DOCUMENTATION POLICY

Documentation is required to be completed by administrative and supported living staff for various purposes and at various times. It consists of the administrative information required by APD and data collected by staff in the course of working with individuals. Administrative information includes but is not limited to hiring information, forms, management plan, training, and policies. Data collected by staff includes but is not limited to service logs, notes, other information as it pertains to an individual. All information is subject to review by APD, Delmarva, and AHCA and is ultimately used to assist in providing quality services.

Documentation must be completed promptly, accurately, and turned in on time. Documentation may NOT contain scratch outs, scribbles, doodles, white-out, erasures. Documentation must contain language that is objective, clear, concise, and accurate. It should NOT contain personal opinions. Documentation should be objective, accurate, and person-centered. Requirements may change at any time and staff must keep up with new and/or modified requirements.

General Documentation Guidelines

All staff are responsible for accurate, complete, timely documentation.

- Contact Notes (Service Logs)
  Notes are written any time staff have contact with the individual. Not all contact with an individual is billable, but all contact is important, part of a legal record, and could potentially become part of a court proceeding. Notes and contact times must be accurate. Forms for documenting your contact time may change, but:
  - when you should document will not change
    If you talk to a client on the phone, you will document that. If you talk to someone either on the phone or in person on behalf of the client, you will document that. If the client is NOT present when you do something for the client, you will NOT bill for that time, but you WILL document it. If you spend an hour on the phone when the client is not present, for example dealing with social security, you will document the content of the phone call and the time you spent, but you will mark zero (0) for your total time.

  - the content of your notes will not change
    You will document WHO did what, WHAT you did to assist the client, WHAT the client did, WHEN it was done, WHERE it was done, and PROGRESS made by the client on his goal.

- Learning Experiences
  Staff is responsible for empowering the client to make decisions, choices, and express his rights as often as possible and at minimum once a month and with documenting any discussions or activities related to this area.

- Individual Choice and Rights
  Individual choice and rights means that a developmentally disabled individual has the right to and can expect to have the same choices and rights that any person who does not have a developmental disability has. As a staff person you provide options, information, and assist with decision-making — options about a variety of choices available, information about the individual's rights, and skills for making decisions.

- Reviews
  Reviews are completed with the client and/or guardian/advocate every quarter based on the client's support plan effective date. A variety of topics are covered and documented. During the Annual review the client must have medication administration forms completed, some signed by the client's physician. During the Quarterly review staff will go over a variety of topics with the client. Use the Client Checklist to ensure you cover all of the required information.

- Disaster Preparedness
  Every April a Disaster Preparedness plan is completed and submitted to the Program Administrator. The Disaster Preparedness is also attached to the Implementation Plan.

- Transitional Guide
  Whenever a client moves, a Transitional Guide is used to assist in the move.

- Financial Information
  Any staff who handles a client's finances (from helping with reconciling bank accounts with check registers to banking, social security, medicaid, spending money, co-pays, etc) must document these tasks and keep accurate records. Staff are responsible for assisting the client with maintaining his finances and living within his means and must provide the client with consequences for not being fiscally responsible and document these discussions.

- Health, Safety, & Well-Being
  Staff is responsible for ensuring the client's health, safety, and well-being and must document efforts to do this whether it is discussions about health and safety or accompanying to a health appointment or assisting with medications. Any staff assisting with medications must have a valid Medication Administration Certificate and must be validated each year.

  Staff is responsible for being aware of the client's health care information such as guardianship papers, living will, advanced directives, behavior plans, etc., as necessary. The Supported Living Coach should ensure these documents are provided to the office as necessary and document the information provided.

- Major Life Events
  Any major life event, such as monetary gain/loss or marriage, will be documented in case notes and verbally communicated to the program administrator and support coordination agency.

- Reporting Measures
  - Significant Events
    An Incident Form is used to report any major incidents, such as hospitalization, law violations, death, or abuse. Staff, immediately after dealing with the incident, will contact the program administrator, support coordination agency, and any other appropriate

agencies/individuals. Subsequent to the verbal report, staff will complete the Incident Report form which will be reviewed by that person's supervisor and a copy sent to the support coordination agency and other required contacts and the original kept in the client file.

