LINKEDSENIOR

RESIDENT ENGAGEMENT 101 SERIES
Personalized Documentation

Documentation, whether in the skilled nursing facility (SNF) setting or in senior living is the process and the art of telling the story of the resident. It is a key factor in our role and responsibility as a person-centered care advocates. It is critical for determining if the appropriate standard of care was provided to the person. Failure to chart and poor communication is hard to defend. Furthermore, research has shown that certain core social and emotional needs tend to be neglected for the frailer adult such as the ones living with dementia when they are in the senior care setting. The concept of person-centered care requires that we plan, document and accompany the person in the most individual fashion to have the best possible outcomes by meeting their needs.

MASTERING THE ART OF DOCUMENTATION

1. **Avoid the word "Resident", "Patient" or "Client":** Rule #1 of person-centered care and customer service is to call the person by name and use the words "he" or "she".

2. **Start from the start – and never stop:** Making the documentation specific to the individual should start even prior to admission or move in and throughout the length of stay.

3. **Interdisciplinary:** Person-centered documentation is an all-inclusive process that should be accomplished by the key departments, and include any person or staff caring for the resident.

4 **Person-centered:** Effective documentation first considers the resident for the individual that they are. The resident needs to be asked how they want to be called, what their preferences are and how they want to be cared for. If they cannot be included in the process, a family member should be reached and if no one is available, past successes or observations should support the personal documentation.

5 **Avoid Copy/Paste:** One should avoid copying and pasting documentation from records to records – at least from one resident to the other. The more individualized the documentation, the better the story is told, the best care and experience will be provided to the person.

6 **Wellness and strength based:** The way documentation is articulated needs to take into account more than the diagnosis of the resident. It ideally includes the person's strength, what they are good at, and their preferences. It is important to consider the wellness or strength models when creating personalized goals.

7 **Dimensions of wellness:** Wellness is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Moving away from the 3Bs (Bingo, Bible, Birthday) and incorporating every dimension of wellness support person-centered care.

8 **Measurable:** The care plan should include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. This will help the rest of the team and serve as a benchmark for noted improvements or necessary modifications.

9 **Document immediately:** The more we wait to take note of an event, the more likely we are to forget or make mistakes – whether good or bad, any event should be noted so the whole team is aware and proper care and engagement can be provided.

10 **Telling a story:** The documentation should tell a story of how we're caring for the person, how they evolve and what we're doing to adapt in meeting their needs.

Linked Senior has made available a care plan/ISP (Individual Service Plan) cheat sheet and other helpful resources to help you, they're available at **linkedsenior.com**. As always, feel free to contact us if you have any questions or want to learn more!

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