



Documentation Policy

I. POLICY

It is the policy of this DHS licensed provider, Marshall County Group Homes, Inc. (MCGH) to meet records requirements set in 245 D.0095. MCGH will ensure that the content and format of consumer records, personnel, and program record are uniform and legible.

II. PROCEDURES

Consumer documentation: documented work on a goal, health concerns, social activity, outings/social contacts, any new or unusual behavior and other activity that is not the recipient's normal routine.

T-Logs

T-Logs for recipients are the most appropriate place to note that the plan of care has been evaluated. The T-Logs provide evidence that regular evaluation is taking place. For recipients: document work on goals, health concerns (such as Dr. appointments, health changes, new treatment, medical concerns, etc.), social activity, behavior, and other activity that is not the recipient's normal routine.

T-Logs are an important method of communicating information to all employees. It is also important to remember the issue of confidentiality, being objective and using clear understandable language. Before you start to write think about who is going to be reading the documentation.

T-Logs are not intended to contain long stories about the day-to-day occurrences for a client. Neither should they contain an employee's subjective response to a situation that has occurred. If an employee has a concern or opinion, they should bring it to the attention of the Resident Program Supervisor (RPS). T-Logs should not contain information that is repeated elsewhere such as on a client's care plan, MAR, Physician orders or log, incident/accident, or behavior report, quarterly, semi-annual, annual reports, or other reports completed by MCGH.

T-Logs are where new treatments or strategies for managing the clients day-to-day can be recorded and to flag that the care plan needs to be or has been altered. T-Logs help in maintaining a record of continuity of care and quality of care to the standards that are required by MCGH and the licensing requirements. They reflect client care in a legal document which can be used to protect the organization/employees if there is a claim made against them by the recipient, family, or legal guardian.

When typing T-Logs, you will need to ensure that they are of the highest quality to meet legal and MCGH standards.

*****It is important to keep the following points in mind*****

1. Remember T-Logs are about the client only.
2. These are permanent records and may be required for legal purposes.
3. Your typing should be clear and complete with proper spelling, punctuation, and grammar.
4. Only use approved abbreviations for MCGH. NO TEXT abbreviations.
5. Be accurate, concise, factual, and present the information in a logical order.
6. Do not record your personal subjective opinions.
7. Do not record the options/thoughts of others outside MCGH.
8. Use quotation marks when recording a direct statement from the client.
9. Consider who is going to read the document, why it is being written and what effect it is intended to have.



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10. Write events in order that they happened and as soon as practical after they happen. Please add follow up notes if you are following up on a T-Log that has already been typed up.
11. DO NOT write the names of others in the T-Logs: use staff, housemate, or consumer.
12. No entry concerning a client's care or treatment given should be made on behalf of another employee.