Recreation Therapy Documentation

An Instructional Booklet with Examples

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Table of Contents

- **Introduction……...……3**
- **Recreation Therapy Assessment…….....4**
- **Recreation Therapy Treatment Plan…….10**
- **Recreation Therapy Progress Note……....……16**
- **Recreation Therapy Group Note……...……21**
- **Recreation Therapy Discharge Summary…….23**
- **Recreation Therapy Charting…….26**
- **Conclusion……....28**
- **References…….29**

Introduction

The process of documentation is one of the most important within the field of Recreation Therapy. Documentation offers the critical information about a client that will be needed by all staff currently working with the individual. This important process allows the recreation therapist to assess the leisure needs and interests of the client as well as advise other professionals of the client's needs and program requirements. Documentation is used to determine if a program is not only appropriate for a specific client, but it can also help determine the effectiveness of a program, through progress and group notes, which can further lead to any revisions needed to make it more effective. Documentation is so crucial to recreation therapy because it passes on important information to other professionals including the client's progress and participation patterns. It helps the recreation therapist write discharge summaries that explain what goals of the treatment plan have been attained by the client, and which goals still need to be worked on. It can also include important information about the client's behaviour and attitude throughout the program implementation.

Documentation is an official and legal record that contains all of the important information that would be needed in a situation where the client reacts negatively to a program, or if there is an emergent or legal situation that relates to a recreation therapy program, therefore recreation therapists should only ever sign their own name with documentation. Recreation therapists need to make sure their documentation is of outstanding quality to ensure the proper level of service; communication among staff members; professional accountability and self-regulation. It is important to note that all documentation must be real and honest, without any opinions or personal feelings of the recreation therapist being inserted. The broad definition of documentation is the comprehensive collection of information related to every aspect of recreation therapy including a variety or methods such as written, verbal, or electronic. This booklet can be used as a guide to each aspect of recreation therapy documentation. The five types of recreation therapy documentation are the assessment, treatment plan, progress note, group note, and the discharge summary. Recreation therapy charting will also be examined in this booklet.

Recreation Therapy Assessment

What is a Recreation Therapy Assessment?

A recreation therapy assessment is a tool or process that measures the level of ability, characteristics, interests, or personal values of the client. Specifically, the recreation therapy assessment identifies many of the client's leisure limitations, deficits, interests, needs, abilities, strengths, and weaknesses. There are two major steps involved in administering a recreation therapy assessment which include gathering the required information and interpreting or evaluating the information that is gathered. After the evaluation has been completed, the recreation therapist has the important information they need in order to recommend programs and activities for each client.

Assessment Formatting Requirements

There are certain pieces of information that should be on every assessment, beginning with the client's name, gender, age, risk factors, diagnosis (if any), and date of admission. It should always be very clear what the purpose of a recreation therapy assessment is so any professional reading the assessment is aware of its purpose. If an interview has been completed prior to, or as part of the recreation therapy assessment, then a summary of the interview should be at the very beginning of the documentation file. This will provide any professional reading the assessment with an overview of what was discovered during the interview.

Quality Assurance and Recreation Therapy Professional Standards

Only original, signed copies of recreation therapy assessment tools should be kept and no photocopies should be made. If typed, these original copies should be typed with an easy to read font such as Times New Roman or Arial, with appropriate spacing to allow for ease of reading. The assessment should be printed off in black ink only, on a laser printer to avoid smudging and fading over time. All copies of the assessment should be signed and dated by the recreation therapist who administered and documented it.

The recreation therapist should be sure to include all important information gathered during the assessment and all observations made in the assessment tool. All

omissions and errors will be the responsibility of the recreation therapist to repair, and so the assessments should be reviewed before completion. The assessment should include the demographic information about the client as well as any important medical information that could affect their recreation therapy intervention.

Recreation Therapy Assessment Example

Client: Client One **Casebook Number:** 12345 **Date of Birth:** April 7, 1988

Assessment Date: November 4, 2014 **Gender:** Male

Diagnosis: None **Date of Admission**: N/A

Assessment information was gathered from a formal interview with the client as well as the administration of all four Idyll Arbor assessment tools: Leisure Attitude Measure (LAM), Leisure Motivation Scale (LMS), Leisure Satisfaction Measure (LSM); and Leisure Interest Measure (LIM). Summaries of the LAM and the LSM assessments will provide further insight into the leisure lifestyle of the client and will assist the therapist in recommending additional programming options.

