Documentation in social work: Remembering our ABCs

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Introduction

Social work in Aotearoa New Zealand has seen a shift towards increased accountability and professionalism. Several recent enquiries within Child Youth and Family services and mental health services have seen social workers' practice put under the spotlight. One of the ways that we can demonstrate our competence in practice is through documentation. Calls have come from district health boards, non-government organisations, CYF (2002) and other agencies for better standards of documentation. While the authors believe that each agency will have its own standards, this article is an attempt to remind social workers about the basics of sound documentation.

Literature review

Considering the importance of the clinical record, relatively little has been researched and written in the area (Kaczmarek and Barclay, 1996; Snider, 1987; Dziegielewski et al., 2002). There are, however, certain themes that arise through the literature which are relevant for consideration here.

In a study by Kane (2001), MSW students in the USA who had completed at least one field placement, were surveyed in relation to their confidence and preparedness as regards documentation. In this study the majority of students indicated that they learned the most about documentation through their field placements. At times it may appear unclear where the responsibility for documentation education lies. Only 33.3% of the students in this study believed that they had the necessary documentation knowledge to protect themselves from lawsuits, and fewer still believed that the classroom or the field practicums had given them the information necessary to protect themselves from lawsuits. Furthermore, 76.8% of students did not understand the rationale behind documentation requirements.

In another article by Kane, et al. (2002), the authors describe the discordance between schools of social work who have moved towards the teaching of post-modernist and strengths-based theories and agencies or social organisations who demand structure and remain in many cases, deficit or problem-based. This can result in students being ill-prepared for documentation requirements within their agencies.

In a series of studies conducted through the 1980s (Kagle, 1982; 1983; 1984a; and 1984b), the author documents that managers and frontline workers in the USA indicated that the biggest impediment to record keeping was lack of time. Workers identified that they were seeing more clients with more severe problems and with fewer social supports available. They acknowledged that this situation had a direct bearing on their documentation, which tended to fall to the bottom of the tasks pile. Managers, who were being pushed to increase efficiency and protect against liability, attempted to pressure workers into improving the quality and timeliness of records. Kagle (1993) says that this sometimes resulted in angry impasses between management and front-line workers. While this research was conducted in the USA, social workers here may recognise similar dynamics which occurred through the forces of neo-liberalism and the New Right of the 1980s and early 1990s (Kelsey, 1993; Cheyne et al., 2004).

Kagle (1993) followed up the previous studies with research intended to learn about record keeping in agencies which were recognised for their quality and innovation in record keeping. She identified that poor results were obtained when workers were simply pressured to do more. Mixed results were achieved when the records were given a narrower focus in terms of only defining a problem and documenting its remediation. Mixed results were also achieved through use of computers. Good results occurred when the record was simplified through the use of such tools as checklists. Not surprisingly, good results were also achieved when agencies devoted resources to the study and practice of time management, or when funds were shifted to increased clerical support for workers.

In a study conducted by Dziegielewski et al. (2002) evaluating a documentation workshop, they found that 97% of the workshop participants felt that professional educational training programmes needed to include more updated content and information on documentation and record keeping. Again, it is acknowledged that this research has been conducted overseas. The authors, both senior practitioners in the field of social work here, would corroborate these findings through practice and supervision of other social workers in Aotearoa New Zealand. While schools of social work and individual agencies attempt to equip students and workers with the necessary skills for documentation, this is often done as a 'one-off' activity in a lecture or orientation session. This paper attempts to encourage workers to consider their documentation practices and to provide some suggestions for sound and safe documentation.

Documentation in social work

> Traditional case records are broadly focused on understanding clients in the context of their history and current relationships and on describing and analysing the process of treatment change (Kagle, 1993: 193).

Social workers see clients in many places: in offices, hospital wards or in clients' homes. Regardless of where contact occurs, the interactions must be documented in case notes or clinical files. This is a recognised practice in all social work agencies. But what is it that we are recording and for what purpose?

Why we record

Many of the workers in the previously cited research by Kagle indicated that they were not aware of the rationale for documentation, and that this was one of the reasons that

documentation is often given a low priority in a harried worker's schedule. The first question that should be addressed is why we record our activities and interventions with our clients. What purpose is served by this activity which consumes such a large amount of our non-client time?

Bodek describes seven key reasons for documentation in social work (Bodek, n.d.: 2):

- To document professional work;
- To serve as the basis for organisation and continuity of care by the practitioner;
- To serve as the basis for subsequent continuity of care by other practitioners;
- To provide risk management [agency, worker, and client safety] and malpractice protection;
- To comply with legal, regulatory and institutional requirements;
- To facilitate quality assurance and utilisation; and
- To facilitate coordination of professional [or interagency] efforts.

