

8-1 Why, where and how to document

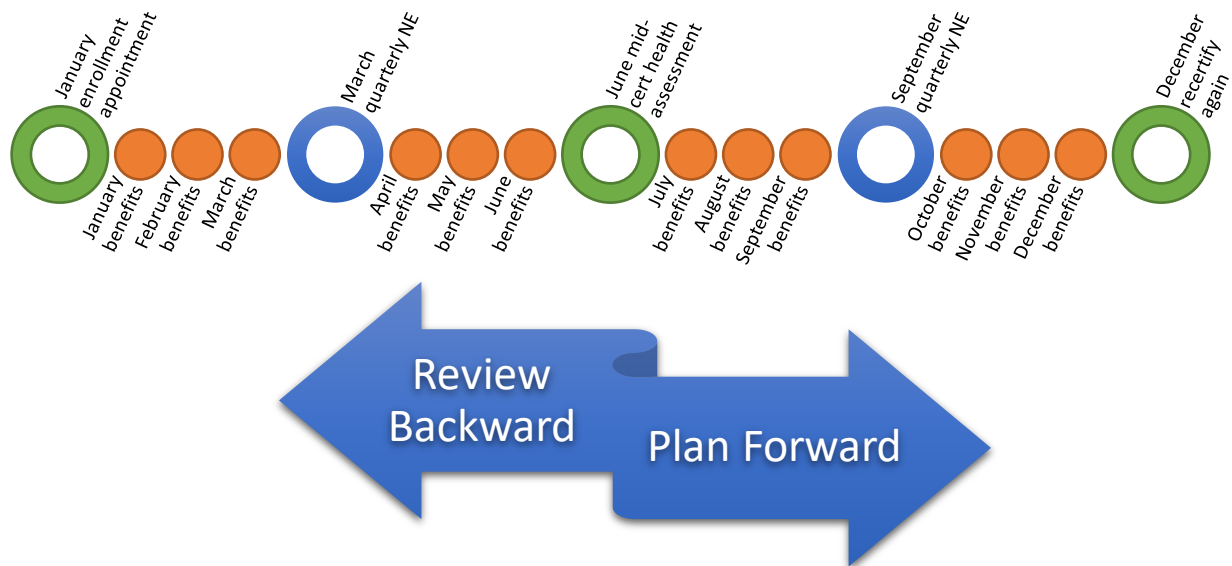
What does documentation mean?

Documentation means that information is typed in the participant’s WIC record in the data system. As a certifier, you are responsible for documenting important information about every participant you have contact with. Documentation is how WIC keeps track of the services that have been provided to WIC participants.



Good documentation is important because it allows other WIC staff to have a “picture” of the participant by reviewing their record. When documentation is thorough and complete, the whole picture is easier to see. Good documentation is a program requirement, but also helps the clinic flow more efficiently.

Documentation through the certification cycle – the whole picture



WIC staff will document what is planned for the participant and what actually happens. This allows us to plan forward and review backward to get the whole picture of the participant’s WIC life cycle. WIC staff will document everything that happens throughout the participant’s certification period– every contact, every phone call, every benefit issuance, every concern.

What is documented?

Information that is documented in the participant's record includes:

- Demographic information (name, address, phone number)
- Certification information (e.g., when the participant was certified, who performed the certification, information gathered during the assessment, and risks that made them eligible)
- Nutrition-focused counseling and education (who received it and what was provided)
- Referrals (which referrals were made)
- Plan (for quarterly nutrition education, follow-up care, progress made in resolving the nutrition concern or risk)
- Other (information that may be helpful to know at future appointments)



Types of documentation

As a certifier, there are 2 types of documentation you will do – fill in the blank or free form notes. Free form notes are documentation that is typed in your own words, rather than filling in a blank or selecting from a list. Sometimes documentation is required by the data system or by policy. Sometimes documentation is optional, but it provides a better picture for the next WIC staff person who sees the participant. For each kind of participant contact, you will document different types of information in the WIC data system.

