DOS AND DON'TS

CBAS Care Planning and Daily Documentation

1. ASSESSMENTS (INITIAL AND ONGOING REASSESSMENTS)

Do:	*Don't:*
Use professional observations	Rely only on asking the participant
Include all required disciplines in the assessment process	List physical therapy as a specialized service but have no Physical Therapist as part of the MDT
Complete assessments timely	Complete assessments after the treatment plan is created
Have all MDT members review completed assessments	Submit documents that show discrepancies and confusion between MDT members
Have qualified personnel sign and date their assessment and the signature page in the IPC	Use signatures of MDT that no longer work at the facility
Assess the participant as conditions change, i.e. hospitalization, medication changes, fall, ER visit, absences etc.	Limit assessments for someone whose condition is deteriorating within the 6-month authorization period
Ensure the assessment and need for services is reflected in the IPC	List problems on the IPC that were not identified during the assessment

2. INDIVIDUALIZED PLAN OF CARE

Do:	*Don't:*
Use information that can be found in the participant's health record	Use information that can't be found in the participant's health record
Create a plan of care that is realistic and achievable	Create a plan of care that is unrealistic and unattainable
Set goals that are realistic and achievable for the participant	Set goals that the participant is physically or mentally not capable of meeting
Develop Problem Statements that relate to the need associated with the participant conditions or disabilities	Only use the medical/mental health diagnosis for a problem statement
Document specifics of what is done to help a participant deal with an identified problem	List problems, but then document nothing daily on what was done to help deal with the problem, e.g. weight problem listed but no documentation of % food consumed at facility; prevent urinary tract infections but no measures described that would achieve this
Use social service interventions that meet the definition for social services	Use social service interventions that meet the definition of a therapeutic activity
Include scheduled core service(s) daily	Leave out core service(s) daily
Include interventions that reflect the	Use interventions that should be part of the

participant's individual needs/problems	**standards of the facility, e.g. keep aisles free from debris; or out of the scope of the facility, e.g. monitor sleep patterns, etc.**
Be specific and use necessary words to convey the problem/need	**Fill the boxes with unnecessary, unrelated words that don't relate to the individual participant ("fluff").**
Use measurable goals with timelines. Include measurements such as frequencies, intensities, percentages, scales, etc.	**Use goals that can not be measured, e.g. participant will sleep better at night.**

3. DAILY DOCUMENTATION

Do:	***Don't:***
Be specific and descriptive regarding the participant. Develop baselines	**Make the reader guess what is going on with the participant/ use the same descriptors for all participants**
Document the participant activities and responses on the flow sheet as described on the IPC	**Use a canned flow sheet that includes information unrelated to what the participant needs or receives while at the facility**
Include a legend/key if acronyms, check marks, +/- are used	**Force the reader to guess what a facility uses as "shorthand"**
Describe/include the participant's responses/reaction to the intervention/treatment being provided	**Only describe what staff are doing or have provided**
Document "unplanned" or PRN interventions done for the participant and explain why they were done in the health record	**Fail to document "unplanned" or PRN interventions e.g. wound care from a fall**
Talk with the participant's caregivers and personal health care professionals. Use informants when indicated	**Forget to document interactions with caregivers and personal health care professionals.**
Document the services you provided on a daily basis or reason service was not provided.	**Document that services were provided when they were not done/provided.**
Enter a "late entry" when you failed to document something on the day it was provided (be sure you actually provided the service).	**Document a late entry without noting it as a late entry.**