



DEVELOPMENTAL DISABILITIES ADMINISTRATION  
Olympia, Washington

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TITLE: STATE OPERATED LIVING ALTERNATIVES (SOLA) POLICY 6.03  
PROGRAM DOCUMENTATION REQUIREMENTS

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Authority: [Chapter 71A RCW](#) *Developmental Disabilities*  
[Chapter 388-101 WAC](#) *Certified Community Residential Services and Supports*  
[Chapter 388-826 WAC](#) *Voluntary Placement Services*

**PURPOSE**

This policy defines minimum standards for documentation of client services offered to individuals served by the State Operated Living Alternatives (SOLA) program operated by the Developmental Disabilities Administration (DDA).

**SCOPE**

This policy applies to all State Operated Living Alternatives (SOLA) employees and contractors who provide services to SOLA clients.

Note: At the time of publication of this policy, the SOLA programs are transitioning to the electronic record-keeping system, Therap. As a result, this policy contains information on both manual and electronic record-keeping.

**DEFINITIONS**

**General Event Reports (GER)** means a report and follow-up on critical incidents and events, which includes but is not limited to injuries, behavioral concerns, medication errors, restraints, allegations of abuse and neglect, accidents, missing persons, death and other unusual events.

**Individual Instruction and Support Plan (IISP)** means a written document that incorporates the residential services guidelines in developing instruction and support activities. The IISP must meet the requirements per [Chapter 388-101 WAC](#) and DDA Policy 4.02, *Community Residential Services: Referral and Acceptance*.

**Individual Support Plan (ISP)** means the teachable programs to track a client's knowledge, skill or participation towards identified goals contained in the client's IISP.

**Participant** means an individual who is receiving residential services and supports provided by the SOLA program.

**Participant Notes** means documentation of day-to-day services and activities provided to the client.

**Secure Communication (S-Comm)** means the intra-communication system contained in Therap. SOLA staff communicate information via this system with other Therap users that is vital and/or pertinent to home management and client support.

**Staff Daily Log** means a document in which SOLA staff manually report information that is vital and/or pertinent to home management.

**Therap** means a specific electronic record system that uses a web-based documentation and communication software system for the documentation, reporting and communication of client services.

**T-Log** means information on non-routine client health, events and activities where action may be required. With high level, shift-to-shift action may be needed.

**Medication Administration Record (MAR)** is a record of all medications administered, taken or refused by a client. See DDA Policy 6.19, Medication Management.

**Individual Home Page (IHP)** means a location within Therap that provides a picture of services, plans and links to all information pertaining to a client.

**Individual Data Form (IDF)** means the place within Therap where staff record current address and contact information, find current medical professionals and other support contact information, attach external documents pertinent to this participant.

**Individual Plan of Protection (IPOP)** means the place within Therap that records the supports necessary for the client in different settings based on identified risks.

## **POLICY**

- A. All information for clients served by the SOLA program will be contained and recorded in the Therap system.
- B. All SOLA programs must transition to implementation of Therap by June 30, 2014.

- C. Documentation in Therap constitutes official legal records and SOLA staff must not remove, alter or delete pages. If using Secure Communications instead of a paper log book, those messages must be kept in “*S-Comm*” folders and not deleted.
- D. SOLA staff will receive program documentation training upon initial hire and then annually or more frequently as needed.
- E. Level of access to information in Therap will be determined and granted by the SOLA Program Manager or designee.

### **PROCEDURES**

All documentation must be done in Therap unless power-outage occurs and in that event, must revert to handwritten documentation. An emergency packet will include the current MAR, a blank T-Log, and emergency data form. At the beginning of each month or when there is a change in a MAR, it must be printed out and included in the emergency packet.

- A. Participant Notes and T-Logs
  - 1. Staff must record information that is important in a participant’s life, including, but not limited to, the following:
    - a. Individual Instruction and Support Plan (IISP) goals;
    - b. Outings or activities;
    - c. Factual observations;
    - d. Direct participant quotes that require management’s attention;
    - e. Any request for medical attention;
    - f. Special health care instructions and health status reports;
    - g. Medication changes;
    - h. Participation in daily living activities;
    - i. Change in participant status (e.g., employment status, vacation, significant family changes, etc.);
    - j. Follow up actions regarding any significant events or situations; and
    - k. Any unusual situations or circumstances.

2. *Participant Notes* and *T-Logs* should not be used to communicate among staff or document employee performance issues.

For example, if follow up with a doctor is necessary, it is acceptable to enter: "*MD will be contacted re: increase in seizures noted here*" or "*Follow up with MD resulted in change in prescriptions.*" It is not appropriate to put direct instructions to staff in the *Participant Notes*. For example, a notation such as "*AC2s, please contact doctor re: increase in seizures and let me know what happens*" should be entered in the *Staff Daily Log Book* or *Secure Communication*.

3. Only SOLA employees or authorized contractors may document in the *Participant Notes/T-Logs*. See Section C of this policy for rules on how to make entries.
4. At the beginning of their shift, Attendant Counselors (AC) must read the *Participant Notes* or *T-Logs*, *Secure Communication*, and *General Event Report (GER)* from the previous three shifts.
5. Each shift must make at least one (1) entry daily in Therap for each participant. A minimum of three (3) entries in a 24-hour period must be made unless something occurs that requires additional entries.
6. If a staff fails to document, the staff must make a late entry and identify it clearly as a late entry in the beginning of the "comment section" in the *Participant Notes/T-Logs*.
7. The Attendant Counselor Manager (ACM) must read GERs daily and document and initiate a plan of correction.
8. The ACM must read *T-Logs* daily. Any concerns about client services discovered in the ACM's review of *T-Logs* must be addressed by the ACM within three (3) working days with the appropriate staff working in the client's home and other supports as necessary. The ACM must document in the *T-Logs* how the client's concerns will be addressed and make timely entries regarding progress achieved in addressing the concerns.
9. The ACM must run monthly reports on progress towards the IISP goals, analyze the data and address issues. The ACM must review the report to ensure compliance with policy requirements.
10. Copies of *Participant Notes/T-Logs* may be sent to the client's legal representative upon request.

B. Staff Daily Log

1. Staff must record information that is important to house management, including, but not limited to, the following:
  - a. Changes in participants' schedules;
  - b. Special instructions from manager;
  - c. Scheduled medical appointments;
  - d. Visiting family members or friends of clients;
  - e. Pertinent information that was charted in the *T-Logs* (e.g., "See Jane's *T-Log* for today");
  - f. House and/or vehicle repair issues;
  - g. Staffing changes;
  - h. Activity reminders; and
  - i. Any issues regarding clients' pets.
2. Staff must make all entries according to the rules for making entries in Section C of this policy.

C. Rules for Making Entries

1. Entries in Therap must be clear and concise. All handwritten entries must be neat, legible, and in permanent ink only.
2. When making a manual entry, staff must ensure that:
  - a. The staff's name is clearly legible;
  - b. The date (month/day/year);
  - c. They sign their full name and include their job title; and
  - d. In situations involving multiple clients, staff must use only the first name of the client that they are documenting for and refer to other clients as "housemate(s)", "friend" or "another program client."

D. Archiving Participant Notes and Staff Daily Log Books

Follow the requirements of [Chapter 388-101 WAC](#) regarding records retention.

**EXCEPTIONS**

No exceptions to this policy may be granted without the prior written approval of the Deputy Assistant Secretary.

**SUPERSESION**

DDA Policy 6.03  
Issued April 15, 2013

Approved: /s/ Donald Clintzman  
Deputy Assistant Secretary  
Developmental Disabilities Administration

Date: January 15, 2014