Interview Summary

The interview was conducted in order to further examine the client's past leisure experiences and interests, as well as his current interests and level of participation. The interview will also be used as a way to identify the client's interests so that he can create recreation and leisure goals as well as a plan to achieve them. When questioned about his past recreation and leisure experiences, the client indicated being a member or the math and chess clubs during his childhood. He was also involved in badminton, baseball, soccer, and hockey as a child. He described growing up in the country which allowed him to hike, camp, and bike frequently. He was very interested in visual art and would draw often. He described his interests in music and indicated that he often plays the guitar and other instruments. When asked if he usually enjoys solitary leisure activities or if he participates in group activities, the client said that he enjoys both group activities and solitary leisure activities. The client said that he believes recreation is an activity that is

done for enjoyment, but also for skill and personal development. When asked what leisure means to him, the client stated that leisure would include activities that are also done for enjoyment and pleasure, but without the skill-development aspect of recreation.

When asked about his current leisure lifestyle, the client indicated that in addition to a full-time job, he is also trying to start his own business on the side, which makes his free time scarce. He said that his current lifestyle is not sustainable as he is always stressed and tired from essentially working two jobs. The client indicated that he tries to relieve this stress by participating in enjoyable activities when he has even small chunks of free time. He stated that he tries to participate in activities that are both enjoyable, but can also be repurposed to benefit the business, such as going to live music shows (client's business is music based).

When asked about the leisure activities that he currently enjoys, the client indicated that he enjoys reading articles and forums online because he likes learning and reading. He said that he keeps his guitar on a stand so that it is easily accessible during his brief breaks between working. He indicated that he also tries to enjoy movies or television shows while he is working in the evening.

When asked about his future leisure goals, the client stated that he would like to spend more time reading books and writing music. In addition, he indicated that he would like to explore his current city and develop non-work related software. The client was able to identify several barriers to his lack of leisure participation. These barriers include his lack of free time due to his full-time job and secondary business on the side. He said that while he enjoys his work in web-development and music media because it feels similar to leisure time, the stress that comes with it becomes a barrier for actual recreation and leisure participation.

Assessment Summary

Leisure Attitude Measure

The purpose of the Idyll Arbor Leisure Attitude Measure (LAM) is to review the client's attitude toward leisure on three different levels which include cognitive,

affective, and behavioural. This assessment tool can be used to find the areas that are currently preventing the client from participating in leisure activities. The client had the highest score (3.8) was in the cognitive domain of the LAM which attempts to gather information on the client's general knowledge and beliefs about leisure as well as it's impact on health, happiness, and work. The client's score indicates that he has acceptable general knowledge about leisure but could be further educated to help him understand the benefits it can have on friendships, relaxing, and self-improvement. The affective component of the assessment attempts to gather information on the client's evaluation of his leisure experiences and activities as well immediate and direct feeling toward leisure experiences and activities. The client's score (3.6) indicates that he has a positive attitude toward his leisure experiences, but does not highly value the time he spends on his leisure activities. The client's lowest score (3.2) was in the behavioural domain of the LAM and indicates that the client is not well educated on how leisure can benefit him. He would benefit from leisure education and counselling in order to establish goals and objectives for his leisure lifestyle. The client's scores for the Leisure Attitude Measure indicate that he has a positive attitude toward recreation and leisure and understands some of the benefits his participation can have, but can be further educated in order for him to lead a balanced leisure lifestyle.

