PRACTICE NOTES

THE CURRENT, ACCURATE AND RELEVANT CLIENT RECORD

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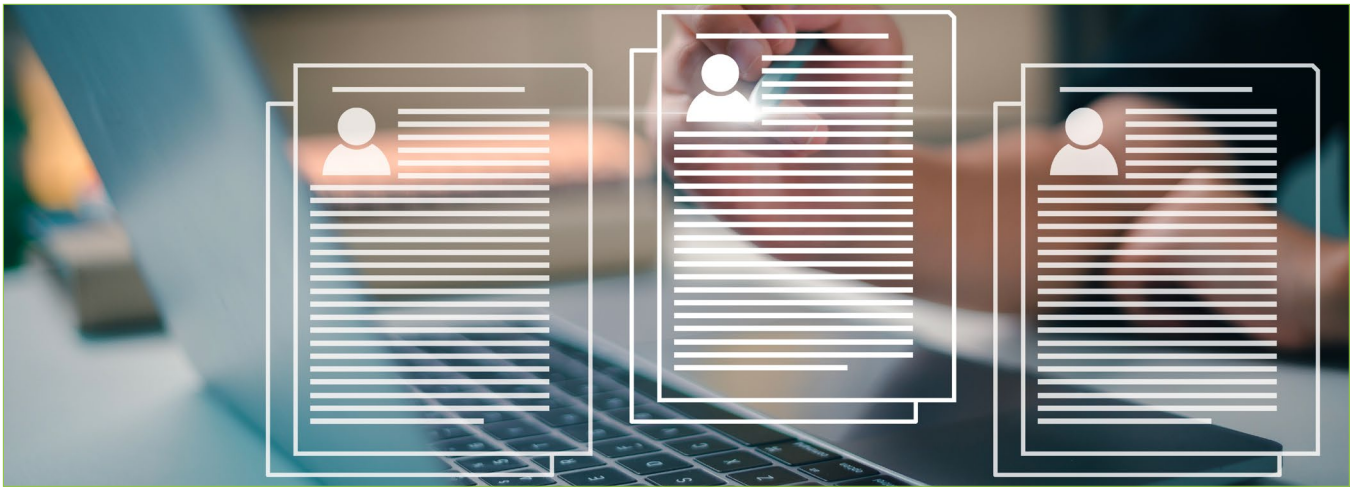

Please note that the second scenario of these Practice Notes contains references to intimate partner violence.

Practice Notes is an educational tool designed 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 College's Professional Practice Department and Complaints Committee that may affect everyday practice. The notes offer general guidance only and College registrants[1] with specific practice inquiries should consult the College, since the relevant standards and appropriate course of action will vary depending on the situation.

The Professional Practice Department conducts numerous consultations regarding the contents of the client record, including the question of how much information College registrants should document.

The Standards of Practice outline the purpose of the client record at the beginning of Principle IV: The Social Work and Social Service Work Record:

> The creation and maintenance of records is an essential component of ethical and professional practice. The process of preparing and organizing material for the record facilitates the understanding of the client and client system and allows for the planning of appropriate interventions. The purpose of the social work and social service work record is to:
> - document services in a recognizable form;
> - ensure the continuity and quality of service;
> - establish accountability for and evidence of the services rendered;
> - enable the evaluation of service quality; and
> - provide information to be used for research and education.

College registrants shall **ensure that records are current, accurate, contain relevant** information about clients and are managed in a manner that protects client privacy and in accordance with any applicable privacy and other legislation.[2] [emphasis added]

RELEVANT

Registrants are entrusted with many important details about their clients' lives. In maintaining the record, registrants must use their skills and professional judgment to discern what is relevant. This may be

[1] Disclaimer: the term "member" and "registrant" are used interchangeably and synonymously as equivalent to the term "member" as used in the *Social Work and Social Service Work Act*, 1998, and the Regulations.

[2] Ontario College of Social Workers and Social Service Workers (OCSWSSW), *The Code of Ethics and Standards of Practice, Third Edition, 2023*, Principle IV: The Social Work and Social Service Work Record, introductory paragraph.

challenging for registrants at the start of their careers or beginning employment at a new workplace. However, registrants should be guided by the purpose of the record to determine what is relevant and must ensure their records meet the standards established by the College.

