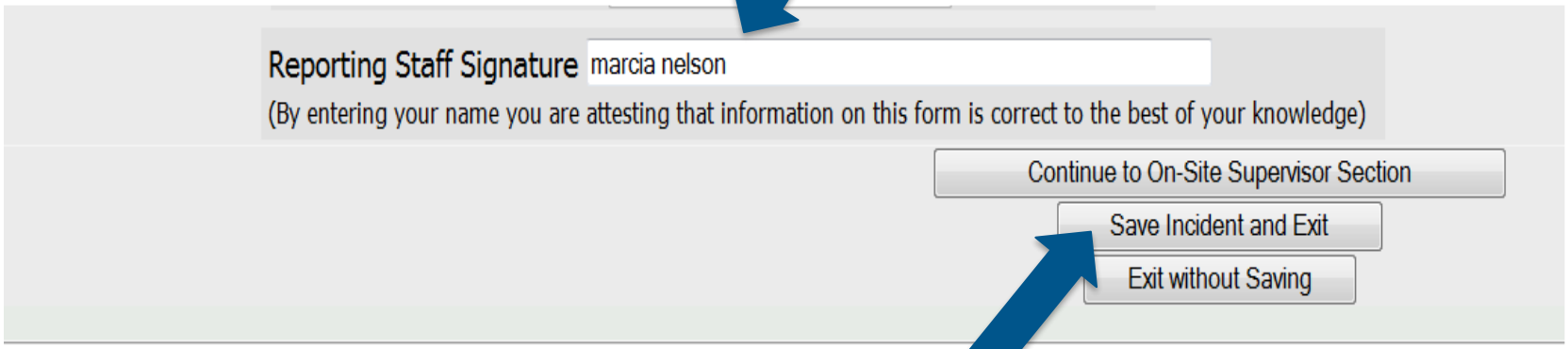
Save and Exit

"Sign" the report by typing in your name



Exit to Incident Acknowledgment Screen and get the Pass code.

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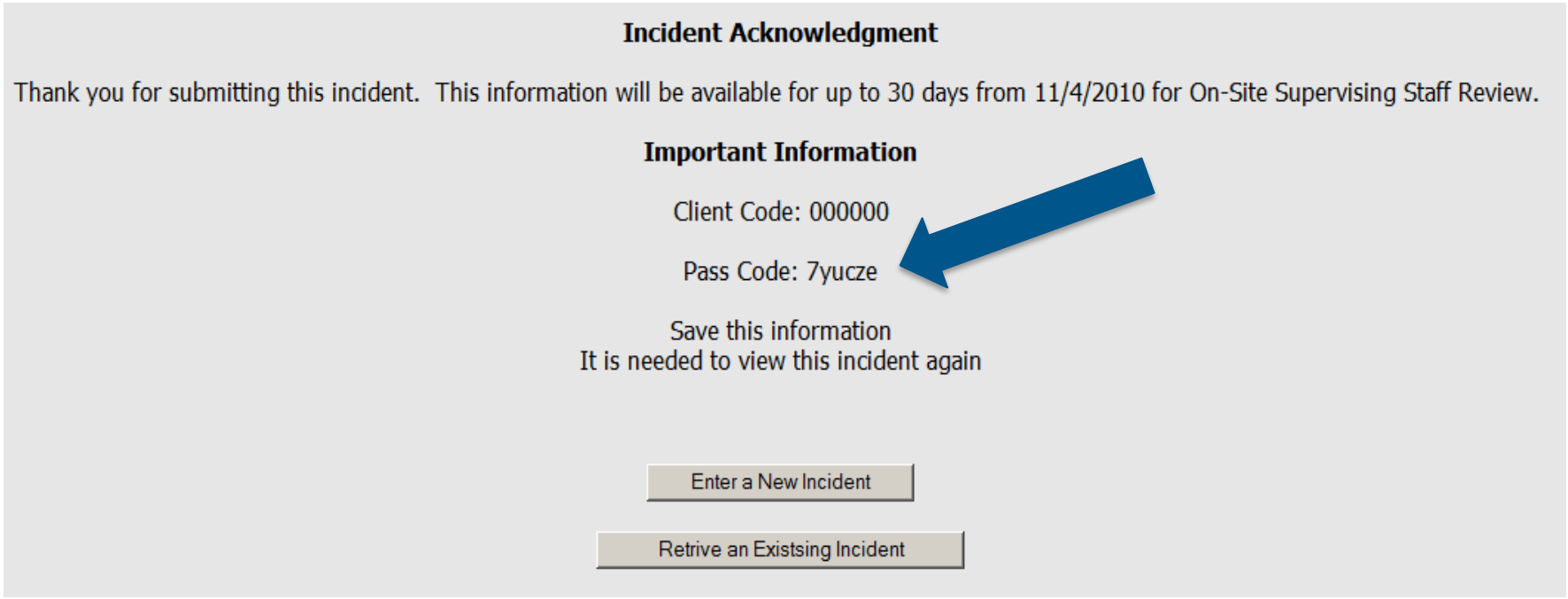
Incident Acknowledgment Screen

Provide your pass code to your supervisor for follow up.