Leisure Satisfaction Measure

The purpose of the Idyll Arbor Leisure Satisfaction Measure (LSM) is to measure the degree to which the client perceives his general needs are being met through leisure experiences. There are six subscales in this tool which include psychological, educational, social, relaxation, physiological, and aesthetic. This specific tool can be used to establish which needs are not being met through existing participation and how further programming can help the client meet all his needs. The client had the highest score (4.25) in the psychological subscale of the LSM which indicates that he enjoys a sense of freedom, enjoyment, involvement, and intellectual challenge from his leisure participation. His score in the educational subscale (3.75) indicates that he enjoys leisure activities that are intellectually stimulating. The client's score in the social subscale (3.75) indicates that he finds the occasional rewarding relationship through participation

in leisure activities. His score in the relaxation subscale (4) indicates that he finds relief from the stress and strain in his life through participation in leisure activities. The client's lowest score was in the physiological subscale and indicates that he does not participate in leisure activities to develop his physical fitness or to stay healthy. His score in the aesthetic subscale (3.25) indicates that he values the visual appeal of his leisure activity choices, but does not necessarily base his choices on aesthetic appeal.

Clinical Impression

It is the clinical impression of this recreation therapist that this client has a very limited leisure inventory and would benefit from expanding his activity participation. In the interview, he indicated that his work and side-business are very much barriers to his leisure participation. He described a past leisure lifestyle that seemed to be much more balanced than his current lifestyle. He has a sufficient amount of motivation to participate in activities and demonstrates a positive attitude toward leisure experiences, however he is unable to make the time for participation. In my opinion, the client would benefit from leisure counselling so that he can learn how to organize his time appropriately, allowing more time for relaxing and enjoyable leisure activities. He has leisure goals that he would like to strive towards, including writing more music and exploring the city, however it seems that he needs assistance in making a plan to reach those goals. The client would also benefit from more participation in physical activities due to his low score in the physiological subscale of the LSM. From the assessment, it can be clearly seen that the client enjoys activities that are educational and intellectually stimulating. Further participation in these types of activities would greatly benefit the client in terms of self-improvement and overall happiness.

Summary

The client is a 26 year old male who has a positive attitude toward leisure participation and understands how a balanced leisure lifestyle can benefit him. From the assessment, it is very clear that he could further benefit from participation in a broader variety of activities. He indicated that he often feels stressed due to his job and side-business and feels that there is not much time for leisure participation. It is recommended

that he become more physically active and participate in activities that can contribute to his physical health. Most of the leisure activities the client participates in are sedentary activities. Although the client demonstrates a positive attitude toward leisure participation, he cannot adequately identify how and why participation is related to the ability to develop friendships, renew energy, relax, or improve oneself.

Recommendations

The following recommendations apply:

1) It is recommended that the client continue participating in his current leisure activities in a relaxing environment that can promote a stress-free lifestyle.

2) It is recommended that the client participate in some leisure counselling in order to further educate him on the benefits of leisure. This would help him organize his time so that he can make room in his schedule for leisure participation.

3) It is recommended that the client continue participating in more intellectual and educational activities. It is clear from the assessment results that the client enjoys activities that are intellectually stimulating.

4) It is recommended that the client participate in more physically involved recreation activities. His current sedentary lifestyle is severely lacking in activities relating to physical fitness and it is my opinion that he should be more physically active.

The assessment was completed and reviewed by: *Alyssa Belch*, RT on November 5, 2014. ***please note in actual documentation, signature should be handwritten, not typed***

Recreation Therapy Treatment Plan

A recreation therapy treatment plan must include several pieces of pertinent information that are taken from the assessment documentation. The treatment plan is a document that needs to be kept in a client's file that outlines the actions that are to be taken with, for, or by the client who is receiving the a recreation therapy intervention. In order to create an effective treatment plan, the therapist must assess the needs and deficits of the client through the assessment process. From the assessment results, the therapist and client must develop a set of goals, objectives, and outcomes for the specific client. The therapist must also take into consideration any of the risk factors that were identified in the assessment, such as activity tolerance, cardiac issues, allergies, dietary needs, and any other issues that may affect the client's participation.

The recreation therapy treatment plan is essentially the basis for all other forms of documentation for a specific client. The treatment plan establishes the goals and objectives of the intervention and also develops a method to reaching them. It is a step-by-step guide that outlines the procedure to be used to reach the established goals and objectives. Every recreation therapy treatment plan should be written in a way that is clear and effective so that all other staff members, in every discipline can understand the procedures and maintain consistency. The information that is included in the recreation therapy treatment plan can vary from organization to organization, depending on their requirements.