Tice (1998) documents the history of case records and describes how documentation from the field was initially used as one of the main teaching tools for new social workers. For many it remains one of the ways we teach ourselves what is expected within our agencies. More often than not, however, we end up copying the mistakes or omissions of others, which perpetuates poor documentation, much like being taught how to drive by our parents!

There are other reasons why comprehensive and accurate recording is necessary. Poor documentation can result in poor practice, such as us being unaware that a child in care has had five placements in an 18 month period. Documentation can be a powerful tool in that it can be the basis for a decision to remove a child from his or her whanau or family. It is, therefore, imperative that it is accurate. Increasingly, managers may also use documentation to measure accountability of a worker's practice and it may also be the determinant upon which funding is based. Well-organised documentation can also be very useful for efficient peer or team review processes (Moreland and Racke, 1991) and can facilitate more beneficial use of supervision.

> A traditional case record documents the evolution of a case worker's diagnostic thinking… (Kagle, 1993: 193).

In effect, the actual process of recording should give us the opportunity to review our recent interactions and is one of the times to reflect on how we plan to proceed. The windows that we have opened on our journey with our client will help illuminate our way forward. Our recording should constantly return to the reason for our involvement and how our current activity is addressing this matter. We then have the opportunity to review our work with our client. Inherent in this is a critique of our work and how any goals are being addressed. The choice of what and how we record effects our future thinking about our direction with our client.

How to record

No case record is useful if it cannot be read. While computerised case records are to some extent ameliorating this situation, many social workers still write notes by hand, particularly in mobile situations or hospital settings. Similarly, a badly written note, full of spelling and grammatical errors can undermine the credibility of the most seasoned worker (Ames, 1999).

It is important to remember that our clients can and may have access to our records. A carelessly written comment can have a very negative effect upon a client and on our relationship with them. If a client dies, the records can also be open to scrutiny by a client's whanau or families, or introduced into the legal or public domain.

A useful mnemonic for framing our recording could be the word 'FACTS' (Brintzenhofezoc, n.d.: 3-4).

Factual
Accurate
Complete
Timely
System

Factual

Recording should be objective and based on observation and received information. The content of the recording should denote sources of information, and be precise in what has been stated, and what has been noted in terms of activity (including body language as appropriate). If opinions are offered, they need to be stated as such.

Accurate

Without accuracy, any record is invalid. The source of the information should be clearly identified, and special care taken to ensure that the events and discussions are recorded in sequence. Where possible, any statements made by other people should be directly quoted and identified as such.

Complete

A good thought to bear in mind when writing case notes is, 'if it isn't written down, it didn't happen'. While this may be particularly pertinent when one's case record is likely to be presented in a legal setting, all records should maintain this consistently high standard. We cannot predict when our notes may be subpoenaed or whisked away to a coroner's inquest, but if they are it is very difficult (if not illegal) to add to or change the record.

While we need to make decisions about which items are recorded, attention should also be given to the environment that the discussion took place within (whether geographical, emotional or historical). To remove the event from its context may distort the event and give rise to interventions that are not soundly based and thereby lead to a failed or inappropriate intervention.

Timely

All recordings should be completed at the earliest possible juncture. This allows us to be clear about the events while they are still fresh in the mind and have not been tainted by other events, discussions, and/or interpretations. Thus an assessment of a client's situation may be recordable after the first visit. Equally it may take several visits to gain the trust of the client and other people who may be involved. and only after this trust has been gained will it be possible for an accurate assessment of a person's needs to be undertaken. In those cultures where there is a greater sense of extended family relationships, the views of a number of people may be needed to ensure that one has arrived at a full picture of the needs of the client. While the assessment may not be complete, it is still very important to document the contact and the process that is underway. A case record should be brought up to date at the earliest point possible. Many agencies will specify what this period of time is.

System

The system of recording will vary from service to service and needs to address the priorities of that service. Many services within Aotearoa New Zealand utilise the SOAP system. (Wilson, 1980).

S – Subjective, the history of the issue from the point-of-view of the client;
O – Objective, the observations of the social worker;
A – Assessment, the assessment of the situation based on the above;
P – Plan, the way to resolve the issue and monitor progress.

While the SOAP system presents some consistent structure for recording, it does not address all situations such as documenting a phone call from a client's relative.

With more and more agencies moving to computerised systems of documentation, a structured approach to content is addressed. Uniformity of approach lessens any misinterpretation by other workers, and ensures good communication and ultimately a more effective service to the client. Computer systems can act as useful prompts for us to obtain expected information in a consistent way. However, while computerised check list systems may be useful and necessary, they are often not sufficient. They may not be able to synthesise complex information and interrelationships of problems (Ames, 1999).

