Individual CLS Documentation Procedures:

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 your scheduled time with the individual. Data submission must occur within the last 15 minutes of the service encounter.** This is the 15 minutes prior to the scheduled "end time" with the individual you are providing services for. Data entries cannot be finalized earlier.

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, that align with your scheduled time with the individual.

Where was the service provided – This would be determined by where the majority of service was spent during the shift; in home or in the community. 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 time 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; person did not go out into the community.

Overall objective- Staff are to complete an overall summary of the person's satisfaction/progress of goals & objectives for the time period in this comment task box. Must reflect a detailed account of what occurred and the person's satisfaction of services. This should be according to the individual.

Submitting data-must occur within the last 15 minutes of the service encounter, by following the above listed guidelines.

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

***** 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