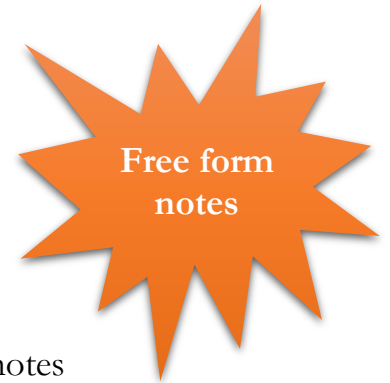
Fill in the blank documentation

- **Specific assessment data** - Some information is documented in a specific location in the data system. For example, the participant's date of birth is entered in the "Date of Birth" field and a hemoglobin result is entered in the "Hemoglobin" field. During certification appointments, the data system tells you what specific data needs to be entered and if it is required. You learned about this kind of documentation during your data system training.
- **Quarterly nutrition education appointment data** – You will document what types of nutrition education appointments the participant is scheduled for, the topics to be covered, and whether they attended the nutrition education.

Fill in the blank

Free form notes documentation:

- **Nutrition-focused counseling information** – This is when you document the topics that were discussed and the next steps the participant has agreed to. Counseling information may be documented in several different places.
- **Notes** – Observations, assessments, education and other information that isn't documented elsewhere in the data system is entered in notes. Notes help the next certifier get a better picture of what is going on with the participant. Clear notes help save time, ensure that follow-up happens, and help the next certifier continue where you left off. Notes are often referred to as **progress notes** because they show the progress of the participant.



Learning activity

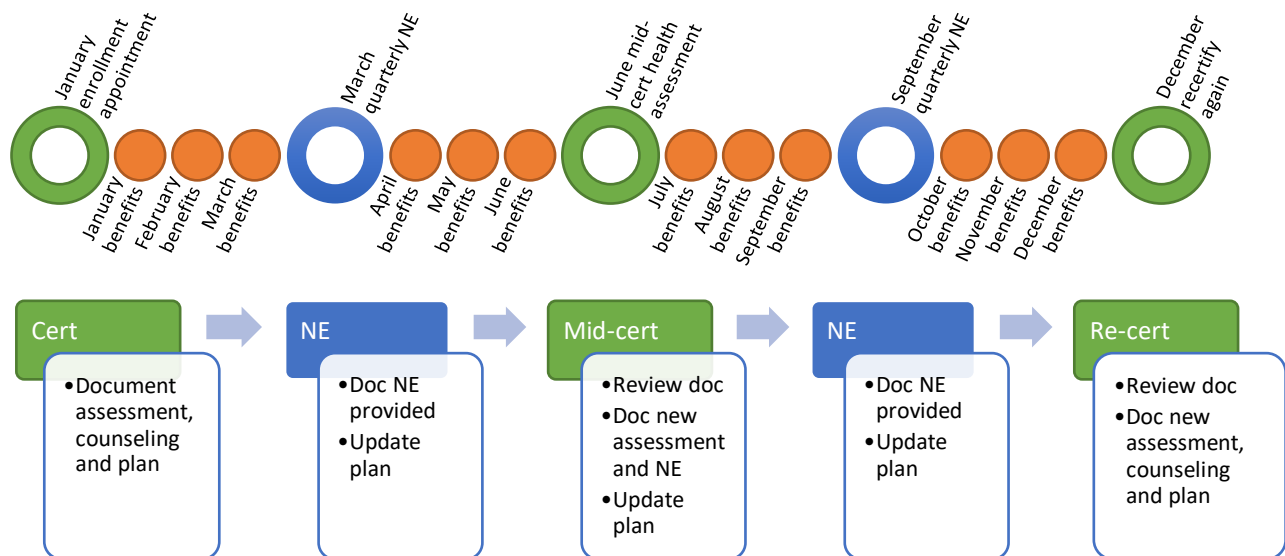


Review the documentation in a participant's record. Locate:

- Specific assessment data
- Quarterly nutrition contact data
- Nutrition-focused counseling information
- Notes or progress notes

Quarterly documentation

Since we document every contact, that means something is documented in the participant's record at least every quarter for nutrition education and benefit issuance.



Learning activity



Review the documentation in a participant's record. Describe the counseling and quarterly nutrition education plan for the participant based on what you read.

How do you write notes?

Notes can be entered in a variety of places in the participant record, some are based on state policy, some based on agency practice. Each agency has a process that they follow so every WIC staff person can find and understand the notes.



Considerations:

- Which data system location does your agency use for notes?
 - Within each local agency, the location must be consistent. This helps everyone know where to find the information after it is entered.
 - Example – Is everything documented in the progress notes location or in notes throughout the participant record?
- Are different kinds of notes documented in different places?
 - Example – Is information about a risk factor assignment in notes in the assessment area in progress notes?
- What specific abbreviations or short-hand for certain words does your agency use?
 - Use the same abbreviations consistently will make it easier for others to understand the note.
 - Example – Is the mother referred to as mother, mom, MOB (mother of baby), MOC (mother of child), parent, or by name?

