Ingersoll Support Services Inc.

Policy: Report Writing	**Policy # S 12** Section: Services
Reviewed and Effective: February 12 2018 **Revision Date:** May 2012, September 2016, February 2018 **Date of Origin:** March 19 2009	**Ministry Requirement – Yes**
Staff and Members of ISSI will ensure thorough report writing while maintaining dignity and respect for all persons, doing so without prejudice.	

Procedure:

1. All employees of Ingersoll Support Services are expected to adhere to the principles and procedures of reporting and record keeping.

2. All employees will be orientated in the principles and procedures of reporting and recording keeping (see the attached documents DOC:S12, Report Writing).

3. All employees are required to read relevant documentation immediately upon beginning their scheduled shift.

4. All documentation is to be completed as soon as possible – prompt recording ensures more accurate recording – no staff person shall leave a shift without having completed the necessary recording, unless under extenuating circumstances and with the approval of the Supervisor. Serious Occurrences, Workplace Injury, and Critical Injury are to be reported immediately to ensure prompt written reporting.

5. File information that is not current or relevant to a current situation will be relocated to an appropriate location in a timely manner.

6. This policy and procedure is to be reviewed annually at a team meeting to ensure best practices. Case and File Management of Service Records is the responsibility of the Team Supervisor and/or Planner or designate. This includes the site location file and the central office file.

7. Failure to comply with this Policy and Procedure may lead to disciplinary action up to and including dismissal.

Some Principles of Writing It Down:

Things to consider when writing things down:

The ABC's
Accurate
Brief
Complete

- Does it portray a person's life experience respectfully and honestly?
- Does it offer insight into a person's interests, aspirations, burdens and relationships?
- Does it meet your standard as you would require if it was your own personal history?
- Use positive language, but be honest.
- Use simple, clear language.
- Make observations, not judgements (never draw conclusions, record facts, not your feelings).
- Be specific, avoiding general characterizations and generalizations.
- Is it relevant?
- Avoid extraneous remarks (arguing, complaining, criticizing or blaming others).
- While services activities are to be a summary of the day/night shift, they should include important details of the day that are important with respect to the person and relevant to pass on to other staff.

Some Do's and Don'ts of writing it down:

Do …

- Record as soon as possible.
- Service Activities - should be completed for each hour the individual is supported throughout your shift, reflecting the supported individual's day. For example, if you are supporting two people for 12 hours, you would complete service activities to cover 12 hours for EACH person.
- Sub-Activities – should be chosen with care to reflect the activity being recorded. The subject of 'Daily Activities' includes regular daily life activities, such as morning routines/personal care, household tasks etc. Other Sub-Activities such as 'Employment', 'Medical', 'People in My Life' would be based on what the individual has planned that day. The Sub-Activity chosen could also indicate a skill or goal that the person is working on such as 'Routines Around my Home' or 'Teaching/Training'.
- When completing Service Activities, write in the hour or timeframe at the beginning of the entry.
- Spell correctly. An improperly spelled word could take on a different meaning. Utilize the spell-check function present within AIMS (right-click on the highlighted word to select the correct spelling).
- Use only standard, fully approved abbreviations.
- Only link multiple people to a Service Activity if it is <u>completely generic</u>. For example: 2200-0700 John, Fred and Sam slept.
- For Overnight Shifts, ensure that Service Activities are entered with the correct date. *If completing Service Activities at shift end, you will need to manually change the date to the day before, as AIMS automatically enters the current date*
- Keep tenses consistent.
- Be exact when noting time. Use a 24 hour clock - this will help in avoiding errors in writing the time.

Don't …

- Do not complete a Service Activity on behalf of another staff person.
- Don't use abbreviations - write the information in full.
- Never record personal comments.

All records can be admitted into evidence in a court of law.
Be cautious when recording.

This chart is a guideline of types of documentation required by ISSI. Please note that additional documentation or more detailed procedures may also be used, depending on the support team.

- All documentation is to be completed as soon as possible – prompt recording ensures more accurate recording – no staff person shall leave a shift without having completed the necessary recording.
- The following people have access to the documentation listed here: Person who the information is about (if they can't read, offer to read it to them with respect for privacy), staff that support the person, management representatives, family if the person consents, sometimes a doctor, clinician or specialist, lawyer if required, Ministry of Community and Social Services representative.

Where to write	Why write it down (Purpose)	What to write	Where it is kept	Who is responsible for the documentation
Service Activities	* record of information that will enhance the supports and services * accountability tool – an account of what has been done to achieve plans, goals, and follow-up on things * accountability tool to the mission statement and goals of the agency * Ministry requirement	***** relevant observations; anything out of the ordinary or observations of the person such as: medical concerns, patterns of behaviour * relationships – introductions made, how existing relationships nurtured, follow up of new relationships * action taken to achieve goals from their plan **What NOT to write:** * anything not relevant * house cleaning done by staff * negative comments aimed at other staff or the person you are supporting * weather – unless it is relevant	* within the 'Service Activities' Module in AIMS * ensure an appropriate support type and sub-activity is chosen for each entry	***** all staff having knowledge of relevant information * each shift, one person will be responsible for completing service activities

