AlayaCare Update – Support Documentation Standards

On May 9, 2024, Nousheen and I shared an article (click here) about challenges and ongoing improvements for AlayaCare. We noted that work was underway to determine standards for support documentation in AlayaCare. This article is our report from that work. Be warned – it's long. You can skim ahead to the chart that's relevant to your work environment if you need to, but if you're a supervisor, please take the time to read through it more thoroughly.

Terminology

Before I share the standards, here are a few words about terminology. Adjusting to new terminology has been a learning curve for all of us. When I first learned about *visits*, for example, I thought we were to only document when a person visited someone or was visited by someone. I know now that in AlayaCare, a *Visit* refers to **"***an event on a person's calendar indicating a specific appointment, activity, or support*".

We have also learned terms like *Care Plan*, and *Progress Notes*. While we need to know and understand these terms to navigate AlayaCare effectively, they do not always represent changes to the terminology that we use outside of the AlayaCare platform.

Pre-AlayaCare Terminology	***AlayaCare Terminology***
Support notes	***Progress Notes***, ***Visit Notes*** We still take great notes about the supports we provide – we just document them in AlayaCare *Progress Notes* or in *Visit Notes*.
Schedule, scheduled appointment	***Visits*** We still organize schedules and make appointments – we just document them as *Visits* in AlayaCare.
Personal Plan Goals Actions	Personal Plan, ***Care Plan*** Goals Actions There's one key, new term here – ***Care Plan***. In AlayaCare, the personal plan is initially entered in the Personal Plan Form found under Client Forms. This is more of static record of the Personal Plan once it is finalized. The live and trackable version of Goals and Actions from the Personal Plan are in the *Care Plan*. This is where goals and actions from the Personal Plan, as well as other actions, are entered and tracked as individual items. The Goals and Actions in the *Care Plan* are also trackable in *Visits*. The *Care Plan* can be found under the *Care Management* section of the person's profile in AlayaCare. From time to time, it's important to go into the Care Plan to understand progress on a person's Goals and Actions and make any updates to indicate completion of Goals and Actions.

*Terminology specific to AlayaCare has been *italicized*

The concept of clocking in and clocking out of v*isits* is also new for Karis. When a *Visit* is created, its status indicates that an activity/appointment/support is scheduled for a person. Clocking in and clocking out changes the *Visit* status to "Completed", which indicates that the service was delivered. Also, it is necessary to clock into a *visit* to be able to track progress on Goals and Actions that are scheduled as

Visits. We are still exploring the best use of this function. For now, it is not necessary to clock in and clock out of a *Visit* at the exact start and end time. In most cases (except night awake supports) you can choose to instantly clock in and clock out of *Visits* you are assigned to before the end of your shift to capture progress on goals and/or actions and to indicate *visit* completion.

Input and Output

I'm mindful that at this early stage of implementation, it might feel like we're putting more into AlayaCare than we're receiving from it. Let me assure you that we are increasingly able to take valuable information from AlayaCare, helping us to review support trends and demonstrate the impact of the support we provide every day. For example, the recent integration of Personal Planning and Goals and Actions allows us to show people, their families, and our funders the connection between the support we provide and the accomplishment of meaningful, self-directed goals. This is direct evidence of our progress towards the Onward outcome of self-direction, and our Karis mission of working together with people with disabilities to accomplish their goals.

Standards for Documentation in AlayaCare

I'm pleased to be able to share this update about our expectations for documentation within AlayaCare.

If you work in an environment with OVERNIGHT, AWAKE support:

Documentation	Purpose	Frequency	Remember…
"Routine Support" Progress Note	Daily support documentation	Minimum twice daily: ✓ one for daily support ✓ one for evening support	The intent is to reduce the number of *Visits* (which require clocking in and out and have limited space for notes) to *Progress Notes* while ensuring daily support documentation. Where a *Visit* exists with accompanying V*isit Notes*, a *progress note* might not be required.
Visit and *Visit Note*	Document overnight support requirements and support delivery	*Recurring Visit* capturing overnight supports as *Actions* attached to the *Visit*. Clock in at night shift start, check off actions completed, and clock out at end of shift.	✓ Add overnight supports as *Actions* to the *Care Plan*. ✓ Schedule a R*ecurring Visit* and attach overnight support *Actions* from the *Care Plan* to the *Visit*. ✓ Document support by checking off actions that are performed.
	Schedule and document *Visits* related to *Goals* and *Actions* in *Care Plan*	As outlined in the Personal Plan. Clock in, indicate progress on Goals/Actions, and clock out.	✓ Refer to the Personal Plan, goals and actions established during the Personal Plan process* - including goals and actions related to Passport funding (Ontario) and Personal Outcomes funding (Saskatchewan). ✓ Schedule a *Visit*, either recurring or non-recurring, for each action.

Documentation	Purpose	Frequency	Remember…
	Schedule and document *Visits* for regular activities and appointments	As they occur. Clock in, indicate progress on Goals/Actions, and clock out.	This could apply to activities like recurring therapy, regular recreational activities that aren't related to goals, family visits, etc. *Visit Notes* can be added if needed.

