

THE QUALITY NEWS

"See people in the light of their potentials, not their problems"

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Person Centered Planning & Thinking PCP Facilitator's Be-Know-Do

This guide is important to all Person Centered Thinking Coaches and facilitators. *This is a small guide to what a PCT facilitator should **BE**, what a PCT facilitator should **KNOW** and what a PCP facilitator should **DO**:*

BE: Approachable; a great listener to both words and behaviors; open; assertive; responsive; be a guide; a planner; be genuine; committed; a learner; be non-prejudiced; be grounded; be empathic; respectful; motivated; acceptable to the person; flexible; non-judgmental; organized; patient; be a good communicator; be an advocate and be empowering

KNOW: Person Centered Thinking tools; who to involve and how; own limitations; where to go if others need more than you can offer; how to network; what can influence what people say; how the individual communicates; whose PLAN it is; that its an ongoing process; the purpose of the plan; principals and values of Person Centered Thinking; knowing "it's not just paper"; you are not perfect; you are not there to solve all problems and it's not about you.

DO: Listen; observe; encourage; Involve and enroll the people that matter to the person; encourage ownership; establish ground rules and purpose; share information; enable everyone's voice to be heard; check everything back with the person; set actions; identify who will do what by when; make sure someone will be following up the actions;

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Therap Tips!

Writing Great T-Logs

We no longer have books or ledgers to document the day to day happenings at our programs as we have the ability, in real time, to record information in Therap using the T-Log Module. Perhaps at first glance, it may not seem that urgent or maybe the details of day to day living seem unimportant. Nothing can be further from the truth. T-Logs are critically important in all operations of our programs. T-Log documentation is not only an agency policy but a DDD Licensing requirement.

By using Therap, we have a module that allows us to enter this data in a simple and effective way allowing us to enter and share daily shift notes, case notes, communication from shift to shift, information and progress notes with other staff members at other locations.

So How Do I Write A Great T-Log?

1. Professionally! Always remember that this is a legal document!
2. It is critically important that a T-Log is documented for each individual for each shift! Be specific and use as many details as possible. Therap allows you to enter 10,000 characters when creating a T-Log! Use it! You are documenting critical information—try not to rush through what you are writing!
3. Do not be vague! Do not write "Personal Care provided to Max". Ask yourself, if you read this—what exactly does this mean? Did Max have a shower, a bath, did he brush his teeth, shampoo his hair...? **BE SPECIFIC:** Tonight, Max had a shower, he had his hair washed, physical assistance provided to brush teeth. Assistance provided to Max with shaving using his electric razor. Another bad example would be: "Max had breakfast". Ask yourself again—that could be anything! For me personally, breakfast could be a hot cup of tea! Be specific: Max had a bowl of cereal, orange juice and coffee for breakfast"
4. Meaningful Information! When documenting a T-Log—think about the person. What kind of a day / night did they have? Did they require any assistance? Did they have a guest? Did they enjoy an activity? Speak to a family member? Did they express any concerns? Did anything unusual happen? Document accurate, yet detailed information that is meaningful and valuable.
5. DO NOT write GROUP T-Logs: such as "Everyone had dinner and personal care"
6. Record FULL NAMES of each staff person working and do not use nick-names. Indicate who is a Substitute from another program. This is also critical information.
7. CLICK TO SHARE!!! Did something occur where that the data you are entering needs to be communicated to another program who is supporting the same person? For example, Did you have to administer a PRN? Is the person not feeling well today? Do they have something wonderful they want to share with others?
8. Entries should also include if a parent/family member or medical professional communicated with the program, if there was an administration of a PRN, new or changes in medication, all incidents (GERS), staffing issues, recreation or outings, Emergency Drills and or ANYTHING that was unusual OR that just has to be documented and communicated.
9. Always be clear, accurate and detailed.
10. T-Logs are NOT OPTIONAL—These MUST be completed for each and every individual on each and every shift!

If you have a Therap tip email us @:
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We are currently using:

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