Treatment Plan Formatting Requirements

In general, the recreation treatment plan is based on the results of the client assessment as well as the scope of services within the particular organization that is implementing the intervention. The treatment plan must begin with the demographic background of the client, followed by relevant history and referrals. The goals and objectives for the client to strive toward will follow the demographic information and the client's history. The goals of the treatment plan must be general and can be long term or short term. These goals must be attainable and realistic, given the time frame and client's abilities. For each goal, there should be one to two objectives that must be specific,

realistic, and measurable. For example, a measurable objective could state that the client must participate in 2-3 activities per week to increase his physical fitness. These objectives must contain the behaviour that the client is striving toward.

The next step of the treatment plan is to develop an action plan to assist the client reach the goals and objectives. This action plan must be organized and categorized into sections of expected achievements and must specify program types, not specific programs. The action plan should be written in three or more steps that are to be followed by the client in order to achieve the goal. The action plan will be specific to the client and will be determined by the recreation therapist.

The frequency and duration of participation should also be stated in the recreation therapy treatment plan, as well as the facilitation styles and approach. There should be a section within the treatment plan which outlines the responsibilities of both the staff and client. A schedule for re-evaluation of the treatment plan must be scheduled so that the client's progress can be monitored and revisions can be made if necessary.

Quality Assurance and Recreation Therapy Professional Standards

Only original, signed copies of recreation therapy treatment plan should be kept, not photocopies of originals. These original copies should be typed with an easy to read font such as Times New Roman or Arial, with appropriate spacing to allow for ease of reading. The treatment plan should be printed off in black ink only, on a laser printer to avoid smudging and fading over time. All copies of the treatment plan should be signed and dated by the recreation therapist who is developing and documenting it.

As goals and objectives are completed by the client, it should be noted in the treatment plan by being highlighted or altered in a way that will be understood by all professionals who review it. Revisions to the treatment plan should be made as needed, and the revision date should be added to the treatment plan.

All omissions and errors will be the responsibility of the recreation therapist to repair, and so the treatment plan should be reviewed often.

Recreation Therapy Treatment Plan Example

Client Information

Name: Client One **Casebook Number:** 12345

Age: 26

Gender: Male

Address: 354 Clinton St., Toronto, ON, M6G2Y9

Education: College Diploma

Marital Status: Common Law

Religion: Christian

Occupation: Web Developer with music magazine; Entrepreneur (moonlighting), Web Developer and Founder of music community website

Financial: Stable

Rural/Urban: Urban-Downtown Toronto

Client History and Referral

Medical: Client is a young healthy adult male, slightly low blood pressure causing occasional fainting spells. Client wears glasses all the time and has very poor vision without them.

Referrals: None at this time

Assessment Results

Areas for Improvement:

- Physical fitness
- Time management
- Stress management
- Balance between obligatory and leisure activities

Interests:

- Music
- Reading
- Self-directed learning

- Hiking, camping, biking (outdoor recreation)
- Badminton, hockey, soccer (sports)

Abilities:

- High cognitive functioning, enjoys learning on his own
- Creative abilities (plays instruments, develops web-based projects, has interest in writing music)

Needs:

- More balance in obligatory/leisure lifestyle
- Increase in physical activity (client's occupation promotes very sedentary lifestyle)

Strengths:

- Musical abilities
- Creative talents
- Enjoys learning and developing personal skills
- Self-motivated

Weaknesses:

- High-stress lifestyle that client recognizes as unsustainable
- Low physical activity
- Unbalanced lifestyle

Client Goals

- Read more books
- Write music
- Explore his city
- Develop non-work related software

Goals and Objectives

Treatment Goals	Behavioural Objectives
1. To improve overall physical fitness	1. After one month of therapeutic recreation intervention, the client will: 1.1. participate in a sport activity at least once per week for the full four weeks 1.2. initiate a simple exercise program on his own to improve his overall health
2. To improve the balance between obligated time and recreation/leisure time	2. After one month of therapeutic recreation intervention, the client will: 2.1. participate in at least three recreation/leisure activities each week 2.2. will schedule at least four blocks per week for non-obligatory activities 2.3. will be able to describe (to the therapist) the benefit of taking time for leisure activities