Learning activity



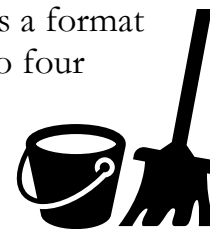
Ask your training supervisor about your agency process on documentation. Review a participant record and find where notes are entered.

What common abbreviations are used in your agency?

Common word or phrase	Abbreviation in notes
Mother, father, caregiver	
Appointments, follow-up	
Doctor, health care provider	
Medical or health conditions	
Others?	

Writing progress notes – remember SOAP

To make it easier to write and organize good progress notes, WIC uses a format called **SOAP** notes. The SOAP note format separates information into four sections – **S**, **O**, **A** and **P**. Each letter stands for a word that helps you remember what information is entered in that section.



SOAP stands for:

- **S** – Subjective
- **O** – Objective
- **A** – Assessment
- **P** - Plan

There are other formats that can be used to document the same information. Some WIC nutritionists may use a different format, such as a PES (problem, etiology, and signs) statement, or add other sections such as I for Interventions. Most people in the health or medical field are familiar with the SOAP note format, but any format that includes the key information is okay.

	Section:	What you write:	Examples:
S	Subjective	<ul style="list-style-type: none"> • Information the participant tells you, including about living situation • Participant concerns or questions • What is important to the participant 	<ul style="list-style-type: none"> • Mom says she has diabetes. • Baby was born with a cleft palate. • Mom is worried baby not getting enough breastmilk.

	Section:	What you write:	Examples:
O	Objective	<ul style="list-style-type: none"> Your interpretation of anthropometric and biochemical data What you observe 	<ul style="list-style-type: none"> Growth tracking on the same percentile. Bruises on baby's thighs.
A	Assessment	<ul style="list-style-type: none"> Your assessment of the participant's condition or growth pattern A summary of your critical thinking about risks assigned and what you have learned 	<ul style="list-style-type: none"> Participant understands her diabetic diet plan. Mom using bottle to keep baby quiet while co-parent sleeps.
P	Plan	<ul style="list-style-type: none"> Plan that has been agreed upon by participant, how it connects to the next step and quarterly NE Questions that need to be answered in follow-up Specific nutrition-focused counseling provided that has not been entered elsewhere Specific referral information that has not been entered elsewhere 	<ul style="list-style-type: none"> Scheduled follow-up appt with RD for next month. Check at next appointment to see if she has found a doctor. Recheck height and weight every month. Discussed why following diet plan is important with gestational diabetes.

Example of a SOAP note for a new pregnant woman:

Subjective – MOB @ 35 weeks gestation. Feels baby is coming any day. 1 visit to ER with false labor. PMD says everything is normal. Mom is eating 1c. yogurt every day and tolerates lactose free milk. Plans to breastfeed “if I can”. Says she knows BF is best for her and the baby. Is okay with formula if things don't work out. Her sister is a lactation consultant and can help her.

Objective – Wt. gain appropriate for pre-pregnancy wt.

Assessment – Doing well with calcium foods. Intends to breastfeed but not feeling confident. May need extra BF support.

Plan – Issued lactose-free milk. Discussed concerns about milk supply and ways to ensure production is adequate, including exclusive and frequent BF. Answered questions about WIC formula issuance to BF moms. Encouraged to talk with her IBCLC sister. Provided with information about BF support group and warm line.

Learning activity



Using the example above:

1. Translate any abbreviations.
2. What are the key issues brought up by the participant? How did the certifier address the participant's concerns?
3. What is WIC doing to support the participant?
4. If you were the next certifier to see the participant, what action would you take or follow-up on?

Document only what is necessary

Documentation takes time – to write and to read. We need balance between putting enough information in to help provide the best service for participants and taking time away from providing services to participants.



Considerations:

- Write concise notes – not long explanations
 - Use commonly accepted abbreviations and phrases.
 - You don't have to write full sentences, but you do need to make sure the next person understands what you wrote.
- Don't duplicate.
 - Don't repeat in notes what is already documented in other places in the participant record.
- Only use the parts of SOAP that are needed.
 - You won't always need to document all 4 sections of a SOAP note. It is okay to just use the part that is needed.
 - Objective data like measurements and hemoglobin values are documented elsewhere, so do not need to be repeated in notes. Instead, add your interpretation of the measurements under assessment and use this to guide the plan that is made.

