Progress Note and Care Log Review 10.2019

Paper Progress Notes:

- Narrative Documentation Section has to be filled out.
  - Notate any refusals of care and any cares/ tasks that were not performed. EX: Client refused to shower, Client had bathed before I arrived or client only needed shopping done today.
  - Always note any changes to the client condition. EX: Client had a recent fall, client was not feeling well slept most of the day or client is having surgery on Friday.
  - If nothing has changed and you have performed all task you can notate "No Changes".
- Cares outlined in the clients care plan need to be performed at each shift. If you do not perform a care/task you need to notate why.
- Mark an "X" next to each task performed, this would include cueing your client. EX: asking your client if they have bathed, encouraging your client to nutritious foods or asking if they have taken their medication. Please refer to the care plan to know what is expected of you.
- Progress notes need to be filled out daily. Take five minutes at the end of your shift to document tasks/cares performed, narrative documentation and capture signature from client.
- If you notice a change in your client's health condition and/or the plan of care is NOT reflecting his/her needs it is your responsibility to contact the office and inform us of the changes (208) 342-3013.

Care Logs done through your phone application and telephony:

- Always leave a general comment when logging your tasks. It is required by Medicaid to document at least your observations during every shift even if the client has no refusals or changes in their health.
- Make sure you are waiting until the end of your shift to document the cares and task you performed for the day.
- If you cannot capture signatures while clocking out you must fill out a paper progress note and let the office know.

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Employee Signature Date