CALGARY FAMILY SERVICES

PROCEDURE STATEMENT

Section: Client (Caregiving Files)

Procedure Number: **PS-104-C**

Good practice dictates the need to maintain client files. The counselling and caregiving files have distinct formats. The following guidelines are in effect for files concerned with caregiving clients.

GUIDELINES

1. The Caregiver Supervisor, and Access Coordinators maintain files on all active cases.
2. Software is used to maintain client files. Hardcopy files are kept in secure file cabinets with Calgary Family Services.
3. Each client's file is to contain the following information:
   - Completed Intake form
   - Completed Assessment form
   - Client Service Agreement
   - Service Plan
   - Signed Medication Release form (if appropriate)
   - Signed Money Release form (if appropriate)
   - Service Authorizations from Calgary Health Region
4. The file recording should include a client's health status, family dynamics, living situation and a description of the required services.
5. A review of the client's circumstances is to be conducted every eighteen (18) months and recorded on the file.
6. The client's file is closed within two (2) months of termination of service. The closing summary should include:
   - Documentation of the service authorization dates
   - The reason for termination of service
   - Any further recommendations for the client
   - Last day of service
7. A file closure should only be done after the needs assessment and Service Plan have been reviewed by the Supervisor, and any needed referrals have been made to other community resources.

FLOWSHEET MANAGEMENT PROCESS

Flowsheet Placement:

- As new **city-funded** clients are assessed, supervisors are to complete the service plan, insert it into the plastic sleeve of an agency 'Red Book' and leave it in the client's home. At the time of data entry into Procura, the supervisor will indicate under 'Reference Numbers' on the client general tab that the flowsheets are in the client's home.
- As new **CHR** clients begin service, the caregiver is expected to ensure that there is an agency 'Blue Book' placed in the client's home, and that a CHR careplan is inserted into the plastic sleeve as soon as possible. If the caregivers assigned to the client do not have a new 'Blue Book', their supervisor is responsible to have the caregiver pick one up from the office, or to deliver one to the client's home within the first 3 days of service. The caregiver's Access Coordinator is to ask the caregiver whether a 'Blue Book' is in the home when setting up the first visit, and indicate under 'Reference Numbers' on the client general tab that the flowsheets are in the client's home . If the supervisor delivers the flowsheets, it is his/her responsibility to verify the placement of the flowsheets in Procura.
- As supervisors visit existing city-funded and CHR clients, they will update Procura to indicate presence of flowsheets in the home.

Flowsheet Return:

- As 'Red' or 'Blue' books are returned to the office from **terminated or discharged clients**, they will be given to Alix Milton to dismantle; then completed pages will be placed in the mail slot of the supervisor responsible for the geographic area. The supervisor then indicates in Procura under 'Reference Numbers' on the client's general tab that the flowsheets have been returned.
  {Click on the add/del drop-down button under Reference Numbers, select 'Flowsheets Returned to Office'. Select arrow to move selection across to the left side of the screen, close, and select 'Flowsheets Returned…', then select 'Y' from the drop-down box}
- As excess flowsheets are culled from **active client** files by supervisors or caregivers to thin the home files, they are assessed by supervisors for charting and sent for filing as directed in the process below. Only the 'Flowsheets in home' is to be indicated in Procura unless the client is **terminated or discharged** and the final set of flowsheets has been returned.
- Supervisors will assess returned flowsheets for accuracy and appropriateness of the caregivers' documentation. Aspects of documentation to be checked are:

  - Client name on each page
  - Each page numbered
  - Year and date correctly documented
  - Tasks signed off match service authorized
  - Tasks initialled
  - Careplan marked as checked at least once per week
  - Documentation completed in pen
  - No white-out or scribbling out of notes is acceptable; errors are to have a single line drawn through them and be initialled by the caregiver
  - Narrative notes are to be objective and relate to significant incidents or status changes. Name of client must be at the top of narrative notes pages. No spaces are to occur between entries, and any empty space in notation is to have a single line drawn though it. Narrative notes must have the date, time, and initial or caregiver signature attached

- Once documentation has been checked, the supervisor will write the client numbers (Procura or C-views, or both) in red ink across the top of the first page of flowsheets, and indicate whether the file is open or closed. The flowsheets can then be placed in the separate 'to be filed' mail slot behind the reception desk for Alix to file.
- The supervisor will follow up with the caregiver related to any documentation issues arising.

Related Policy and/or Procedure: C-04

Procedure Developed By: _____ Date: _____

Chief Executive Officer's Authorization: _____ Date: _____

Revised: January 2006