Learning activity



Evaluate these progress notes:

- Subjective – Mom worried about baby’s growth.
- Plan – Check weight at follow-up.

What is going on with this participant?

What else would you like to have known, if anything?

What information would you look for elsewhere in the participant record?

What would you do when you see them next?

Learning activity



Write progress notes for the case study. Think about what you would want to know if you were the next certifier to see this participant. Make up a nutrition education plan based on what you know.

Case study:

Maribel brings in her 13-month-old daughter, Ari. Ari was in the emergency room last month with an anaphylactic reaction to peanut butter. Maribel now keeps an EpiPen with her all the time. Maribel is worried that Ari might have other allergies since she gets a rash and black circles under her eyes when she drinks milk. Ari’s pediatrician has referred her to an allergist. She has heard that evaporated milk might be better but would rather use something like PediaSure. Ari’s measurements remain at the 50th percentile.

Subjective	
Objective	
Assessment	
Plan	

Situations where additional documentation is required

There are 3 situations where additional notes must be documented:

- If you are unable to complete a required certification task (measurements or blood test);
- Certain risks require additional information when they are assigned;
- High risk participants require care plans (see Lesson 7-3 High Risk Referral Process).

Documentation when unable to complete a required certification task

Occasionally you will not be able to take accurate measurements or obtain bloodwork. You need to document the reason why and the plan to get that information.



What to document:

- The reason you were unable to collect the measurement or bloodwork
 - Examples:
 - Parent refused blood test due to child tantrums.
 - Child is in a cast so unable to get accurate measurement.
- Your plan to get the information needed
 - Examples:
 - Parent will text results from blood test at doctor's office by end of month.
 - Will check weight at next appointment after cast is removed.

Learning activity

Case study:

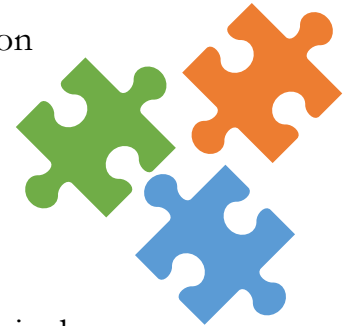
Simon brings in his 2-year-old son, Chester, for a certification. Chester has severe eczema on his hands and feet. Simon doesn't want to irritate the skin further by doing a blood test. Chester sees his doctor next week and will have blood work done then.



Write a sample note here:

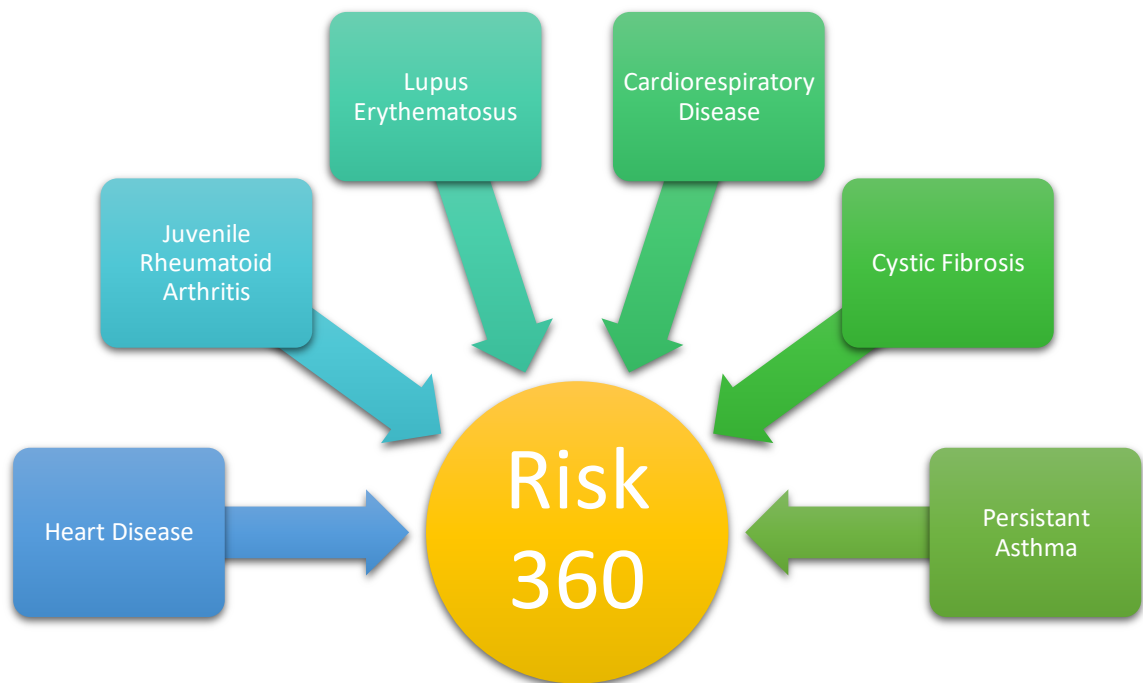
Documentation is required to clarify some risk assignments

