CHILDREN'S FILES: SUMMARY OF SERVICES
FACE SHEET AND PROGRESS NOTES

I. Face Sheets

A. Face sheets will be the responsibility of designated education or family services staff (file managers) to complete.

B. All entries must be dated. Information documented on face sheet that has been identified as a problem/need or needs further information in general, must be recorded in the progress notes (child's file).

II. Required information

A. Center staff will attach the following information behind each tab page in the order given :

Program Face Sheet

EN-1 Enrollment Summary of Services
Application
Recruitment Home Visit
- Recruitment Notes
- Recruitment notes reviewed by CFA/Teacher/FE and date reviewed
- Verification of Income
- Documentation of Need (Referral Letters, Documentation of Disability/Special Needs

EN-2 Enrollment
Date of Enrollment
- Emergency Notification/Bus Policy
- Letter of Agreement
- Parent's Consent Form
- Authorization to Release Information

Attend Open House
- Initial Home Visit Scheduled

EN-3 Intent to Re-enroll (Head Start only)
Intent to Re-Enroll/PIR Update completed (file in front of application)

2. Education Component Summary of Service
E-1 Child Screening and Assessment
- Screening (ASQ and ASQSE and marked "potential problem or OK as needed)
- DECA
- Developmental Assessment (baseline entry and updates)

E-2 Comprehensive Parent Staff Conference
E-3 Individual Child Goal Tracking Sheet
E-4 Classroom and Home Visit Observation
E-5 Transition
E-6 Special Event and Field Trip Permission
E-7 Classroom Attendance
E-8 Home Visit/Home Base Attendance

E-9 Classroom/Home Visit Attendance Plans

1. Health Component Summary of Services
   - H-1 Certificate of Immunization Status (date and check appropriate box)
   - H-2 Developmental History (date and check appropriate box)
   - H-3 Health History (date and check appropriate box)
   - H-4 Medical Alerts/Allergies (indicate concerns with a date identified)
   - H-5 Vision Screening (date and check appropriate box)
   - H-6 Audio Screening (date and check appropriate box)
   - H-7 Nutrition Assessment (date and check appropriate box)
   - H-8 Well Child Exams (note date in appropriate box)
   - H-9 Dental Screens (EHS)/Dental Exams (EHS/HS) (note date in appropriate box
   - H-10 Internal Referral (date and brief explanation)
   - H-11 Incident Reports (date and injury type)
   - H-12 Emergent Health Concerns/Issues (date and description)
   - H-13 Medication Administration Authorization (date)

2. Social Services Component Summary of Services
   - SS1 Family Partnership Agreement (date)
     Assessments Reviewed monthly(date of reviews)
     Family Goals Developed/Written (number of goal, date written and completed)
   - SS2 Emergent Needs Identified (date need identified & follow up done)
   - SS3 Emergency Crisis Assistance
     Emergency/Crisis Identified (date)
     Emergency/Crisis Plan written (date)
     Emergency/Crisis Plan reviewed/updated (date)
     Child Abuse & Neglect Concerns (dates reports are made and dates when Child Welfare reports back)
   - SS4 Parent Education/Support Group Participation (Day and month attended)
   - SS5 Parent Center Meeting Attendance (check months parents attended)
   - SS6 Home Visit/Contacts (date and type of contact)

6. Mental Health Summary of Services
   - MH1 Potential Social-Emotional Developmental Issue Identified (date)
     Social-Emotional Issue Discussed with Parent (date)
   - MH2 Request for Mental Health Consultation (within UMCHS)
     Need for Referral Discussed with Parent (date)
     Parent Permission Granted (date)
     Internal Referral (date completed)
     Individual Observation/Assessment/Consultation (date completed)
     Parent Conference (date completed)

Positive Guidance Plan Developed (date completed)
Positive Guidance Plan Evaluated/Revised (dates)

MH3 Mental Health Referral to Community Agency
Need for Referral Discussed with Parent date)
Parent Permission Granted (date)
Release of Information signed (date)
Screening/Referral Information Completed by UMCHS MH Professional (date)
Parent Conference (date)
Referral Made: Agency: (date of referral and name of Agency)
Follow Up (dates)

7. Disabilities Summary of Services:

D1 Potential Developmental Concern
Concern Identified (date and source)
Concern Discussed with Parent (date)
Internal Referral (date)
Internal Observation (By Head Start) (date)
Release of Information from Parent obtained (date)

D2 Parent/Program Referral to ESD
Referral Date (date)
Observations/Evaluations by ESD (date)
Qualified for service/Not Qualified for services (date)

D3 Disability Documentation
Referral/Summary Form or Letter from ESD (date)
IFSP Eligibility Meeting (MDT DATE) (date)
Disability (name of documented disabilities)

D4 IFSP Dates
Initial IFSP (date) Current IFSP (date)
6 mo. Review (date) Annual (date)

D5 Progress Notes RE: Head Start Education Services related to IFSP Goals or ESD Consultation (progress notes)

D6 Services provided by ESD Consultants/Specialists (date)

8. Child Care Summary of Services

CC1 Child Care subsidies eligibility (date of eligibility on appropriate line)
JOBS DHS/Employment Related Day Care/Enhanced Contract (date eligibility ends, date met with caseworker, date co-pay received)

CC2 Parent Handbook Reviewed with Family (date)

CC3 Feeding and Toileting Charts (Infants & Toddlers) (date and indicate type of feeding)

CC4 Special Concerns (date and type of concern)

