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

PURPOSE

This policy defines minimum standards for using Participant Notes and Secure Communication in the State Operated Living Alternatives (SOLA) program. The information is used to communicate and document important information with SOLA staff and is essential for participant services and home management.

SCOPE

This policy applies to all State Operated Living Alternatives (SOLA) employees of the Developmental Disabilities Administration (DDA).

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 written report and follow-up on an incident, including injuries, behavioral concerns, medication errors, restraints, allegations of abuse and neglect, accidents, missing persons and other unusual events.

Participant means an individual who is receiving residential services and supports provided by the SOLA program.
Participant Notes means a log in which SOLA staff document information that accurately reflects each SOLA participant’s life. These are referred to as “T-Log” in Therap.

Secure Communication means an electronic record kept in Therap in which SOLA staff report information that is vital and/or pertinent to home management.

Staff Daily Log Book means a book 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 written information on a participant’s daily events and activities. It also includes staff-to-staff communication, shift notes, and nursing notes.

POLICY

A. Each SOLA program will maintain a log book or use Secure Communication in Therap. All documentation must be made according to the procedures established in this policy. In addition, Participant Notes will be recorded in Therap. All SOLA programs must transition to implementation of Therap by December 31, 2013.

B. SOLA staff must treat Participant Notes and Staff Daily Log Books as official legal records and must not remove, deface, alter, or delete pages.

C. SOLA staff will receive program documentation training upon initial hire and then annually or more frequently as needed.

PROCEDURES

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.

Note: 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.

2. Only SOLA employees may document in the Participant Notes/T-Logs. See Section C of this policy for rules on how to make entries.

3. 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. Participant Notes must be initialed and dated by the ACs.

4. Each shift must make at least one 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.

5. 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.

6. The Attendant Counselor Manager (ACM) must run weekly reports in Participant Notes/ T-Logs weekly. The ACM must review the report to ensure compliance with policy requirements.
7. Any concerns about client services discovered in the ACM’s review must be addressed by the ACM within three (3) working days with the appropriate staff working in the participant’s home and other professionals as necessary. The ACM must document in the Participant Notes/ T-Logs how the participant concerns will be addressed and make timely entries regarding progress achieved in addressing the concerns.

8. Copies of Participant Notes/ T-Logs may be sent to the participant’s legal representative upon request.

B. Staff Daily Log Books

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 participants;
   e. Pertinent information that was charted in the Participant Notes (e.g., “See Jane’s Participant Notes 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. All handwritten entries must be neat, legible, and in permanent ink only. Entries in Therap must be clear and concise.

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 participants, staff must use only the first name of the participant that they are documenting for and refer to other participants as “housemate(s)”, “friend” or “another program participant.”

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 Assistant Secretary.

SUPERSESSION

DDD Policy 6.03
Issued March 1, 2009

Approved:  /s/ Kathy Leitch  Date: April 15, 2013
Assistant Secretary
Developmental Disabilities Administration