Practice Notes: The Broken Record

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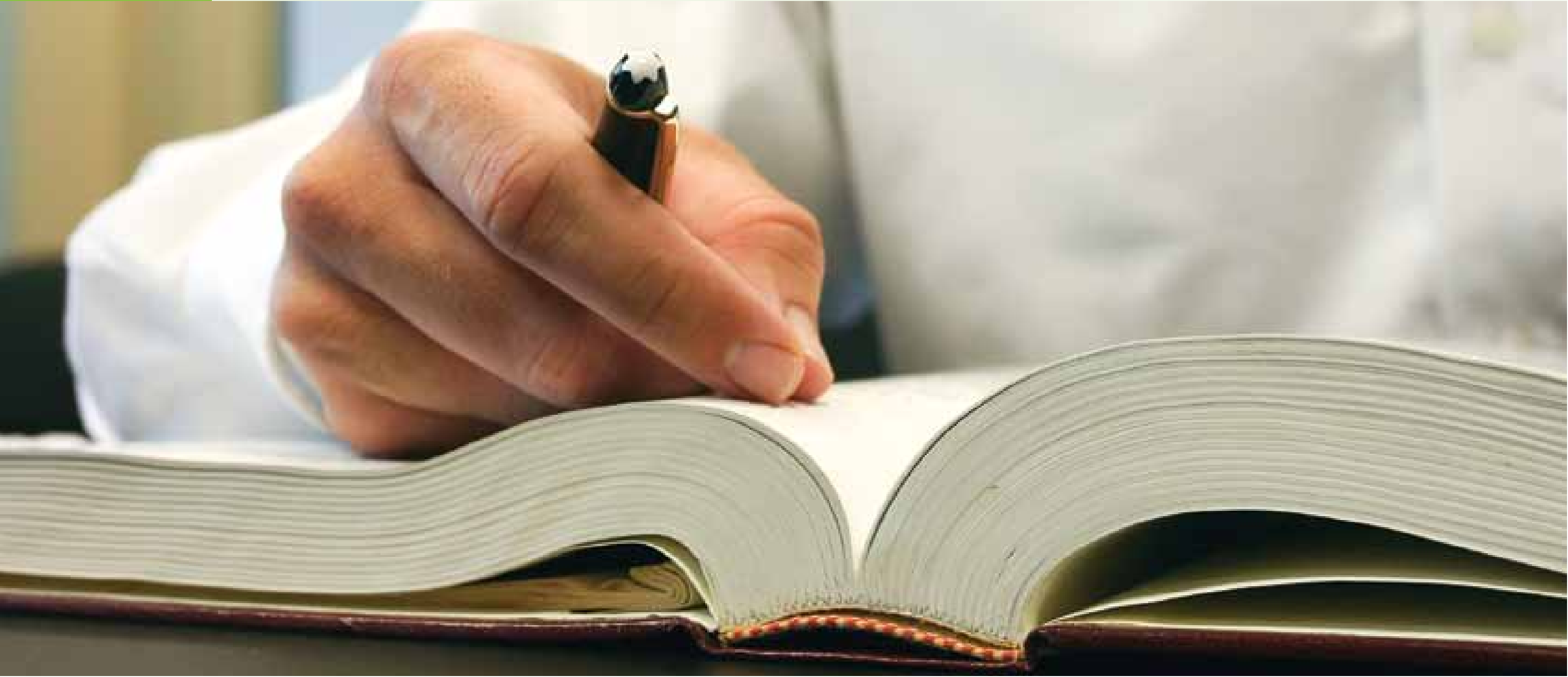

Practice Notes is designed as an educational tool to help Ontario social workers, social service workers, employers and members of the public gain a better understanding of recurring issues dealt with by the professional practice department and the Complaints Committee that may affect everyday practice. The notes offer general guidance only and members with specific practice inquiries should consult the College, since the relevant standards and appropriate course of action will vary depending on the situation.

RECORD KEEPING – AN EXTENSION OF ASSESSMENT AND GOAL-SETTING

Previous Practice Notes addressed the importance of assessment and goal-setting, noting that the initial assessment of the client is the foundation on which the presenting issues are conceptualized and paves the way for collaborating with the client in setting goals. As the work moves ahead, it is important to revisit goals and when appropriate, renegotiate those goals.[1]

The importance of the assessment and goal-setting process is undisputed regardless of one's theoretical orientation or work setting. What may at times be less clear to members is the need to create and maintain records. Some members' priority is direct contact with the client, as they feel this is where they can optimize their effectiveness. Consequently, they may place low priority on record-keeping. While work pressures often necessitate that members juggle competing demands on their time, the crucial importance of record-keeping, in compliance with the Standards of Practice, must be underscored. Members should be aware that "failing to keep records as required by the regulations and standards of the profession" is defined in the College's Professional Misconduct Regulation as an act of professional misconduct.[2] Members should also note that client records may be paper or electronic files and may relate to direct or indirect, clinical or non-clinical practice.

WHY IS RECORD-KEEPING IMPORTANT?

Members are required to "keep systematic, dated and legible records for each client or client system served."[3] Further,

1 Practice Notes: Assessment and Goal-Setting – Etched in Stone or Moving Target? *Perspective* Fall 2007

2 Paragraph 20 of section 2, O. Reg. 384/00 (Professional Misconduct), made under the *Social Work and Social Service Work Act, 1998*.