- Reporting Abuse, Neglect, Exploitation
  Neglect, abuse, and exploitation will not be tolerated. Any suspicion of neglect, abuse, or exploitation will be reported to the Program Administrator immediately and procedures will be followed for reporting abuse. At least once a month, staff will go over and document discussions about abuse, neglect, and exploitation concepts with the client.

  As with any individual who does not have a developmental disability, persons with developmental disabilities have the right to expect kindness, a gentle approach, respect, and dignity. As a staff person, it is your responsibility to recognize abuse, neglect, and exploitation and if you suspect any of these or have knowledge of any of these, you must ensure the health and safety of the individual and then report your suspicion or knowledge immediately following specific guidelines.

- Complaints, Conflicts, and Grievances
  Complaints, conflicts, and grievances should be resolved in a timely manner, noted in staff notes, and if not resolved, the Program Administrator should be notified immediately and procedures for resolving grievances will be followed.

  There are a variety of conflicts and disagreements that occur as part of daily living. As a staff person, your responsibility is to observe, recognize, assist with resolving issues, document, and report any disagreements or conflicts that may occur between one client and another client, a client and staff, a client and any one of his circle of support (natural and paid), a client and neighbors, etc. If a small problem can be resolved quickly, then assist with the resolution before the problem becomes big. If a small problem becomes big or starts out big, then your responsibility is to take steps to assist in the resolution of the problem by reporting the problem to the Program Administrator and then following the steps for grievance procedures.

- Self-Assessment Procedures and Protocol
  Once a year both staff and clients will complete self-assessments to assist the Program Administrator in ensuring quality services. In providing person-centered services and supports, it is the responsibility of the provider and each staff person to continuously re-examine and review the supports and services provided and the way they are provided. It is also important to provide consistent, flexible, careful, cooperative, and thoughtful training. Ask for help, if necessary, for new or different training techniques, but stick to things that work. Be willing to change if something isn't working, but don't try things differently every day on a whim. Observe and talk to the client — find out what he can and cannot do, what he wants to do, where, when, and how he wants to do things. Make suggestions, not demands. Work *with* the client and other staff and the client's circle of support. Consider carefully what the skills are of the client, what he can and cannot do, and how you can best assist him in achieving as much independence as possible for his own personal needs and wants.

- Casebook Review
  Casebooks are kept for each individual in the program. The casebooks may be reviewed at any time by state authorities. In addition, the casebooks as well as the company business practices are audited by state authorities once a year. It is essential that as a staff person, you do the required paperwork, including service logs in an accurate and on time manner and submit them to the Program Administrator on time so that casebooks are kept up-to-date and accurate. Each quarter and just prior to the annual audit, supervisory staff reviews each casebook to ensure they are being kept in an orderly, complete, and accurate manner.

- Development and implementation of the implementation plan
  The Support Plan is an integral part of your work as a staff person. From the Support Plan, specific guidelines for implementing training to assist the individual in achieving his annual goals are written down in the Implementation Plan. It is essential, as a staff person, that you have a copy of the Implementation Plan and know how to use it. The Support Plan meeting, held once a year, is attended by the client, the client's support coordinator, and anyone else the client chooses to have attend the meeting. For the most part, all staff who provide supports to the individual will be invited to attend the Support Plan meeting, but if you are a Supported Living Coach for the client and you are not invited or are not aware when the meeting is coming up, you must find out why you weren't invited and why you didn't know about it. The tasks and skills you will work on with the client are presented at the Support Plan meeting. As a Supported Living Coach, you are responsible for specific paperwork both prior to the Support Plan meeting and subsequent to the meeting. If you aren't there or you aren't properly prepared, you will not be able to provide quality input for future training with the individual. Once the Support Plan is received from the individual's support coordinator, the Supported Living Coach must complete an Implementation Plan which is reviewed by the Program Administrator and then submitted to the support coordination agency for approval. All staff, the client, and the client's circle of support must have input into the Implementation Plan and once completed must have a copy. The Implementation Plan is your guideline for working with the individual for the year.

- Training
  Each staff person is responsible for his own training and for submitting proof of training to the office.