Communication Logs	***** to share information between staff for consistency or follow-up required * reminders * if a person who lives there wants to tell staff or others about something	***** anything that staff need to know about – but **NOT** negative comments aimed at other staff or a person who lives there	* within the 'Communication Logs' Module in AIMS	***** all staff having knowledge of relevant information
Clinical Notes	* Ministry requirement * communication between staff * medical history * see medication policy	***** administering of medications and treatments * medical interventions * medical appointments, outcomes and follow-ups * hospitalizations * treatment procedures	* within the 'Medical' Tab in AIMS	***** all staff having knowledge of relevant information
Financial Information	***** Ministry requirement * See policy S 5	* every transaction – refer to policy QAM 4	* within the 'Personal Financial' Module In AIMS * Community Participation Supports utilize the 'Service Financial' Module	***** all staff who have touched money, including daily money counts * Supervisors are responsible for reconciling the

				ledgers at month end * Managers are responsible for signing off to show that quarterly checks have been completed on the ledgers
Incident Report	* means of quickly relaying information to management * data collecting for patterns * to record any 'out of the ordinary' event; the form in AIMS will adjust to whichever incident descriptor(s) is chosen from the dropdown * process of review, ensuring identi-fication & follow-up * documentation for future reference * Ministry and legal requirement	* examples of Incidents could include: Medication Error Accident of supported individual Incident that caused an injury (also do an Injury Report) Chemical or Physical Restraint Incident of aggression Seizures * incidents can be service related as well, including: Water Temperature over 49 C	* within the 'Incidents' Module in AIMS * Some situations will require staff to notify on call and/or Management immediately (Restraint or Serious Occurrence)	***** all staff having knowledge of relevant information – each staff person is to write their own separate account of the incident * reports are to be forwarded to the direct supervisor through the 'Notification' function at the end of the report

Injury Report (Supported Individual)	* to have record of injuries * to be able to see patterns/red flags * part of medical history	* how the injury happened * an injury is left 'unresolved' until a resolution date is entered	* the incident that caused the injury is recorded within the 'Incidents' Module in AIMS (as necessary) * the injury is recorded within the 'Medical' tab in AIMS (can be generated directly from the incident report or vice versa)	*all staff having knowledge of relevant information .
Accident Report (Staff)	* means of quickly relaying information to management ***** data collecting for patterns * process of review, ensuring identification of follow-up * documentation for future reference * Ministry and legal requirement	* any injury including near misses	*** <u>not completed in AIMS -- paper copy</u> only** ***** once signed off by Supervisor it goes to office for Manager review. After/Manager has reviewed, a copy goes back to the team and the original is centrally filed * some situations will require staff to notify on call and/or Management (ie: potential WSIB form)	* all staff having knowledge of relevant information – each staff person is to write their own separate account of the incident

Serious Occurrence Reports	* MCSS requirement	* all serious occurrences as per Serious Occurrence Policy	* immediate notification of Management and/or Executive Director	* staff person to immediately document and report to management * management will report to Ministry as per Serious Occurrence Reporting requirements
Monthly Report	***** report on progress towards goals established in plans * report on new, emergent information * communicate to all parties engaged in the work * organizational accountability	*** refer to resource manual**	* copy in person's blue binder at home * copy to Management so it can be centrally filed	***** staff person is to immediately document and report to management * management will report to Ministry as per the Serious Occurrence Reporting requirements
Charting	* person specific			* Planner is ultimately responsible for ensuring this is completed and submitted to Manager

Writing it down – training

Keeping in mind the principles, turn these vague/biased or disrespectful entries into objective entries:

1. He refused to go out today.
2. She was constantly attention seeking.
3. She was so happy all day long.
4. He was lazy again today.
5. He is sick.
6. She neglects personal hygiene.
7. She was aggressive.
8. He was non-compliant.
9. She was depressed.
10. Boy did he stink. I cleaned up the disgusting mess in the bathroom.
11. He didn't want to go, but I told him he had to.
12. It was a good shift.
13. He completed his morning hygiene

Writing it down – Training – Appropriate Documentation

Vague/Biased/ Disrespectful Recording	Objective Recording
1. He refused to go out today.	Jim chose to stay home today.
2. She was constantly attention seeking.	Every time I left the room, Diane would take all the food out of the cupboard.
3. She was so happy all day long.	Diane was singing and smiling while eating breakfast this morning. At 1000 hrs her mother came to pick her up. When she returned home at 1500 hrs, Diane was smiling and talkative about what she and her mom did today.
4. He was lazy again today.	Jim did not want to help make supper tonight. He refused offers of assistance to clean up his apartment.
5. He is sick.	Jim did not eat lunch. He was pale and complained of pains in his abdomen. Oral temperature was taken and reading normal. No PRN given at this time.
6. She neglects personal hygiene.	Diane's hair is frequently uncombed, her teeth are not brushed and her face not washed without prompting and physical assistance from staff.
7. She was aggressive.	Diane pushed Kim out of her chair and hit her twice on the top of the head with the palm of her open hand. Diane's arm was extended straight above her own head as she motioned downward onto Kim's head.
8. He was non-compliant.	Jim sat on the floor when it was time for lunch. When asked to come to the table he said "bug off".
9. She was depressed	Whenever Diane was asked a question today she started to cry.
10. Boy did he stink. I cleaned up the disgusting mess in the bathroom.	Jim had diarrhoea 5 times between 0900 hrs and 1200 hrs. He was unable to get to the toilet successfully and required assistance to clean himself and the bathroom
11. He didn't want to go, but I told him he had to.	Jim said he did not want to go to his doctor appointment. I explained the importance of attending this appointment and encouraged him to go.
12. It was a good shift.	I dialled the phone for Diane to speak to her mom. They talked on the phone for 10 minutes. *(Something happened – what?)*
13. He completed his morning hygiene.	Jim was up and ready to go to work at 0800 hrs.