What to record

Each agency will develop its own priorities and style of recording. While there may be variation from agency to agency, the following may be used as a guide to the minimum information which should be collected and documented:

- Date and time of the contact;
- Description of the type of contact (e.g. in person or by telephone);
- Indication of who initiated the contact (e.g. regularly scheduled session, phone call by client's family, inquiry from another clinician/service provider);
- Statement of where the contact took place (e.g. office, if a home visit – the address visited, if by phone – the phone number called);
- Indication of who was involved in the contact (e.g. client, family, other clinician, family friend);
- Description of the themes of the contact;
- Details of any new significant history obtained;
- Details and description of relevant problems newly identified;
- Details and description of relevant significant new events;
- Description of therapeutic interventions with clinical justification and reasoning to support these in relation to the treatment plan and clinical circumstances, particularly when in response to crisis situations or special/markedly changed circumstances. (We are in a much 'safer' position when there is a bad outcome, if we documented the reasons for our decisions and interventions. Similarly, it is important to document all consultations and team or peer reviews surrounding a 'case');
- Statement of what was accomplished in the session;
- Statement of what wasn't accomplished in the session that needs to be followed up on, and who is going to do what;
- Details of obstacles to progress in treatment, if any, and a plan to address these;

- Description of a plan for further care, changes in treatment plan/goals, if any, and reasoning to support these, particularly when in response to crisis situations or special/markedly changed circumstances.

(Adapted from Bodek, n.d.: 4-5.)

All notes should be signed and dated, with the worker's name and designation printed below.

The importance of language

The language we use to record our case notes needs to be addressed so that we continue to be accurate and fair in our recording. No discussion should be needed here on using language that is discriminatory (e.g. sexist, racist, homophobic, etc.) except where it is attributable to a specific person or source.

For example: 'The person was obviously mentally ill'.
As a description of the client's mental health, this gives us no information as to the current state of health of the person concerned. It would be much more accurate to record the symptoms being presented (e.g. suspicious of other people's intents, may be having hallucinations, expressing suicidal thoughts, etc.). In this way any other worker coming to the case would have a clear picture of what he or she might encounter and be able to prepare appropriately.

The action or statement should be recorded dispassionately, and in an accurate manner. This means that we need to record the circumstances that were occurring and the context, where these have significance to the event.

For example: 'The person was swearing and exhibiting threatening behaviour'.
Such activity may be indicative of the need for assistance and intervention. It may be assumed to be a spontaneous action or could be seen as a legitimate reaction to events. Without the context, the statement is vague and open to a number of interpretations.

If the client, or another person, has an interpretation of events, then it is appropriate to ensure that any such comment is clearly attributed to that person.

For example: 'The agency worker was homophobic'.
In this example the statement was made by the client, but this was not clear in the record. The recording, therefore, suggested that the worker believed that another agency was acting from a prejudiced position. Ensuring that such a statement is noted as a quotation helps to ensure that it is not seen to be made by the worker, but has its source elsewhere. This can also then help any other worker to see what other people are saying/believing, and how this may then possibly affect any planned intervention.

Other considerations

There are other considerations in relation to documentation, which go beyond the scope of this paper. Cultural issues in relation to documentation need to be considered. How records are kept also needs to be considered, with many agencies moving from paper to electronic

files. Who writes the notes is an issue. Some agencies have moved towards collaborative notes being written by clients and workers together. There are issues in regard to access and ownership of records, as well as questions about privacy, security and storage. This article has not attempted to address the complexities of documenting psycho-social histories or initial assessments. These issues and many others all need to be considered.

Social workers are encouraged to determine if their agencies have policies around these issues and to make themselves aware of them. We can also be advocates for better systems of documentation and ongoing training regarding safe documentation and storage practices.

Conclusion

The purpose of recording is to clearly establish the content and nature of our contacts with our clients and to illuminate the reason for the various actions that have resulted. It also lays down a history of involvement, illuminates why we have been involved, and what we and our clients have achieved. It is not only our colleagues who need to understand the reasons for our actions, but also our clients who may read their notes and other third parties who may have an interest – especially those who may need to address the recording through a legal prism.

In a very real sense, for workers recording their involvement, 'if it isn't written down, it didn't happen'. This is certainly true in the context of legal proceedings, but also true for our colleagues who may come to such recordings in our absence or those who may read the files in the future. A well-documented social work assessment can provide important information for many years to come.

The responsibility for clear and accurate recording rests with each individual social worker and the agency that employs that worker. Each agency needs to draw up its own guidelines for such recordings. It is also the responsibility of the schools of social work and fieldwork educators to teach recording and documentation, so that a student is prepared for the reality of practice when they enter the work place as a student or as a qualified professional. It is a mark of our professionalism to our clients that we record our interactions factually, accurately and respectfully.

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