Specific Documentation Guidelines

Documentation begins before a new client starts services. Staff will be trained on documentation requirements. Staff make copies of all the required paperwork as needed; in some cases 2 copies of completed paperwork are needed, 1 for filing and 1 to give to the WSC.

Reviews are done quarterly and annually to update information about the client. The Annual Review is based on the client's support plan effective date. During the Intake, Annual, and Quarterly reviews, a Checklist is used to ensure all areas are covered.

During **Intake**, forms are used to assist staff in pinpointing the clients needs, wishes, and goals and also his health history, strengths, and weaknesses. Interviews with the client may occur prior to the client starting to ensure there is a good match between the client and the services provided. Client demographics, medical information, and a variety of topics are covered during intake and then annually and/or quarterly thereafter.

The **Annual** Review covers the previous 9 months of the client's current support plan year and the last 3 months of the previous support plan year and provides a comprehensive overview of the client's goal progress as well as other information about the client. This Annual Report is due each year during the 3rd Quarter. The Annual Report consists of all of the items shown on the checklist.

The **Quarterly Review** covers 3 months prior to the actual meeting with the client and WSC. Each quarter review is based on the individual client's Support Plan Effective Date (the month the support plan begins). The Quarterly Review includes a summary of activities and progress the client has made on his goals.

Person-Centered Planning is an approach used to assist the client with using his own capacity and potential for constructive action to realize his goals. Staff act as facilitators rather than directors, offering respect, acceptance, and understanding to the client to help empower him to realize his own potential. This approach is used when working with any client, particularly when planning for annual goals and working on goals from the individual's Support Plan.

Staff plan with the client what he wants his goals to be, how he will work on the goals, which staff and how staff will help, time limits and frequency for each goal, how progress will be assessed, and how the client will know he has accomplished his goal. For each goal, a plan of action is developed:
✴ **Performance** - what the client will do (activities, tasks, etc) to work on the goal
✴ **Strategies/Assistance** - what staff will do to help the client to achieve the goal
✴ **Training Method(s)** - most appropriate for the client and the goal (demonstrate, verbal prompts, physical prompts, repetition, explanation, pictures)
✴ **Frequency** - how often staff will provide help/support the client
✴ **Time Limit** - how long the client wants to work on the goal/when he should be finished
✴ **Assessment** - how progress will be measured, including how the client will know he is making progress on the goal, his satisfaction with the goal, and the projected results of the training

When the person-centered planning is complete, the goals are written on the Annual Summary and provided to the support coordinator to use when writing the Support Plan. The Person-Centered Planning may then be used to develop the **Implementation Plan** once the Support Plan is received. If the goals on the Support Plan are not the same as the goals the client decided on during his person-centered planning, a **Support Plan Update** is provided to the WSC to ensure the Support Plan reflects a person-centered approach, driven by the client. This Support Plan Update is also used throughout the individual's support plan year to track goal additions, deletions, and completion.

The **Topics/Charts** is reviewed on Intake, every quarter, including annually. It is a form that lists of all areas to be covered during a review. Each topic area has an associated form containing information about that topic. At Intake all the associated forms are signed by the client and guardian/advocate. Quarterly and Annually thereafter the Topics/Charts form needs to be signed once each area is reviewed and checked off. Staff may use the forms with information associated with each topic when reviewing the information with the client so as to not miss any important areas.

In addition, there are 2 charts associated with 2 of the topics: **Reporting Measures Chart** and **Rights, Responsibilities, & Choice Chart**. These charts must be available to the client. They can be posted inside of cabinet door if the client chooses.

Copies of all associated forms and the charts are provided to the individual and/or guardian, if requested. Areas covered include:
* Rights/Responsibilities/Choice and Chart
* Reporting Measures and Chart
* HIPPA
* Due Process
* Abuse Topics (must be signed annually)
* Fire, Safety, Emergency Procedures
* Bill of Rights
* Circle of Support
* Key Authorization
* Staffing Authorization
* Financial Authorization (signed and copy provided to WSC annually)
* Grievance Form (provided to client if needed)
* Functional Community Assessment - to determine the individual's abilities and needs (using the FCA Categories as a guide)
* Client-Guardian Release (signed annually)

The **Demographics/Health History** provides information about the client's circle of support, health history, address, phone numbers, and other personal information.

