Documentation – Clients – Work Instructions

Log Notes

1. Log Notes are for reference purposes only:

   - To refer to other documentation or information
   - To highlight important dates or appointments
   - To highlight significant changes

2. Log Notes are not to include any personal information about the clients or information that may need to be retained long term.

3. Log Notes are to be completed daily and include:

   - The date
   - The number of clients present and absent
   - The name of each employee working that day and their shift
   - Each medication time and the name of the medication designate and alternate
   - Any remarks referencing other information
   - List of any invited guests or drop in visitors, maintenance personnel, etc including anyone not living in the home or employees that are not on the schedule

4. Log Notes will be retained in the Service Area for the current year and up to one year past, and then shredded. Log Notes will not be retained long term.

Contact Notes

Contact notes are records of any information specific to a client that is non-medical. They may include, but are not limited to:

- Contact and messages from guardian, family, friends, or other support persons
- Information about visitors
- Recreation and leisure information
- Appointments other than medical
- Reference to other pertinent documentation
- At times it may be necessary to include reference to other clients' first names. In doing so, ensure that all information is factual and does not contain personal views or opinions about the other client
- Contact notes will be written on contact note forms or on loose-leaf paper
- The contact notes must be kept separate for each client

- Upon completing a client's contact note, reference to the contact note is made in the log note

Medical Notes

1. Medical notes are records specific to a client's health. They may include, but are not limited to:

    - Recording of illness, injury, recovery, follow through, recommendations
    - Daily medical progress
    - Medication changes
    - Medication information
    - Dental
    - Optometric
    - Physiotherapy
    - Medical consultations
    - Medical appointments
    - Health and nutrition issues
    - References to other reports specific to medical situations

2. The following is an example of information that could be written in medical notes:
   Jane felt warm to the touch and her face was flushed. Temperature at 2:00 p.m. was 38 degrees C (100.5 F). Please monitor. DATE and SIGNATURE.

3. Employees will be familiar with the medical documentation requirements for the persons they support. Always refer to the guidelines under procedure for determining what and how to write.

4. Information recorded in medical notes should be factual, concise and pertinent.

5. Medical notes may be written on Medical Note forms or on loose-leaf paper and must be kept separate for each client.

6. To draw attention to medication changes, this information will be highlighted in some format (written in red pen, underlined or highlighted).

7. Upon completing a client's medical note, reference to the medical note is made in the log note.

Personal Profile

1. The personal profile provides immediate access to personal and emergency information. It is to be completed upon entry into services and is to be reviewed and updated as required; minimally annually.

2. The original personal profile will be kept on the client's main file.

3. The original personal profile on the main active file, and the copy forwarded to the services area, must both contain a current color photo of the person.

Active Files

1. Each client has an Active file; these are located at the ASC Services Support Building and are kept in the locked main file room.
2. Active files contain information from the current year and two years past. Decisions made to keep information more than 2 years may be directed by specific policies, documents, or at the discretion of the Program Director or Executive Director.

3. Active files are contained in hanging files labeled with the client's name and stored alphabetically by surname.

4. Files will be color-coded as follows:

   - Beige Legal/Correspondence
   - Blue Service Plans
   - Yellow Behaviour Support Plans
   - Pink Contact Notes
   - Red Incident Reports
   - Green Financial Information
   - Grey Funding Information
   - Teal Medical Information
   - Purple Employment Services (where applicable)

   A color coded legend is also posted in the main file room.

5. All current filing is placed on labeled cardboard backings.

6. Information is date ordered, using month and year in ascending order, e.g. January on the bottom to December on the top.

7. Active files are reviewed and rotated annually and duplicates are shredded.

FILE FOLDER	CONTENTS
Beige Legal/Correspondence	**Application for Services** – (Any information regarding Individual prior to coming into service with ASC), Initial Contact, Application Package, Getting to Know Your Family, Placement Committee Minutes, Letter to Individual/Family advising outcome of Placement Meeting, Service Orientation Checklist, , Placement Committee Checklist for Accounting, Placement Committee Meeting Checklist , Client Application Checklist, Exit Summary **Advanced Care Plan – GCD Order – Personal Directives** (do not purge) **Consent Forms** – (General, Specific) **General Correspondence** **Guardianship** **Individual Service Agreement (ISA)** **Inventory** **Personal Profile** – (Stapled to inside cover of file folder and updated yearly) **Referral/Service Plan** (usually a one-time document unless there are changes) **Service Agreement including Schedule "A"** **Service Agreement Renewal**
Blue Service Plans .	**Assessments** – (includes REISS, Transitional & Self - Administration of Medication Assessment, Risk Analysis, SIS, Dementia - do not purge until a new one is completed **Course Certificates** **Evaluation of Parental Support** **FSCD Referral** **Goal Plan** **Goal Review** **Goal Review Outcomes** **Individual Support Plan/Outcomes Star/Review of Goals** **Monthly Summaries** **PCP** **Reviews** **School Reports** **Sensory Analysis** **Survey/Questionnaire** **Transition Planning –** (Own backing)
Yellow Behaviour Support Plans	**Analysis of Sensory Behavior Inventory** **ATEI** (Assistive Technology & Environmental Intervention Device Authorization) **Behavior Specialist** **Behaviour Review Committee – Minutes** **Behaviour Support Plan** **Consent - Behaviour Support Plan** **Functional Assessment** **Positive Learning Plans** **ROMS** **Support Care Plan –** (own backing)

Pink Contact Notes	Contact Notes Individual Updates Meeting Minutes
Red Incident Reports	Incident Reports Informal Concern Resolution Summary
Green Financial	AISH Annual Report Banking Related Information In-House Account: Transaction Data

Grey Disability Services (Adults)	Budget/Funding Related Information and Correspondence Contractual Funding Budgets
Grey FSCD (Family Support Services)	Funding Confirmation/Agreements Funding Related Information and Correspondence
Teal Medical	Annual Medication Review Sheet Medical Information Sheet Medical Notes Medical Review Sheet Medication Coversheet Medication Signing Sheet (A) and (B) Seizure Chart – General Seizure Chart - Hourly Seizure Report Self - Administered Medication Checklist
Purple Employment Services	Employee Evaluation Employer WCB Coverage Employment Contracts Resume Updates /Correspondence Specific to Employment Work Experience

Pending file

1. Information received from initial contact or other information received pertaining to inquiry or application for services will initiate the opening of a pending file.
2. Information is maintained in a pending file until services are commenced. When services commence the information is forwarded to open an Active File.
3. If services are not scheduled to commence, or there has been no further contact for a six month period of time, the pending file may be closed.

Back Files

Back Files are boxes containing historical information on clients who are currently receiving services. Back Files are:

- Filed according to ascending date order
- Placed in a file folder labeled with name/year
- Boxed, and labeled “Back Files”

Closed Files

Closed Files contain information about clients who are no longer in service. These include pending files which have not reach commencement. All information is:

- Removed from current and back files
- Sorted by year
- Shredded (if duplicated)
- Filed alphabetically in a box dated with the year of closure
- PDD related files are archived as per PDD Record Management – Individual File Standard
- All non PDD related files will be maintained on site and archived as per specific contract requirements

Rolodex

1. The Rolodex contains information on clients who have inquired, received, or are currently receiving services.

2. The card will indicate the client’s name and the date of:
    - Initial contact
    - Application for services
    - Commencement
    - Discontinuation of services
    - File closure