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Guidelines for Handwritten Documentation

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Guidelines for Handwritten Documentation

- **DO'S**

- Describe events in the order they occurred
- Sign first, last name and job title
- Use person's legal name or case #
- Draw a line through unused space between the end of your comments and your signature.
- Write in permanent black Ink
- Write legibly so other can read your writing.

- **DON'Ts**

- Erase, scribble, blot, or white out errors
- Postpone
- Change any record for any reason
- Use one person's full name in another person's record
- Erasable inks, felt-tip pens or pencil are not permitted.

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- No portion of the original document is to be obliterated, erased, altered, or destroyed.
- The only individual who may change an incorrect entry in the record is the individual who originally entered the incorrect information.

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- Falsification of information or tampering with a record is a criminal offense, which is subject to progressive discipline up to and including immediate termination from employment or other legal consequences.

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How to correct an error

- Draw one line through the error. The incorrect information must still be legible. Do not obliterate the error with white-out, or scribble over the writing.
- Designate the entry as an error.
- Initial and date the error.

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Summary

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Documentation plays an important role by:

- Sharing important information to assist staff in providing supports and treatment
- Recording unusual incidents and changes in baseline health and conditions
- Tracking a person's progress over time
- Ensuring treatment is effective and if any changes are necessary
- Provides evidence that our agency is in compliance with Regulatory Bodies and Statutory mandates

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All Records are Legal Documents

- Can be used in a court of law to determine innocence or guilt
- Will be examined during an audit to determine if an organization is in compliance with standards
- Must be kept confidential
- Original documents cannot be obliterated, erased altered or destroyed.
- Falsifying or tampering with a record is a criminal offense.

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Good Documenting Skills

- **Prompt**–completed by the end of the workday
- **Accurate**–personal observations only
- **Specific**–Uses quotes, Complete statements, detailed
- **Objective**–Non-judgmental, avoids personal opinions
- **Measurements**–Uses amounts that can be measured
- **Confidential**–Location inaccessible to other consumers and unauthorized personnel
- **Chronological**-Events should be described in the order they occurred
- **Legible**-Written in permanent black ink so other can read it.

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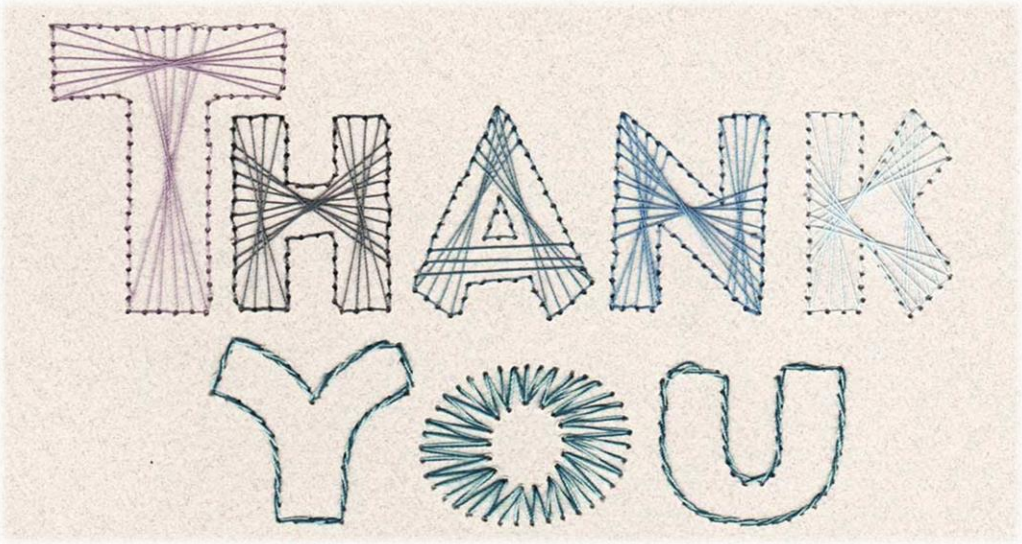

For completing
Documentation Guidelines for
CMHA-CEI Direct Care Staff
training requirement.
You must complete the final exam to receive credit .

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