Intervention Action Plan

Goal: Improve overall physical fitness and health

Action Plan:

1. Recreation therapist will have discussion with client about what kinds of physical activity he would like to participate in
2. Based on the discussion, the recreation therapist will research options and provide physical fitness and sport activities in the client's city that he can participate in
3. Recreation therapist should help client make a choice based on his interests and abilities
4. Client will be educated on the benefits of improving overall physical fitness level and about why entirely sedentary lifestyles are unhealthy

Goal: Improve balance between obligated time and recreation/leisure time

Action Plan:

1. Recreation therapist will have discussion with client about how he can better balance his time (between work and leisure activities)
2. Recreation therapist will assist client in creating four scheduled blocks of time each week where he can enjoy a personal activity of his choice
3. Client will be educated on and offered leisure activity choices
4. Client will be given a day planner that he can use to schedule his time
5. Client will be provided with a journal in which to write about the changes he has made to create a more balanced lifestyle

The treatment plan was completed and reviewed by: *Alyssa Belch*, RT on November 6, 2014. This treatment plan should be reviewed on December 19, 2014. ***please note in actual documentation, signature should be handwritten, not typed***

Recreation Therapy Progress Notes

Recreation therapy progress notes should include important information about the client's progress at each stage of the therapeutic intervention plan. These notes will be similar to smaller, more short-term evaluations that happen at smaller stages of the intervention. There are several different styles and types of client progress notes. The type that is used will be determined by each individual facility or organization depending on their process and procedures as well as whether the intervention plan is multidisciplinary, medical, or computerized.

Types of Progress Notes and Formatting Requirements

Narrative Progress Notes

The first type of common recreation therapy progress note is called a narrative progress notes which delivers the information as story or a narrative account of events or experiences. These narrative progress notes do not have a specific structure and are written in any logical way the recreation therapist feels is necessary and productive. Like all progress notes, a narrative note must reflect the client's progress, to date, toward any of the previously established goals.

SOAP (Problem-Oriented Medical Record) Progress Notes

The second type of recreation therapy progress note is a SOAP note, which is also known as the problem-oriented medical record. SOAP is an acronym that stands for **subjective** data; **objective** data; **analysis** or assessment; and **plan.** In the **subjective** section of the SOAP progress note, the recreation therapist document statements made by the client or the friends and family of the client. These statements could include the client's feelings about the program, goals, or the progress (or lack of) that is being made during the intervention. In the **objective** aspect of the SOAP progress note, the recreation therapist documents information that is gathered through observation of the client during the intervention implementation. These subjective statements must be written without any opinion and must be stated in overt behavioural terms. The objective aspect of the SOAP

note must only include observational information that pertains to the client's identified issue or initial treatment plan. The **analysis** portion of the SOAP progress note is based on the subjective and objective portions of the note. In this section of the SOAP note, the recreation therapist can indicate any progression or regression that the client has made (they can also indicate if there has been no change). The **plan** portion of the progress note is based on the analysis portion and indicates any additional information that the recreation therapist feels should be included. This section makes notes of any specific programs that the client is participating in; intervention techniques that are being used by professionals; as well as the frequency and duration of client participation. In this section of the progress note, the recreation therapist should make note of when the client is to be re-evaluated and whether there are any new goals or objectives.

SOAP(IER) Progress Notes

The SOAPIER progress notes follow the same layout and format of the SOAP notes, with the addition of **intervention, evaluation,** and **revision** to plan. These additions to the original SOAP format are for interventions that are multi-disciplinary and are used when there is a need for revision to the intervention plan. The **intervention** section of the progress notes states the type of intervention that is being completed with the client. The **evaluation** section of the progress note is where the recreation therapist evaluates the client's progress as well as the effectiveness of the intervention. Here, the recreation therapist would indicate the client's response to the intervention and notes whether any of the goals were reached. The **revision** section of the progress note includes any changes or alterations that were made to the intervention plan.

