SECTION 3012 – Documentation

SUMMARY STATEMENT:	Adult Protective Service (APS) records are business records of the Department and thus must reflect true, accurate and unbiased information. All statements, observations, notification, correspondence and hard copy evidence used to evaluate the client's condition and needs, as well as actions taken by APS on behalf of the client must be placed into the record.
PURPOSE	Documentation provides a detailed and accurate picture of the investigation, assessment and service activities that will allow APS to: • demonstrate the need for services; • provide case history that can mark improvements, as well as deterioration; • take appropriate actions based on the recorded evidence; • provide continuity of service; • evaluate adherence to policies and procedures; and • provide evidence when legal actions are taken.
COMPONENTS OF A CASE RECORD	The case record consists of: • Electronic case notes, which are the chronological narrative of contacts made with, or on behalf of, the client; • DON-R assessment • SLUMS assessment • APS A/N/E assessment • Other assessments, as appropriate • A signed HIPAA Notice of Privacy Practices form • A signed Release of Information • Copies of all documents, relating to the client, which have been received or sent by the adult protective services agency.

	• Case closure summary • Documentation of all supervisory approvals and case consultations.
PROCEDURES	APS documentation consists both of a physical record and an electronic record.
Physical Record	Maintaining a physical record requires staff to file: • A printed copy of the Adult Protective Services Intake Report • A printed copy of the acknowledgement letter (Refer to section 2006 of this manual). • A signed and dated copy of the HIPAA Notice of Privacy Practices form or unsigned and dated copy of this form, with a written statement of why the form was not signed (e.g. client unwilling to sign, client unable to sign due to paralysis). • A signed and dated copy of the Release of Information form or unsigned and dated copy of the Release of Information form, with a written statement of why the form was not signed (e.g. client unwilling to sign, client unable to sign due to paralysis). • Any physical documents obtained by APS staff and mentioned in case notes and/or used as a determining factor when making the Disposition and/or Findings. These documents may include but is not limited to: o Bank records; o Household bills; o Medical records; o Rental Agreements/Deeds; o Powers of Attorney/Letters of Guardianship/Conservatorship; o Tax Records; o Release of Information; o Correspondence; and o Evidence obtained via internet search. • A physical copy of any correspondence or documents completed on behalf of the client, which may include but is not limited to:

PROCEDURES Cont'

- Referrals for resources;
- Guardianship and/or Conservatorship petitions;
- Request for records; and
- Correspondence (written and/or electronic) sent to the client and/or collaterals.

- Completed assessments not available in electronic form (e.g. UAB Financial Capacity Assessment).
- Physical records shall not be removed from office.

Note: Do Not print records obtained digitally

Electronic Record

Refer to Appendix A Record Keeping for guidance maintaining the physical record.

Maintaining an electronic record requires staff to document all statements, observations, assessments, notifications and hard copy evidence.

All electronic documentation must be completed within 10 calendar days of the activity.

Unsuccessful Contacts must be documented

Attach to the electronic record all hard copy evidence, pictures, text, audio files and assessments not completed in the electronic record with a corresponding note containing a description of the evidence.

Description shall include:

- the time which the activity was completed, or the documents obtain;
- the reason for or circumstances under which the activity was completed; and
- a description of the activity (i.e. assessment outcome, description of photos, summation of correspondence).

Hard Copy Evidence containing original signatures and legal documents will be maintained in the physical record. All other evidence (e.g. medical records, bank records, correspondence etc.) will be shredded or returned to the original owner.

PROCEDURES Cont'

Required Activities – An explanation must be given when required activities are not completed during the assessment and investigation (*e.g. Interview was not conducted with the alleged perpetrated per request from law enforcement*.)
(Refer to sections 3002 and 3003 of this manual for a list of required investigation/assessment activities.)

Case Closure

The case disposition and findings must be recorded in the electronic record. A disposition will be documented for each area of maltreatment (abuse, neglect, exploitation, sexual abuse, self-neglect and self-abuse). The case findings will be documented in the Justification Statement. The Justification statement shall include a brief but clear statement identifying:

- the case disposition(s);
- findings addressing the client's personal vulnerability, social vulnerability and risk for further endangerment;
- and what will or will not occur as a next step, and why.

Modifications

Once the disposition(s) and findings have been documented the case shall be submitted for approval by the supervisor.

The Supervisor must indicate in the record concurrence with the disposition and finding. Non-concurrence by the Supervisor will result in the case being reopened. Guidance will be given to the case manager indicating what additional actions need to be taken before concurrence can occur. Supervisors have 5 calendar days to complete these actions.

In order to preserve the integrity of the record, changes **shall not** be made to documentation after it has been saved.

Documentation errors made (i.e. misspelled words/names, incorrect telephone numbers or addresses, grammatical errors etc.) will remain in the record. If the errors represent a misstatement of facts or could lead to the misinterpretations by a reader, an additional case note must be added, which is identified

	as a **correction** or **modification** to a specified entry and clarifies/corrects the identified error. *Correction to collateral contact with Mrs. Smith on April 3rd, 2014. Case manager documented that "Mrs. Smith witnessed client's mother slap client across the face". Documentation should have read that "Mrs. Smith did not witness…* **Note Exception:** If information concerning another client, unrelated to the case, has been accidentally put into the wrong client's documentation, removal of this case note shall only be made with supervisory and state office approval. Request for modification exceptions will be made via email to the Operations Analyst with a copy to the Supervisor and District Manager.
REFERENCE	***Record Keeping*** ***HIPAA Notice of Privacy Practices Form*** ***Release of Information Form***