

SOFT CHART AUDIT

CLIENT NAME: _____

INTAKE COORDINATOR RESPONSIBILITY:

- _____ Referral
- _____ New Client Admission Check List/Initial Care Planning Sheet
- _____ Coupon/SCSA/or Payment Agreement in record
- _____ Signed Admission Forms/PIF

RECEPTION STAFF RESPONSIBILITY:

- _____ Transportation ____ Para ____ Shuttle ____ Private
- _____ Name Tag
- _____ Complete Attendance Sheet
- _____ Picture of client (Reception staff responsible/sign off)
- _____ Input Dayware profile
- _____ Input Electronic PIF

CASE MANAGER RESPONSIBILITY:

- _____ 3 Day Visit Assessment (*Intake Summary*)
- _____ Professional assessment check:

- OARS** **Nursing** **Activity** **OT** **Tinetti**
- Nsg* _____
- OT* _____
- SW* _____

- Initial treatment plan

READY FOR HARD CHART:

Once all of the items above have been signed off it is ready for hard chart. File in “ready for hard chart drawer” (Clerical/Intake cabinet)

It is all staff responsibility to file all initial assessments directly to client’s record. **Not in file shelf!**

This Intake QA will be kept in the binder.

Discharge Client Record Procedure

Case Manager

1. Consults with the Interdisciplinary team to determine if discharge is appropriate.
2. Will indicate in the transportation book to discontinue transportation due to discharge.
3. Documents a progress note indicating discharge.
4. Completes a Discharge/Outcomes Summary; faxes it to the MD, (DSHS/PCHS Case Manager) staple successful fax confirmation to the discharge paper work.
5. Completes the Dayware profile.
6. File these two items in the **front** of the client's chart.
7. Place chart in gray **clerical file** drawer labeled Discharge.

Reception/Clerical Staff

8. Will QA for completeness and report to the **Case Manager who will be responsible of providing any missing paperwork** for completion.
9. Will file the discharged client's manila file folder in the Discharged drawer of the file cabinets. Any late filing will be placed in this discharged file.