DARP (Focus Charting) Progress Notes

Focus charting progress notes follow the outline of DARP which stands for **data, action, response,** and **plan.** This type of recreation therapy progress notes places the focus on the client's current concern or behaviour; a sign or symptom that is crucial in the intervention plan; an acute change in the client's condition; or a significant event that is happening in the client's life. The focus in this type of progress note could reflect a

positive or negative aspect of the client's life. Each DARP progress note must begin with the focus

The **data** that is included in a DARP progress notes can include subjective or objective information. The **action** section of a DARP progress note should describe the actions taken by the recreation therapist in terms of interventions or programs that the client has been a part of. The **response** section of a DARP progress note should outline the client's response to the recreation therapy interventions and whether any of the goals or objectives have been attained.

PIE Progress Notes

This type of progress note examines the client's **problem** which leads to the recreation therapist developing an **intervention** or the staff's response to the problem. Following the intervention is the recreation therapist's **evaluation** of how effective the intervention was and the plans for the client's future.

DAIR Progress Notes

The DAIR format of a progress note begins with the subjective or objective **data** that relates to the client as well as the intervention. The data is followed by the **assessment** of the client's behaviour, which is then followed by what steps for **intervention** were taken with the client. The progress note then reviews the client's **response** to the intervention plan.

BIO Progress Notes

When a recreation therapist writes a BIO progress note, they first focus on the client's notable **behaviour** that is related to the client's reason for admission This is followed by the important information on the **intervention** that has been implemented by staff, including what has been said to the client or what has been done and where. The next step in a BIO progress note is to review the client's **outcome** or their response to the intervention, including their verbal and physical response.

Quality Assurance and Recreation Therapy Professional Standards

Only original, signed copies of recreation therapy progress notes should be kept and no photocopies should even been made. If not handwritten, these original copies should be typed with an easy to read font such as Times New Roman or Arial, with appropriate spacing to allow for ease of reading. These progress notes should be printed in black ink only, on a laser printer to avoid smudging and fading over time. All copies of the progress notes should be signed and dated by the recreation therapist who writes it.

Progress notes should be properly and accurately dated with the day, month, year, and time of the note creation. All omissions and errors will be the responsibility of the recreation therapist to repair, and so the progress notes should be written carefully, and reviewed before completion.

Example of Recreation Therapy SOAP Progress Note

21/11/14 2:00pm **Recreation Therapy Progress Note:** Client has begun participating in a local ball hockey league; an indoor soccer club; and has also made an appointment with a leisure counsellor to discuss a better way to manage his time between work and leisure. During a meeting with the client, he expressed his happiness at having time to spend doing activities that are fun and not work. He indicated that the physical activity has been really beneficial and he has felt much more energetic. He said he is "excited to meet with the leisure counsellor to find out how he can manage his time better and make more room for other activities".

By observation, it was obvious that the client was more alert and energetic than during the assessment period. He appeared to be more relaxed as well, more at ease. The client is very clearly progressing toward his goals and objectives and should continue to strive toward them. He has added at least two new activities to his routine and has taken the Continued on next page ----------

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initiative to meet with a leisure counsellor.

The client plans to continue with his ball hockey and indoor soccer participation and will meet with the leisure counsellor at least twice a month for the next three months.

The intervention has been successful so far, and the client is encouraged to continue with the activities he has been enjoying.

The progress note was completed and reviewed by: *Alyssa Belch*, RT on November 21, 2014.The client's progress should be reviewed again on December 6, 2014. ***please note in actual documentation, signature should be handwritten, not typed***

Recreation Therapy Group Note

A recreation therapy group note is completed when the client participates in a group program and is similar to regular progress notes. The difference between progress notes and group notes is that a group note focusses specifically on the client's participation in one activity, while a progress note reviews the client's overall progress in the intervention plan. Recreation therapy group progress notes are often written in the narrative style and can contain a variety of information.

Recreation Therapy Group Note Formatting Requirements

A recreation therapy group progress note must be written about participation in one specific group and include information such as client attendance or participation; goal achievement; future direction; and the next review date. A narrative recreation therapy group note should include the date, note type, client name, casebook number, unit (if applicable), and recreation therapist's name.

