

Ground Rules for Paperwork

(First, the pep talk.) As a student clinician/speech ólanguage pathologist, sometimes the first impression you make on someone is made by your *paperwork*. If that õsomeoneö is a doctor on whom you depend for referrals (and therefore, for a job), you want to impress him or her with your professionalism and your competence. Misspellings, ungrammatical sentences, thoughts not clearly transmitted, and failure to follow commonly accepted practices relating to documentation make exactly the *wrong* impression. If the doctor can't confidently and fully trust you with his or her patients (based on that all-important first impression) then that first impression may also be your last!

Also, when communicating with your supervisor and peers, you want your thoughts to be expressed as accurately as possible. Your supervisor should be able to tell the outcome of your assessment(s); your goal(s) are measurable & objective; and your therapy plan(s) are well conceptualized and follow your long term goals. Additionally, your observations of the client's behavior should demonstrate awareness and insight. So your supervisor's feedback is designed to teach and guide you, not simply to catch typos. Remember that SOAP notes, Lesson plans, the Initial Therapy Plan/Updated Therapy Plan, and all the reports will go into the client's permanent record; they will represent you for a long time to come.

Now, do you see why we're so hard on paperwork? But don't worry. We try to remember you are a student and we *expect to have plenty of supervisory comments and corrections*. As you allow us to shape your writing, our comments will diminish . . . guaranteed. By the end of the semester, and by the end of your course work, you will not only be able to impress your referral sources, you may even surprise yourself with your professional writing style!

(Now the rules.)

- Include the full date on every note, and on every new page when a note carries over, include appropriate footer information. *Clients' initials, date and Page ___ of ___*. When the note or report is longer than 1 page.
- Underline test names, but not their abbreviations, put the initials of the test in parenthesis. Later you can use the abbreviations to refer to the test.
- To fix a mistake: WRITE the word "error" in parenthesis next to the mistake, then write the correct word and put your initials by the word in error. e.g., (~~articulation~~^{error}) cb
- Avoid the use of first person pronouns. Refer to yourself in the third person (e.g., "the clinician").
- Refer to the child clients by their first name, adults by their title (Mr., Ms., Dr., etc) and last name.
- Write your initials at the end of each SOAP note, in other words, once after the "P" section. If a note carries over to another page, initial at the bottom of the first page (even though it's in the middle of the note), so that each page will stand alone.

- Plan Ahead.
- Run your spell checker.
- Proof read what you've written. The *spell* checker is *not* perfect. (Yes, that passed my checker.)
- Any questions and comments from the supervisor are there for you to contemplate and incorporate into your next document. If we expect you to re-write something, we will say "re-write," "re-word," or "address," and/or "re-submit."
- Once the document has been "approved" with the supervisor's signature, it's finished! File the document in the client's chart immediately! Do not wait until the end of the semester to do this. Periodic chart audits will be conducted. Missing documents will be taken off your grade. As a professional, you do not want to have this type of confidential documentation on your person, remember HIPPA?