Documentation Procedures:

Progress Notes and Data Sheets (ISP Data entries) must correspond with the Person's Plan of Service (Person Centered Plan). **All data is to be completed daily by the end of the shift.** Staff can start their electronic data entries and update data throughout their shift; however, **the final "update" must occur within the last 15 minutes of the service encounter.** This is the 15 minutes prior to the "end time" of your shift. Data entries cannot be finalized earlier in the shift.

Must use Person's Legal Name on all documentation. No Nicknames allowed on documentation.

ISP Data entries in Therap must include:

Date of Service – Must click on the calendar box in Therap and choose the date the service was provided.

Start & Stop Time- All ISP Data must have a start & stop time, align with shift (i.e. 7a-3p, 3p-11p,12a-7a).

Where was the service provided – In the location box, enter the name of the program where the services are being provided i.e. the name of the SIL or Licensed home. The description of the location is completed within the **Task section**- this is where you put location in the community-Grocery store, Bank, Library, Gym, etc.

The interventions offered and provided by staff during the shift with the person-Select the correct level of support from the scores dropdown menu. Document what level of support staff used to provide services- i.e. Guided, Directed, Assisted, Reminded, Trained, Supported, did for the person. Include the # of times the level of support was used in the comment section. (i.e. # of verbal prompts used for that specific task).

Progress toward the Person's specific goals & objectives addressed during the encounter- Document the **current status** of how the person made progress towards meeting their goals & objectives in each task comment box. If No Progress was made towards the goals & objectives, you must document WHY i.e. Person did not want to participate/refused today, person did not have the opportunity.

Overall Summary Task- Must reflect a detailed overall account of what occurred and the persons satisfaction of services by following the guidelines given within the task box.

Comments section (on bottom of ISP data)- Time in/out of when a person leaves the location during shift MUST be documented within this section.

Electronic Documentation Error-Simply update your entry, giving a reason for the correction within the comments section prior to submitting the data. Data errors must be corrected prior to the end of the month of the service date.

3rd Shift Progress Notes ISP Program Data entries (additional details): Must contain all of the above criteria listed, and is to be completed on EACH SHIFT daily from:

- **3rd Shift Progress Notes – 1st Entry ISP Program:** Completed for all individuals from (11p-12a)
- **3rd Shift Progress Note – 2nd Entry ISP Program:** Completed for all individuals from (12a-7a); unless the person has a 3rd Shift RMHA Goals ISP Program, then it is not required. Must include time in/out if the person leaves the location within the narrative overall comments section at the bottom of the ISP Program.

Tasks and Task Comment Box- This is where you will document the tasks that you worked on with the person you support outside of their RMHA Goals & Objectives, as well as what occurred throughout your shift. In the description box you will find the task that may occur during shift and the important details to remember when documenting. If this task was not completed while on shift, you may select "*Not Done Today (Non Reportable)*" from the scoring method dropdown menu. In the scores/comments section this is where you will document status and type of support offered by you during the shift (using the dropdown). Be sure to include the # of times a level of support was provided.

***** In the event the electronic health care record (THERAP) is down you must complete paper documentation & include these additional steps for documentation:**

Legible signature – Must have legible signature of person providing the service and **the date** must be next to the signature. If illegible signature you must print name legibly below signature.

Documentation Errors – If you make an error on paper documentation you must draw a ***SINGLE line*** through the error, write the word **error,** put your ***initials*** next to the error. Include the ***reason for the error***, if you do not have enough room you can write the reason on the back of data or include an attached sheet with the reason. Do ***NOT*** under any circumstances scribble on the documentation, or use white out.

See Documentation Do's and Don'ts for sample notes and other helpful resources! 1/2021, 8/2021, 2/2022, 5/2022