<u>If you work in a location with NIGHT SLEEP support:</u>

Documentation	Purpose	Frequency	Remember…
"Routine Support" Progress Note	Daily support documentation	Minimum twice daily: ✓ one for daily support ✓ one for evening support ✓ Add a progress note if intervention is needed in the night	The intent is to reduce the number of required *Visits* (which require clocking in and out and have limited space for notes) to *Progress Notes* while ensuring daily support documentation. Where a *Visit* exists with accompanying *Visit* Notes, a *Progress Note* might not be required. *Enter "*Communication Log", "Routine Support"*, or "*Health and Wellbeing*" *Progress Notes* as needed. "
Visit and Visit Note	*Schedule and document Visits* related to *Goals* and *Actions* in *Care Plan*	As outlined in the Personal Plan. Clock in, indicate progress on Goals/Actions, and clock out.	✓ Refer to the Personal Plan, goals and actions established during the Personal Plan process* - including goals and actions related to Passport funding (Ontario) and Personal Outcomes funding (Saskatchewan). ✓ Schedule a *Visit*, either recurring or non-recurring, for each action.
	Schedule and document *Visits* for regular activities and appointments	As they occur. Clock in, indicate progress on Goals/Actions, and clock out.	This could apply to activities like recurring therapy, regular recreational activities that aren't related to goals, family visits, etc. *Visit Notes* can be added if needed.

<u>If you work in a SIL (Semi-Independent Living) or CPS (Community Participation Supports) environment:</u>

Documentation	Purpose	Frequency	Remember…
"Communication Log" and "Health and Wellbeing" Progress Notes	Documentation about communication & health and wellbeing	As needed	This is to capture communication about or involving the person and changes in their health and wellbeing.

Documentation	Purpose	Frequency	Remember…
Visit and Visit Note	Schedule and document *Visits* related to *Goals* and *Actions* in *Care Plan*	As outlined in the Personal Plan. Clock in, indicate progress on Goals/Actions, and clock out.	✓ Refer to the Personal Plan, goals and actions established during the Personal Plan process* - including goals and actions related to Passport funding (Ontario) and Personal Outcomes funding (Saskatchewan). ✓ Schedule a *Visit*, either recurring or non-recurring, for each action.
	Schedule and document *Visits* for regular activities (including scheduled personal/direct supports) and appointments	As they occur. Clock in, indicate progress on Goals/Actions, and clock out.	This could apply to activities like recurring therapy, regular recreational activities that aren't related to goals, family visits, etc. *Visit Notes* can be added if needed.

<u>If you are supporting someone in a HOST FAMILY setting:</u>

Documentation	Purpose	Frequency	Remember…
"Home Sharer Contact" Progress Note	Contact with Host Family Provider (information about the Home Sharer) or the Home Sharer	As needed	Include details of contact with the Host Family Provider or the Home Sharer. Enter "*Communication Log*" and "*Health and Wellbeing*" *Progress Notes* as needed. Note: Tracking And Monitoring System (TAMS) will still track the required check-ins and visits with Home Providers and Sharers. Except for information about the Home Sharer, the documentation of contacts with Home Providers will continue to be tracked in as-is process.
Visit and Visit Note	Schedule and document all *Visits* supported by Karis Staff including *Visits* related to *Goals* and *Actions* in *Care Plan*. Also, unannounced *visits*.	As outlined in the Personal Plan. Clock in, indicate progress on Goals/Actions, and clock out.	✓ Refer to the Personal Plan, goals and actions established during the Personal Plan process* - including goals and actions related to Passport funding (Ontario) and Personal Outcomes funding (Saskatchewan). ✓ Schedule a *Visit*, either recurring or non-recurring, for each action.

<u>For all Service Types:</u>

a) Support outside of Karis Disability Services

Support that is received by a person outside of Karis Disability Services should be documented as a *Visit*, whether planned / unplanned, recurring / intermittent / periodic/ occasional. Select "Services Not Provided by Karis" under Services and enter the service provider name under Service Instructions. If this does not suit the situation you are navigating, please use a minimum of a *Progress Note*.

b) Goals and Actions in Personal Plan

Goals and Actions identified in the Personal Plan should be captured in the AlayaCare *Care Plan* so that progress and completion can be tracked.

In May 2024, we hosted webinars about Personal Planning, Goals and Actions in AlayaCare. Click here for more details. All existing goals and actions should be entered into AlayaCare by **August 30, 2024**.

Also releasing this week…

- I am pleased to share that the headings for Visits tiles will become clearer. Instead of having to open a visit labelled "Clinical and Medical Appointment" or "Community Participation and Relationships", it will show as a much more specific "Dental Appointment" or "Bowling". The new setup of services and service codes for Visits will enable you to select more granular details for the tile headings when creating a Visit.

We have seen a wide range of engagement with *Progress Notes* and *Visits* in AlayaCare – some people hardly use it, and some use it so much that the screen can't contain the notes! The standards provided here are intended to inform good practice. In general, a range of 0-6 visits is an effective utilization of AlayaCare's calendar function. If there are no appointments or activities to reflect as Visits, there must be at least one *Progress Note* for the day and one *Progress Note* for the evening to document supports provided.

We hope these standards make things clearer as we continue our transition to AlayaCare.

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