3 Code of Ethics and Standards of Practice, Second Edition 2008, Principle IV, interpretation 4.1.3

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recorded information must conform with "accepted service or intervention standards and protocols within the profession of social work and social service work, relevant to the service provided, and be in a format that facilitates the monitoring and evaluation of the effects of the service/intervention."[4] The initial process of preparing and organizing the materials for the record provides a means to understanding the client and planning the goals. As stated, these should be revisited periodically to evaluate progress and to make any changes in the original contract with the client. Good record-keeping will assist the member in accurately recalling the starting point with the client, the agreed-upon goals and process, and evaluating the extent to which the goals have been achieved. Referring to the record will also assist members in being "aware of their values, attitudes and needs and how these impact on their professional relationships with clients."[5]

A good record will establish accountability for and evidence of the services rendered. While important at all times, this is especially critical for members in the event that their work is called into question. Typically, social work and social service work services are delivered in the absence of other parties. A record that will document "the client's situation/problem exactly and contain only information that is appropriate and useful to the understanding of the situation and the management of the case"[6] will be an asset to the member who is asked to account for their work or is in the uncomfortable situation of being challenged about their work with the client, for example in the event that a complaint is made to the College about the conduct or actions of the member.

In addition to fulfilling several purposes for the member, a record is acutely important to the client. An accurate record ensures, for example, the continuity of care if the member is unavailable. This may be due to an anticipated absence, such as a member's vacation or maternity leave when a colleague is providing coverage. Absence may be unanticipated if the member falls ill, or if the client requires urgent care after regular hours of service, and for example goes to the emergency department of a hospital where they are usually seen as an outpatient.[7] Regardless of the particulars, it is essential that in settings where the record is accessible to colleagues, it provides the necessary information to enable another professional to provide quality care to the client. Members will periodically refer their client to another professional for a consultation or when the member determines that the client's needs fall outside the member's competence or usual area of practice. With the client's consent to disclose information, an accurate and up to date record will assist the member in making an effective referral on the client's behalf.

While the record may be seen as important only in the present, members should bear in mind that recorded information can have importance for the client for many years to come. A former client who seeks help from another professional in the future may benefit greatly when their record is shared, with their consent, with their new service provider.

WHAT AND WHEN DO I RECORD?

Members frequently turn to the College for direction about the specific content of the record such as, for example, what should be included in a psychosocial assessment. Members will find ample guidance in the Standards of Practice regarding what documents and information can be included in a record and what an accurate record will contain.[8] However, the specifics of the record will be determined by many factors including the nature and setting of the member's work, the purpose of the contact and the member's judgment about what is relevant to understanding the client's situation and should therefore be included. For example, the content of an initial assessment of a woman seeking psychotherapy to

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4 Code of Ethics and Standards of Practice, Second Edition 2008, Principle IV, interpretation 4.1.1

5 Code of Ethics and Standards of Practice, Second Edition 2008, Principle I, interpretation 1.5

6 Code of Ethics and Standards of Practice, Second Edition 2008, Principle IV, footnote 2. a)

7 According to the Code of Ethics and Standards of Practice, members inform clients early in their relationship of any limits of client confidentiality, including with respect to the client record. See Principle IV, interpretation 4.4.1 and Principle V, interpretation 5.4.

8 Code of Ethics and Standards of Practice, Second Edition 2008, Principle IV, footnotes 1, 2 and 3

address her history of trauma will differ from an assessment of a client's eligibility for subsidized housing, though both will be expected to meet the guidelines contained in the Standards of Practice.

Members must also exercise judgment regarding the wording they choose to document the client's situation and are reminded to "report impartially and objectively the factors relevant to the client's situation. The record clearly distinguishes the College member's observations and opinions from the information reported by the client".[9]

Members from time to time ask for direction about how soon after they provide service they must complete their recording. The Standards of Practice state that "information is recorded when the event occurs or as soon as possible thereafter".[10] Here again the member must exercise professional judgment regarding the timeliness of their recording, taking into consideration the nature of the contact and any legislated requirements or organization policy. A member whose client presents with suicidal ideation clearly has an immediate obligation to document the nature of the contact, their assessment and disposition and any other relevant information, while a member working with a community group on a funding proposal may not have the same kind of time requirements.

CONCLUSION

Record-keeping is an essential component of professional practice. A record helps the member to understand the client and set goals for the intervention, ensures continuity and quality of services, establishes accountability for and evidence of the services provided and enables the evaluation of service quality. Records also may provide information to be used in research and education, subject to any applicable privacy or other legislation. Keeping records in compliance with the Standards of Practice is a necessity. Keeping a good record is an asset to both the client and the member.

Members are encouraged to review Principle IV, The Social Work and Social Service Work Record in its entirety. For more information, please contact the Professional Practice Department at 416-972-9882 or 1-877-828-9380.

9 Code of Ethics and Standards of Practice, Second Edition 2008, Principle IV, footnote 2 b)

10 Code of Ethics and Standards of Practice, Second Edition 2008, Principle IV, interpretation 4.1.6