There are certain nutrition risks that require additional information be documented in the data system when the risk is assigned. This information clarifies why the risk was selected or the specific medical condition diagnosed. When the information is documented, it helps other staff provide targeted, appropriate follow-up care for the participant.



There are two risk assignment situations when documentation is required.

1. There are multiple reasons why the risk can be assigned. For example, multiple conditions exist under one risk code.



○ Examples:

- Risk 360 - ***Other Medical Conditions*** could be many different diagnoses. You will need to document the specific condition the participant reports (e.g. Participant reports diagnosed with persistent asthma; or which specific heart disease)
- Risk 353 – ***Food Allergies*** could be many different foods. You will need to document the specific food allergy (e.g. Milk allergy diagnosed by doctor)

2. Extra information is needed to clarify why the risk was assigned.



○ **Examples:**

- Risk 411.2 – ***Inappropriate Use of Bottles or Cups***. You will need to document the specific reason why it is inappropriate (e.g. baby is put to bed with the bottle every day)
- Risk 334 – ***Lack of or Inadequate Prenatal Care***. You will need to document weeks gestation and the number of visits (e.g. First visit to PMD was at 5 mo. gestation).
- Risk 425.2 – ***Feeding Sweetened Beverages***. You will need to document the specific sweetened beverage (e.g. child is getting Kool-Aid with most meals)
- Risk 427.1 – ***Inappropriate Use of Dietary Supplements***. You will need to document the specific inappropriate use (e.g. Mom is taking double doses of prenatal vitamins because she thought it would help her tiredness).

The Risk Information Sheets from the ***Nutrition Risk*** module and many of the risk job aids identify which risks require additional documentation when assigned.

Learning activity

Use the ***Job Aid: Risk Summary***. Highlight the risks that need additional documentation (see the column “Additional Documentation”).



Learning activity



For each case study below, use the job aid and write what you would document in the participant's record.

Case study 1

During the diet assessment, Juanita tells the certifier that she eats tissue paper to keep from getting sick during the day. The certifier selects ***Risk 427.3 – Pica***.

Your documentation:

Case study 2

During the diet assessment, Samuel's mom tells the certifier that she gives Samuel diluted, sweetened, condensed milk because he thinks it tastes better than regular milk. The certifier selects ***Risk 425.1 – Inappropriate Beverage as Milk Source***.

Your documentation:

Case study 3

During the health assessment, Susie tells the certifier that she is having pain and problems eating because she has an abscess in her tooth. She shows the certifier her decaying tooth. The certifier selects ***Risk 381 – Oral Health Conditions***.

Your documentation:

Case study 4

During the health assessment, the mom tells the certifier that her son had surgery last month to have his appendix removed. The certifier selects ***Risk 359 – Recent Major Surgery, Trauma, Burns***.

Your documentation:

Document special concerns or why you referred a participant to the WIC nutritionist

It is important to document any special concerns you have about a participant. This could happen regardless of what risks are assigned or what risk level the participant is. It is especially important for high-risk participants because they all must be referred to a WIC nutritionist for a follow-up appointment. In these cases, it is helpful to write a progress note to give the nutritionist or health professional specific information about the participant. Good documentation of the risk or the concern will help make the follow-up appointment more efficient.



Example of additional documentation about a special concern

During the health history, Miranda tells the certifier that she smokes marijuana twice a week. **Risk 372 – Alcohol and Illegal and/or Illicit Drug Use** is assigned.

In the progress notes the certifier enters:

- **S:** Smokes marijuana twice a week. Wants to stop.
- **P:** To see Joan (health educator) next month for follow-up.
Gave referral info for Clinica Rosa Drug Treatment Program.