Quality Assurance and Recreation Therapy Professional Standards

Only original, signed copies of recreation therapy group notes should be kept and no photocopies should even been made. If not handwritten, these original copies should be typed with an easy to read font such as Times New Roman or Arial, with appropriate spacing to allow for ease of reading. These group notes should be printed in black ink only, on a laser printer to avoid smudging and fading over time. All copies of the group notes should be signed and dated by the recreation therapist who writes it.

Group notes should be properly and accurately dated with the day, month, year, and time of the note creation. All omissions and errors will be the responsibility of the recreation therapist to repair, and so the progress notes should be written carefully, and reviewed before completion.

Recreation Therapy Group Note Example

Client: Client One **Casebook Number:** 12345

24/11/14	**3:30pm**	**Ball Hockey Team**	**Recreation Therapy Group Note:** On November 12, 2014 the client enrolled himself in a local, weekly ball hockey league which runs two nights a week. The first ball hockey game took place in the evening of November 14, 2014 and the client has attended 2 games since the group began. After observation of the client by the recreation therapist, it was clear that the client was actively participating and was encouraging toward other players. He was very social in the breaks between games and was smiling and laughing. After a discussion with the client, RT noted that client stated "Friday nights are his new favourite nights. It's nice being active and then following it up with being social. I want to keep doing that." The client was smiling and stated that he feels more energetic from the physical activity. The client has obviously progressed in a short amount of time and has taken initiative by registering for a sports league. *New Objective:* To find second physical activity that he would like to join that runs a different night of the week, but does not have to be weekly. This would be beneficial for client since he is thoroughly enjoying the first sports league.

The group note was completed and reviewed by: *Alyssa Belch*, RT on November 24, 2014.The client's progress should be reviewed again on December 6, 2014. ***please note in actual documentation, signature should be handwritten, not typed***

Recreation Therapy Discharge Summary

The recreation therapy discharge summary has a much flexible form than the other forms of recreation therapy documentation. It can contain any information that the therapist feels is relevant and important to the client's progress and success. Recreation therapy discharge summaries should also include specific recommendations for the client's continued participation in recreation and leisure activities.

Recreation Therapy Discharge Summary Formatting Requirements

The recreation therapy discharge summary should include information such as the progress achieved to date toward present goals; goals left to be achieved; programs the client is currently involved in and their status within them; programs within the community that the client is involved in; and possibilities for carry-over into the community. The discharge summary can also include recommendations for community-based programming that the client would benefit from; information regarding a possible follow-up (including information about when it will happen); contact information; and referrals that have already been made for other agencies.

Quality Assurance and Recreation Therapy Professional Standards

Due to the amount of information that is often communicated in recreation therapy discharge summaries, they should be written in paragraph form. Discharge summary reports should always be printed on black ink in a legible font with appropriate spacing. Discharge summaries, along with all other recreation therapy documentation should be printed using a laser printer to avoid fading and smudging. All copies of the discharge summary should be signed and dated (day, month, and year) by the recreation therapist who writes it.

All omissions and errors will be the responsibility of the recreation therapist to repair, and so the progress notes should be written carefully, and reviewed before completion.

Recreation Therapy Discharge Summary Example (written as if client has been admitted on October 28, 2014).

Name: Client One

Age: 26

Gender: Male

Address: 354 Clinton St., Toronto, ON, M6G2Y9

Education: College Diploma

Marital Status: Common Law

Religion: Christian

Occupation: Web Developer with music magazine; Entrepreneur (moonlighting), Web Developer and Founder of music community website

Financial: Stable

Rural/Urban: Urban-Downtown Toronto

Admission Date: October 28, 2014

Discharge Date: January 8, 2015

Goals Attained to Date: Client has been participating in a local ball hockey league and an indoor soccer league since early November. He has also been attending bi-weekly meetings with a leisure counsellor. He has improved his physical fitness and has also begun a simple exercise regime outside of his weekly sports league participation. Through his meetings with the leisure counsellor, the client has also begun participating in two to three leisure activities each week for the past 4 weeks. These leisure activities include reading non-work related books for and hour each week; playing guitar and learning at least two new songs each week; and meeting with a web developer group to learn more about the hobby of "hacking." The client found the time for these activities by discussing with the leisure counsellor how he can balance his work with leisure time.

