


DOCUMENTING OUR EFFORTS: GROUP DISCUSSION & PRACTICE*

▶ ABOUT THIS ACTIVITY

 **Time:** 40 minutes

 **Objectives:** By the end of this session, participants will be able to:

- Defined reasons for documenting our efforts.
- Discussed ways to communicate interactions with outreach peers.
- Reviewed Peer Education Training Site (PETS) documentation forms.

 **In This Activity You Will...**

- Facilitate a discussion about the purposes and importance of documentation (15 minutes).
- Walk through a scenario and work with peers to document findings (25 minutes).

 **Materials:**

- Handout- Documentation Scenario
- Handout- Educator Clinical Notes (one for each participant)
- Blank flipchart
- Markers

 **Preparation:**

- Identify a peer volunteer to read the scenario.

Instructions

1. Ask what the purpose of documentation is. Record responses on the flipchart sheet. Make sure the list includes the following:

- To communicate with team members
- To record and evaluate progress
- To determine what works and what doesn't
- For billing purposes
- To remember what is being worked on
- To document that it happened

2. Explain the importance of documentation for PETS purposes.

- Documentation is very important. You have mentioned some positive things about it, and also some problems.
- Peer Educators work closely with other health care providers to provide the best care. As Peer Educators, you will be responsible for documenting each contact you have with the peers you work with.
- In many health care disciplines, they say, "if you didn't write it down, it didn't happen." It is very important to make a brief note every time you have an interaction with a peer for future reference.

3. Discuss the essential components of documentation, record on a flipchart sheet.

- Documentation is different from other kinds of writing, like journals or letters. What are your ideas about how a chart or clinical notes should be written? [Make sure the list includes the following:]
- Include "just the facts" (objective)
- Describe behaviors, not opinions
- Keep it simple and succinct (K.I.S.S.)
- Note critical information, like the person has thoughts of suicide or death.
- Avoid judgmental terms
- Avoid descriptions of illegal or other activities that could affect

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insurance coverage

- Write notes immediately after seeing patient
- Record what is necessary to know as opposed to “nice to know”

4. Introduce the key “rules” for documentation

- Unless your clinic says otherwise, there are some general guidelines about documentation. [Elicit group feedback about this. Record on a flipchart. The list should include the following:]
- Write neatly, legibly
- Use black ink
- If there is an error, don't use white out. Write a single line through the error and add your initials and the date above.
- Use only agency approved abbreviations
- Except for professionals, no other person's name should be included. You can use. “Joe's boyfriend.”
- Complete the records in a timely manner

5. Introduce PETS documentation forms.

- Clinics often have their own forms and protocol for filling them out. If the clinic or organization where you're working has their own form, then you should use those. However, many organizations don't have specific forms, so let's create a good sample note together that might be helpful to you in the future. Please take out your peer educator clinical notes handouts.
- Let's use the documentation scenario to practice writing a note. Will someone be willing to read the scenario? Using our PETS documentation, let's write a progress note together.

6. Following the peer educator clinical notes handout, go through the scenario with participants. Record details from the scenario on a flipchart.

Summary

Wrap up session.

* This module is part of the online toolkit Building Blocks to Peer Success. For more information, visit http://www.hdwg.org/peer_center/training_toolkit. This module comes from Duke University, Partners in Caring; Center for Creative Education, 2006.

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SESSION HANDOUT #1 of 2

DOCUMENTATION SCENARIO

Jane Doe has come to the clinic only twice but seems eager to follow a medication regimen. She had a high viral load at the first visit and was started on her first regimen after her second visit. She has now missed two appointments and her health care provider is concerned that she may be lost to follow up at a time when her viral load was already high. He also tells you that Jane has a history of drug use, and that he suspects that she may be using at this time.

You contact Ms. Doe and she agrees to meet you at her home which, at the time, is a motel. When you are invited in, she tells you that she is living with her husband in the motel because they have not been able to find housing or afford the initial deposits. You notice that Ms. Doe has a bruise over her cheek and that she seems withdrawn. After you have introduced yourself and asked Ms. Doe if you can talk about her health, she agrees and tells you that her husband wants to be a part of her health care decisions. During your conversation, Ms. Doe says that her husband questions why she has to take all her medicines when they make her sick. She also tells you she is now pregnant and that she and her husband think that the medicines will hurt the baby.

There are a number of knocks on the door as you are talking to Ms. Doe. As you talk to her, you recognize that Ms. Doe seems to like you. When you tell her that you are a peer and are also HIV+, she tries to talk more.

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Patient Name: _____

Medical Record Number: _____

PEER EDUCATOR CLINICAL NOTES

Date: _____ Length of session: _____ minutes

Setting: _____ (i.e. home, clinic, other)

Referred by: _____

Reason: _____

Today we discussed the following issues (check all that apply):

_____ How things are going in general.

_____ Treatment plan (a plan that patient and provider agreed upon to manage HIV infection).

_____ How patient has been taking care of self (check all that apply):

Adequate Self Care	Area of Concern	Addressed in Session
Exercise		
Nutrition		
Body image		
Rest		
Faith or spirituality		
Disclosure		
Relaxation or recreation		
Social support		
Substance abuse (ex: drugs, alcohol, tobacco)		
Safer sex practices.		
Keeping appointments		
Medication adherence		

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Patient Name: _____

Medical Record Number: _____

The patient identified the following strengths s/he can draw on:

I assisted the patient in developing the following action plan:

Actions to take:

I made the following referrals for assistance:

Suggested topics/issues to address during the next session with the patient:

Signature of Peer Educator: _____

Date: _____

SESSION HANDOUT #2 of 2 (cont.)