Example of additional documentation for high-risk referral:

During the health history, Samantha tells the certifier that she was diagnosed with Type 1 diabetes when she was 17 years old. Samantha is seeing a doctor who specializes in diabetes during pregnancy. The certifier selects **Risk 343 – Diabetes Mellitus**. Samantha is referred to the WIC nutritionist for follow-up.

In the progress notes the certifier enters:

- **S:** Pt diagnosed with Type 1 diabetes at 17. Seeing Dr. Wong twice a month. Has seen nutritionist at Dr. Wong's office and is following the diet plan.
- **P:** To see WIC nutritionist next month for follow-up.
Samantha to bring diet plan from Dr. Wong's office to next WIC appointment.

Example of additional documentation for high-risk referral:

During the health history, Victoria tells the certifier that she has epilepsy and is taking a medication called Depakote. The certifier selects ***Risk 348 – Central Nervous System Disorders***. Victoria is referred to the WIC nutritionist for follow-up.

In the progress notes the certifier enters:

- **S:** Has epilepsy and is taking Depakote.
- **P:** To see WIC nutritionist at next visit

Learning activity



Write progress notes for the case studies below.

Case study 1

Rambo’s mom tells you that he really enjoys Gatorade and that she gives it to him instead of water or milk because he is such an “athletic boy”. You assign ***Risk 425.2 – Feeding Sweetened Beverages***.

What progress note would you write?

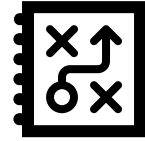
Case study 2

Unique’s grandmother says she is giving Unique homemade formula made from canned milk because “It worked just fine for Unique’s mom.” You assign ***Risk 411.1 – Use of Substitutes for Breast Milk or Formula***.

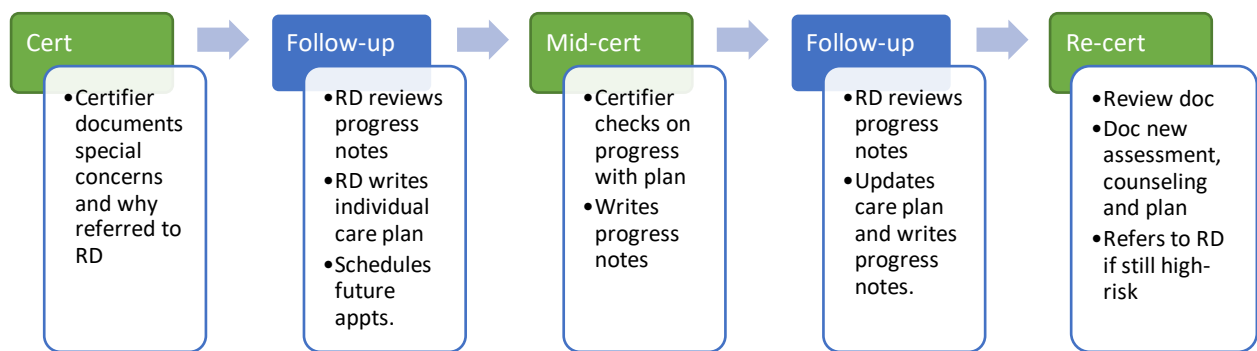
What progress note would you write?

High-risk individual care plans

The WIC nutritionist must document an individual care plan in the progress notes for every high-risk participant. Usually this happens when the nutritionist sees the participant, either at the certification or at a follow-up appointment.



If the first time the nutritionist sees the participant is at a follow-up appointment, they will review the information that was documented by the certifier at the initial appointment. This documentation will save time and help the nutritionist coordinate care. The nutritionist will need to see the participant at least twice during a year-long certification period.



The individual care plan must summarize the nutrition-focused counseling that was provided and describe what is planned to help address the participant’s nutrition risks, including suggested next steps, actions, and scheduled appointments. See ***Lesson 7-3 High Risk Referral Process*** for more information.

Learning activity

Ask your agency’s nutritionist to discuss an individual care plan they have developed for a high-risk participant.



Talk it over

Talk with your training supervisor about any questions you have related to documentation.



References



[Policy 626 – Hemoglobin and Hematocrit Screening in WIC](#)

[Policy 640 – Documentation Requirements for Certification](#)

[Policy 830 – Nutrition Counseling and Services for High Risk Participants](#)

[Policy 840 – Documentation of Nutrition-focused Education and Counseling](#)