I. Progress Notes

A. All entries must include:
   1. The recording date
   2. Actual dates of services/observations
   3. Signature and title of person recording the entry
B. Required Information
   1. Center staff will record:
      a. Document on a monthly basis or as needed, information regarding child and family progress in relation to Comprehensive Parent Staff Conference goals, Family Partnership Agreement, monthly observations and parent input. Record goals and individualized plans, information related to health, nutrition and dental progress, as well as, high risk concerns/issues and disabilities.
      b. Pertinent information required on the Face sheets for each component will be recorded in the Progress Notes
      c. Record information, observations and referrals about questionable behaviors received from Special Education/Mental Health Consultants, Education Director and Mental Health/Disabilities Director.
      d. Record information received regarding sporadic home visit and classroom attendance and plans made with parents to correct the problem. Then record progress made toward correcting the difficulty
      e. Record hearing and vision information received from the Health Resource Specialist.
      f. Disabilities services/information provided by consultants and IFSPs.
      g. Other information as necessary.
   2. Grant County Center Manager, South Morrow Child and Family Advocate/ Family Educator and Wallowa County Education Manager/Family Advocate, will ensure the completion of:
      a. Information on speech, disabilities and mental health services on the Mental Health/Disabilities face sheet
      a. Social Services information on the Social Services face sheet
      b. Health information on the Health Services face sheet

GUIDELINES FOR DOCUMENTATION IN CHILDREN'S FILES\PROGRESS NOTES

Reporting systems not only document efficient and effective services, they also serve as legal tools, providing a channel of communication between members of the helping team, and ensure continuity of services. Thus, it is essential that staff members understand and utilize the principles that enable them to maintain professional standards in their documentation. A review of these principles are as follows:

I. Document services provided to the client that are not documented clearly and/or completely elsewhere in the file (on home visit forms, goal sheets, etc.) "If it wasn't recorded, it didn't happen".

II. Document all direct and referral services as clearly and concisely as possible. This includes client actions, perceptions, and observations as well as how staff members have worked WITH not FOR families.

III. Write neatly and legibly. This facilitates communication between members of the team. It is also important if agency correspondence or records were reviewed for legal reasons. Clear, legible notes would be evidence that time was taken to help service the client. These notes would also serve as an accurate reminder of the nature and sequence of events that took place.

IV. Use proper grammar and spelling. Notes free of errors create a positive impression. They imply that a staff member has a good education, intelligence, and concern for doing a job in a professional manner. Be sure to keep a dictionary handy and use it! Write clear concise sentences. Avoid useless or unnecessarily long words.

V. Write in blue or black ink. This enables a permanent record to be photocopied clearly, if needed.

VI. Sign and date all entries. Every entry into agency case notes should begin with a date and identify when services were provided if not on that date. Documentation should end with the worker's signature. Reports and evaluations should include dates, place, and time of evaluations as well as the credentials of involved professional(s).

VII. Be specific and separate fact from opinion. Record what you can perceive through your senses, describing specifically what was stated, seen, smelled, felt, or otherwise experienced. Clearly label opinions, interpretations, or personal feelings as such. Compare the following entries.

   A. **A poor entry**: Client's home was both filthy and unsanitary...She appears to be an unfit mother. . .

   B. **An appropriate entry**: While on a home visit, I observed several pots and dishes in the living room with food crusted on them. The home also smelled of urine and unwashed clothing. The client stated that she hates being the maid "...

   The first entry would be judgmental since it is an interpretation of what was observed. It would also be unclear after a significant lapse of time. In contrast, good records are clear, objective, specific, and accurately separate fact from opinion.

VIII. Record case notes promptly. Accuracy and validity are enhanced by recording direct or referral services in a timely fashion. Therefore, notes from interviews and observations from home visits should be transferred into official recordings as soon as possible.

IX. Clearly identify who provided the services. This can be done by identifying the provider of the service as the subject. For example, "I called the state department of social services

after speaking with other staff members." Written in this way, the writers' actions are differentiated from others involved in the case.

X. Use only authorized abbreviations. Staff members should only use abbreviations accepted by the team. When in doubt, spell it out.

XI. Fill in all blank spaces on standard forms. Blank spaces imply that incomplete services have been provided to clients. If a request for information is not applicable to a specific client, put N/A in the blank. If a client refuses to give information, use an entry such as "client refused to answer." Share perceptions of obsolete or useless segments of standardized forms with supervisors.

XII. Clearly identify late entries. Sometimes important information from case records may be omitted inadvertently. In such cases, document needed information under the title "late entry." Remember to include the date and time it should have been entered as well as when it was actually entered. Entries should be made on the next available line of case records, **never** in the margin or squeezed in between other entries. Keep records free of entries that may look as if they have been altered to cover up errors.

XIII. Correct errors by drawing a single line through entries. Erasing, using whiteout, or heavily crossing out is unacceptable procedures in maintaining professional case notes. Never try to cover up an error. If an entry is recorded in the wrong way or place, it should be stricken with a single line or an "X" or the words "mistaken entry." In addition, the date and the writer's initials are to appear next to the inaccurate entry.

XIV. Include client strengths as well as problem areas. Although clients face multidimensional challenges on a daily basis, they also have strengths which help resolve some of these problems. Hence, a client's strengths as well as needs should be included as part of the case records.

XV. Omit irrelevant, unsupported information. Information which has no bearing on the delivery of services should be omitted. This may include such topics as a client's political, religious, or personal views; intimate, personal details or medical conditions which have little meaning to the helping process; gossip; problems and frustrations with agencies and other sources of information; entries which could be damaging to the client should she/he review his/her file.

The stability of a strong program is directly related to the caliber of its documentation. The agency's integrity within the community is maintained when its reporting system is completed in a professional manner. Moreover, exemplary documentation skills reflect quality services offered to families.

Adapted from NHSA Magazine