Goals Not Attained: The client did not manage to reach the goal of scheduling at least four blocks of time per week for non-obligatory activities. While he has been able to participate in two sports leagues and to take time to participate in three activities each week, he has not been able to successfully schedule his time appropriately. He plays guitar and reads whenever he can fit it in, but has not yet been able to create time slots to step away from his work and participate in an activity.

Client Recommendations: It is recommended that the client continue to participate in the sports leagues because he has reported a significant increase in his energy levels and his feelings of overall well-being. The leagues that he is currently participating in are already run within his local community. These two leagues are coming to an end in the next month, however the client is already looking for physical activities to replace them with. It is recommended that the client continue to meet with the leisure counsellor, perhaps only once a month, to further learn how to manage his time better and how to schedule his leisure participation.

Referrals: None at this time

Additional Recreation Therapist Comments: The client has been very cooperative and excited to work toward a more healthy leisure lifestyle. It has been a pleasure seeing him learn more about the benefits of a healthy leisure lifestyle that includes physical fitness. He has reported feeling happier and healthier, which is a pleasure to hear. During periods of observation, he has expressed enjoyment and excitement through body language and facial expressions. His tone of voice has also indicated enjoyment of the activities.

The discharge summary was completed and reviewed by: *Alyssa Belch*, RT on January 8, 2015 at 3:00pm.The client's progress in the community should be reviewed again on February 20, 2015. ***please note in actual documentation, signature should be handwritten, not typed***

Recreation Therapy Charting Format

Recreation therapy charting should always be handwritten in black ink and should be legible. Any chart notes should state that they relate to the recreation therapy intervention since there will be several employees from different professions charting in the same area. Any observations or comments that are made by the client should be in quotation marks. If there is going to be a blank space in the writing, for example before the text moves to a second page, there should be a straight line to prevent any additions to the chart note afterward that would alter the meaning or context. If the chart note is continuing on a second page, the words "continuing on next page" should be written on the end of the first page, and "continued from previous page" should be written at the top of the second page. Any errors or alterations in the chart note should be crossed out with a straight line that makes the previous text still legible. The word error should be written and the correct information should be writing near the error. All errors and alterations to chart notes should be initialed by the recreation therapist.

Recreation Therapy Charting Example

21/11/14 2:00pm Recreation Therapy Progress Note: Client has begun participating in a local ball hockey league; an indoor soccer club; and has also made an appointment with a leisure counsellor to discuss a better way to manage his time between work and leisure. During a meeting with the client, he expressed his happiness at having time to spend doing activities that are fun and not work. He indicated that the physical activity has been really beneficial and he has felt much more energetic. He said he is "excited to ----Continued on next page

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meet with the leisure the counsellor to find out how he can manage his time better and make more room for other activities''.

By observation, it was obvious that the client was more alert and energetic than during the assessment period. He appeared to be more relaxed as well, more at ease. The client is very clearly progressing toward his goals and objectives and should continue to strive toward them. He has added at least two new activities to his routine and has taken the initiative to meet with a leisure counsellor. The client plans to continue with his ball hockey and indoor soccer participation and will meet with the leisure counsellor at least twice a month for the next three months.

The intervention has been successful so far, and the client is encouraged to continue with the activities he has been enjoying.

The chart note was completed and reviewed by: *Alyssa Belch*, RT on November 21, 2014 at 2:00pm.The client's progress in the community should be reviewed again on February 20, 2015. ***please note in actual documentation, signature should be handwritten, not typed***

Conclusion

As stated before, documentation is one of the most important aspects of recreation therapy because it is a legal written document. All forms of documentation could be pulled and reviewed for up to five years in a situation where there is a lawsuit. This is why it is so very important for recreation therapists to know how to properly document client information, goals, objectives, treatment plans, progress, regress, etc. It is especially important for recreation therapists to always note any peculiar behaviour or statements made by or to the client, because these are where lawsuits could arise.

This documentation booklet will certainly be useful to me as a recreation therapist in my future career. It will be used as a reference to look back on when I am beginning my career in long term care, and am required to write a SOAP progress note or a discharge summary. I think the experience of creating this documentation booklet has been one of the most enjoyable and invaluable assignments I have done during my time at Canadore College and it will be of great use to me in the future.

References

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