The **Status/Medical Update** provides current information about what the client is doing, working on, and interested in as well as current medical information, including medications, appointments, and health care providers.

The **Health, Safety, & Housing Checklist** is a checklist to update any safety and housing issues and the client's general health.

The **Individual Financial Profile (IFP)** is used to identify the client's financial situation. It is done on Intake, prior to the client moving into supported living, and annually thereafter based on his Support Plan effective date or when the client's situation changes (he goes into debt, he moves, etc). It is recommended that the IFP be done every Quarter because a client may experience financial difficulties in a very short time. If the SLC does not keep on top of the financial situation, doing the Profile once a year may be too late to identify or recover from financial problems.

The **Implementation Plan/Transition Plan** is written based on the goals from the client's Support Plan. A Transition Plan is used when a new client starts in order to get the client started.

Service Logs provide documentation of each contact hour staff works with a client. The Service Log is composed of 5 parts:
Identifying Information, Goals, Contact Log, Casenotes, and End-of-Month Summary.
1- The Identifying Information specifies the client (name, medicaid number), the staff, the service being provided, and service limitations.
2- Client goals are listed by number from the Support Plan or as updated on the Support Plan Update.
3- The Contact Log provides documentation of each contact hour staff works with a client for a specified period of time, usually covering 7 days. The Contact Log includes the date staff works with a client, if discussions or activities occur during each contact (topics include rights, responsibilities, HIPAA, choice, social inclusion, security, social roles, dignity, respect, health, safety, abuse, conflicts, satisfaction), when appointments or quarterlies occur, and when goals are addressed. Areas marked must match the casenotes. Staff time in-time out, # of clients worked, hours and quarter hours worked with are also specified. For PS-Day, the Contact Log includes whether the client was home, accomplished a typical routine, and wake up/bedtime and if staff did overnight monitoring.

4-The casenotes include documentation of everything staff does, what supports are provided, what the results of contact with the client are, and plans for what's next. There are two parts to the casenotes depending on what activities are worked on at any given time:
1) general tasks and activities that are not goal-related for the specific client
2) goal-related tasks and activities where the client is working toward accomplishing a specific goal

> To summarize non goal-related contact, staff should answer the questions Who (who provided support in addition to you), What (what support was provided, what did the client do, what did staff do), When (times of service - exact month, day, year, and contact hours), Where (location of support).
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> In addition, to summarize goal-related contact, staff must show Who (who helped with the goal), What (what staff did to assist or support the client and what the client did toward accomplishing his goal), When (when the support was provided), and Where (where the service was provided). Staff should also show whether the client is satisfied with his goal progress and what he plans to do next.

A Weekly Goal Progress is not required, but can be included at the end of each week. This would include a summary at the end of each week about the client's progress toward completing each goal worked on during the week, describing what the client and the staff did and what was accomplished toward progress on the goal which may include the client's own statement and satisfaction about the goal and staff comments and observations.

5- The End of Monthly Summary is a summary of the month's non-goal related activities, meetings, appointments, problems, decisions/choices made, new things learned, talk/action about rights/responsibilities, etc. A summary of the month's goal related activities and client's progress toward completing each goal (a summary of the weekly goal progress section). This summary can be used when writing the Quarterly/Annual Report.

Other items filed in the client's casebook annually or if the client's situation changes include:
* Lease/Deed
* Guardianship Papers/Living Will/Health Care Surrogate Papers
* Medicaid/FS/SS/Rep-Payee

The SLC is responsible for ensuring copies are provided to the office for filing. Medicaid, Foodstamp, Social Security, and Representative Payee reports and updates must be done on a timely basis, when required.

The **Service Authorization Form** provides authorization for each service provided to the client.

The **Support Plan** is written by the WSC after a meeting with the client and after having received the Annual Report. It identifies personal information about the client and also specifies the goals he will work on for his support plan year. The Implementation Plan is written within 30 days of receiving the Support Plan and specifies how the client wants to work on accomplishing his goals.

I have read and fully understand the Documentation Policy and agree to follow its dictates.

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Staff Signature Date