Clinical Documentation Notes Instructions

e.g. SOP, DARP, PCARE, etc. Notes

Purpose:

- Record experiences with client care.
- Use entries to prepare for and reflect on participation with treatment activities.
- Examine the clinical significance of the client's condition and current functional status to the identified goals and selected treatment activities.
- Demonstrate ability to accurately document according to guidelines of facility.

The Role of the Student	The Role of the Clinical Supervisor
1. Completes structured clinical notes for a minimum of **<u>3 clients</u>** using the format of the placement facility. Have the Clinical Supervisor make corrections on your clinical notes. 2. Continues to document on your clients with input from your Clinical Supervisor. Once you have determined your entries are consistently written accurately, complete a minimum of **<u>additonal 3 clinical notes</u>** which are error free and have your clinical supervisor sign the "Clinical Documentation & Caseload Management Form" 3. **Submit** the signed/Verified "Clinical Documentation & Caseload Management Form" at the end of the placement to the appropriate assignment drop box on eCentennial. ***Blank template and samples are available for your use, but you do not need to use them, you can create your own, or use those of the facility.***	1. **Review student entries** (frequency to be arranged with student) and correct the first set (minimum of 3 clinical notes) written by student. 2. Continue to review clinical documentation to ensure accuracy of entries. Once you have determined that student's clinical documentation is according to facility standards, sign off on "Clinical Documentation & Caseload Management Form". 3. Signed/Verified "Clinical Documentation & Caseload Management Form" will be submitted by the student at the end of the placement to the College.

~SAMPLE~

Clinical Documentation Form Sample

Student Name: John Smith **Date:** Jan. 1, 2013

PLACEMENT: ☐**Introductory** ☐**Intermediate** ☐**Internship 1** ☐**Internship 2**

DATE	REPORT
Jan. 1, 2013	S. Obtained consent c/o pain in right knee, “not bad” O. Right knee, no swelling, no redness, no warmth noted No pain on standing Treatment: Taught knee exercises in lying Ambulated with LWW, min. assist x 1 Tolerated treatment well, no significant pain when ambulating Client left sitting in wheelchair at bedside, call bell in reach. P. Inform PT about right knee pain.
Jan 1, 2013	D. A. R. P.
Jan 1, 2013	PCARE

SAMPLE

This is a worksheet to practice clinical documentation. Use of initials or first name only is acceptable for maintaining of client confidentiality.
DO NOT USE FULL NAMES.
This is NOT to be submitted to the College

CLINICAL DOCUMENTATION FORM

Student Name: _____ **Date:** _____

PLACEMENT: ☐ **Introductory** ☐ **Intermediate** ☐ **Internship 1** ☐ **Internship 2**

DATE	REPORT

SAMPLE