DOCUMENTATION/PERSON FILES

I. Policy: Opportunity Matters will maintain a data file for each person receiving services including all the information required by MN Statutes.

II. Procedure:

A. Required information for each person file:

1. Identifying information which includes date of birth, medications, legal representative, history, medical and other person-specific information, and names and telephone numbers of contacts
2. Person health information, including person medication administration and monitoring information
3. The person's CSSP and CSSP Addendum
4. Copies of assessments, analyses, summaries and recommendations
5. Progress review reports
6. Incidents involving the person
7. Required reports
8. Discharge summary (when applicable)
9. Record of other license holders serving the person that includes a contact person and telephone numbers, services being provided, services that require coordination between two license holders, and name of staff responsible for coordination

B. Required Books:

1. Program Book: Contains data from the outcomes and behavioral observations made on the person.
2. Permanent Book: Contains all information listed in the table of contents.
3. Permanent Medical Book: Information pertaining to any appointment or referrals, current diets or restrictions, record of any illnesses or hospitalizations, vaccines, anything else pertaining to the person's health.
4. Medication Administration Book: Contains record of current medications administered. Side effects information sheet for each medication given. An Over-The-Counter sheet signed by the physician and a chart to collect data for OTC's given.
5. Incident Report Book: Contains current year's reports which include incident reports, EUMR reports and reports from day program/school.
6. PTO/GO and Crisis have variations to these books.

C. Charting Guidelines:

1. All charting done for persons are considered legal documents.
2. Maintain all original records.
3. Each page should contain the name of the person.
4. All entries should be permanent, typewritten or made in blue or black ink.
5. Date and time all entries and end entry with a single line to the end of the page.
6. Authenticate all entries with a signature and job title. Initials may be used as long as there is a legend indicating to whom the initials belong.
7. Use only standard, approved abbreviations.
8. Write legibly.
9. Use correct grammar and spelling.
10. Never erase or use white out
11. To change an inaccurate entry:
    a. Draw a single, thin line through the inaccurate material, making certain it's still legible.
    b. Write "Error" next to the inaccurate material.
    c. Write your initials next to the inaccurate material.
12. All notations should be made as soon as possible after the observation and never before.
13. Describe person conditions/problems with professional terminology.
14. Keep personal feelings and opinions out of the record unless requested.

15. Never make or sign an entry for someone else.
16. Never tamper or change the record with self-serving interest.

D. Documentation
1. Document in the third person, meaning that you refer to yourself as “staff” within the person record.
2. Only the person’s name can be used in their record. If you need to refer to another person, use the term(s) housemate, roommate, or peer.
3. Do not skip lines between entries.
4. Use professional terminology.
5. Document atypical treatment, unusual occurrences, and the reasons for it, corrective steps taken and the follow up.
6. Avoid generalizations, be specific instead. Describe what you witnessed or heard instead of “seemed to be” or “appeared to be”.
7. Don’t draw conclusions, record the facts.
8. Be complete, record everything significant to the person’s condition.
9. Use quotes when appropriate.
10. Use specific time frames rather than vague terms such as “usually, frequently”
11. Read previous entries and follow-up on previously noted problems
12. Display thought processes, especially if it leads to important care decisions.
13. Progress Notes:
    a. Should reflect the person’s response to the care/program or address new problems or symptoms.
    b. Must contain narrative description of what took place during your shift.
    c. Comments on the progress of the person.
    d. Home visit reports and therapeutic leave reports.
    e. Leisure activities reports.
    f. Absences from work.
14. Heath Progress Notes:
    a. Document any illness or injury that occurs during your shift.
    b. Contain specific health or medical problems and treatment given.
    c. Document after medical appointments or when you receive test results.
15. Outcome Sheets:
    a. These are specific to each person.
    b. All outcome sheets include a key indicating how to chart the completion of the objective.
16. Treatment Sheets:
    a. These are specific to each person; they include ADL’s but could also include specific medical cares needed.
17. Leisure Record:
    a. Document all home and community activities the person participates in.
18. Miscellaneous:
    a. Clothing Chart: document what clothing item(s) the person is wearing for the day.
    b. Target Behavior Record: document any target behavior not on an objective sheet, including SIB; document verbal aggression between two persons.
    c. Sleep Log: document the time person is awake during the night.
    d. Other: each person may have individualized charting forms. Directions for how to chart will be listed on the form.