SECTION 4008 – DOCUMENTATION

SUMMARY STATEMENT:	The Adult Protective Services staff shall enter into the client's case record written documentation describing findings, actions, activities and contacts with or on behalf of the client receiving APS.
BASIC CONSIDERATION	Documentation includes: • Information that is clear, factual and complete within 10 calendar days of documented action. • Information regarding referrals and collateral contacted on behalf of the client. Information describing the social, physical and mental status of the adult. Statements and actions by the client, caregiver, service providers and collateral contacts that are relevant to the service provision, risk reduction and case management
PROCEDURE	All actions are documented in the electronic case record: • Date of contact; • Type of activity (telephone contact, home visit, etc.); • Who was involved (i.e. name, title, relation to client of person contacted) and whether the client was seen; • The purpose of the contact; • Significant information and/or observations; • Assessment related to the progress toward the case plan goals; • The result of the contact and plan for next contact. • Any documents completed or obtained on behalf of the client as a part of ongoing service provisions will be uploaded into the electronic case record. A physical record will also be kept and contain any documents with original signatures and any legal documents. (*refer to section 3012* of this manual for

PROCEDURE contd.	additional policy and procedure related to documentation and record keeping)