

Subject: Daily Note documentation in Therap

Purpose: To establish procedures to ensure that daily documentation occurs on each individual receiving service in accordance with the Individual Support Plan.

Tlog basics:

Daily documentation of the individual's served daily activities is required of all staff providing direct support. The Direct Support Professional (DSP) is required to complete the documentation daily before the end of their shift. Staff should budget their time to be able to complete documentation for each individual served by the end of the shift. They should not stay past their shift to complete them without supervisory approval and may not complete them from home after their shift. It is critical that staff complete documentation in a timely manner and while the information is still fresh in their mind.

If the Internet is down the DSP should type their documentation on a Microsoft Word document and save it to the work computer. They should inform their Home Coordinator (HC) that the Internet is down as soon as possible so it can be repaired quickly. Again, this should be completed prior to the end of their shift that day. When staff has access to the Internet, again it is their responsibility to copy and paste their documentation from the Word document to Therap. They will need to date the documentation for the appropriate day and shift.

If the computer is not working staff should complete the documentation on a daily note form. This form should be available in the home; they will need to ask their HC for the location of the paperwork if needed. Staff should complete this documentation prior to the end of their shift that day. Staff should write down the day and time of their shift just as they would do in a normal tlog. The HC will be responsible for collecting those sheets and scanning them into Therap within a week. THE DSP SHOULD LET THEIR HC KNOW THEY COMPLETED THE PAPER DOCUMENTATION.

Exceptions:

If there are extenuating or exceptional circumstances that prevent the staff from documenting before the end of their shift, they should let their Home Coordinator know immediately and complete the tlog during their next shift. **DISCIPLINARY ACTION WILL RESULT IF STAFF DOES NOT COMPLETE THE DOCUMENTATION WITHIN 72 HOURS.**

- Examples of extenuating circumstances can include: a personal or family emergency, an emergency with the individual supported (medical or behavioral), or sudden illness of staff. These are at the discretion of the Home Coordinator and Program Manager so staff should not assume it's okay to document on the tlog later unless they have **received permission** to do so. Poor time management is not an acceptable reason for documentation to not be completed prior to the end of the shift.

The HC can give permission for staff to stay late if required but staff should expect to be flexed out during the same pay period to avoid overtime when possible. **STAFF MUST HAVE PERMISSION FROM THEIR SUPERVISOR IN ORDER TO STAY LATE TO COMPLETE DOCUMENTATION.**

Information to be included in a documentation:

Documentation should include the following information:

- The date and time of the shift should be recorded at the time of documentation. For example: 1/7/14 6:30a-2: 30p

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- In documentation staff should refer to themselves as “staff”. Staff should avoid using the names of the roommates of the individuals served in documentation; instead they should note by their relationship to the individual whom documentation is being written about.
 - Documentation should include a complete summary of the day’s activities, with emphasis on any objectives that may have been completed during that shift.
 - Documentation **should be written objectively. Staff should avoid inserting subjective language into the** documentation. Staff should only document what they observed or heard **without giving their personal thoughts on the event.** Staff thoughts about an event are not relevant to the documentation (though should be shared with their Home Coordinator). For example, staff should **NOT** say:
 - “Joe was mad because he couldn’t go to the Columbia Mall today.”
 - “Sally was crying-she wouldn’t talk about it. Staff thinks it’s because she couldn’t go home for Thanksgiving.”
 - Instead staff should say:
 - “Staff explained that Joe would not be able to go the Columbia Mall due to the weather. Joe yelled at the staff that he wanted to go to the Mall and staff should take “him right now”. He then went to his room and slammed the door.
 - “Staff observed Sally crying in her room. Staff asked Sally if she wanted to talk about what was wrong. Sally said she did not want to talk. “
 - Documentation should include:
 - Who the individual supported interacted with that shift. This would include anyone the individual came into contact with- either at home or in the community.
 - What the individual did during the shift in detail. For example, don’t say the individual supported watched television, explain what he/she was watching. “_____ watched Gilligan’s Island and then helped this staff prepare dinner by opening the can of peas, pouring them into a pan and stirring them while staff observed.”
 - Where did the individual go during the shift? What activities took place during this activity? Were there any unusual or notable interactions or behavior(s)?
 - Any objectives that were completed during the shift should be noted within the documentation (as well as documented on the individual objective on Therap). For example:
 - “Joe watched Gilligan’s Island. After the show was over Joe was assisted in preparing supper. He opened the peas and poured them into the pan. Joe was then assisted in pouring the pasta into the water (cooking objective).”

Approved: _____
Director of Residential and Community Services

Date: _____