At times, it may seem unclear how much client information is appropriate to document. However, registrants should remember that record-keeping practices can lead to more or less favourable client outcomes. Poor record-keeping, including records that lack pertinent information, can ultimately put clients at risk.

This is not to say that clinical records are intended to be transcripts of client encounters. Registrants should balance having a record with sufficient information and detail while succinctly explaining decision-making and critical information needed for efficient client care. Client interventions or treatment plans should be written clearly to avoid confusion and misunderstandings within the care team, with the client and potential third parties (should they request a copy of the record). In a non-clinical setting, care should be taken to ensure that records are clear to avoid misinterpretation of community assessment or policy recommendations by decision-makers. which may result in poor community and systemic outcomes. Documentation must be clear and concise within the client record.

CURRENT

The purpose of a client record is clear; registrants must ensure they can provide accountability for and evidence of their services. When considering that records must be current, the Standards of Practice outline that documentation must be timely and "College registrants shall record information when the event occurs or as soon as reasonably possible thereafter."[3] In addition to this, registrants must ensure the information documented in the record is recent and up to date.

ACCURATE

Additionally, Principle IV: The Social Work and Social Service Record, interpretation 4.1.3 states that:

College registrants shall keep accurate records. An accurate record shall:

i) clearly document the client's situation as they (or the client system) have described it;
ii) contain only information that is useful to the understanding of the situation and the desired outcome;
iii) report impartially and objectively the factors relevant to the client's situation, and make a clear distinction between the College registrant's observations and opinions and the information reported by the client;
iv) be easy to understand, avoiding vague, unclear or obscure language and/or symbols;
v) clearly identify corrections;
vi) be free of bias, prejudice and/or discriminatory remarks;
vii) identify sources of data; and
viii) indicate the identity of the service provider.[4]

Current, accurate, and relevant records are interrelated. The requirement that a record be current may be more straightforward, and an accurate record contains only information useful to understanding the situation and the desired outcome. This helps inform what is relevant to include in the record, an issue many registrants struggle with, and is explored in the following scenarios.

SCENARIO 1 – GETTING LOST IN THE DETAILS

A registrant started their career at a child welfare agency and attended a client's home for the first time. One of the client's family members reported that the client was hoarding and that their home was not safe for the two children who lived there. The registrant found the house full of many items which appeared unsafe. The registrant spoke with the client, who provided them with a detailed family and personal history. Upon returning to the

[3] (OCSWSSW), *The Code of Ethics and Standards of Practice, Third Edition, 2023*, Principle IV: The Social Work and Social Service Work Record, interpretation 4.1.12.

[4] (OCSWSSW), *The Code of Ethics and Standards of Practice, Third Edition, 2023*, Principle IV: The Social Work and Social Service Work Record, interpretation 4.1.3.

office, the registrant informed their supervisor of what happened and documented the home visit. The registrant included a detailed description of the items in the home and an exhaustive family history, which was difficult to follow. After reading the registrant's documentation, the supervisor informed the registrant that they included far more information than was necessary making it difficult to ascertain the current situation, identified risks and recommendations, and to be more concise in the future. The registrant then contacted the Professional Practice Department to help ascertain what information should be included in the record.

Professional Practice staff explained that registrants must use their professional judgment to determine what is required in any practice setting and context. However, the registrant was reminded to consider the purpose of the clinical record serves. The registrant was asked to consider, for example:

- Rather than provide an inventory of all objects in the home, could the registrant have been more concise by describing categories of items, highlighting those items of particular safety concern? Would it have been more effective to describe the state of the home and include what items posed the most significant safety risks?
- Could the Registrant identify the aspects of the family history that were relevant to recent events?
- If the Registrant obtained a very detailed history, could the note have been organized differently to assist in distinguishing what was reported by the client, the registrant's observations, the services offered and the treatment plan?

Professional Practice staff discussed that when a registrant is considering what information to document, they should ensure the content of the record includes the following:

- Information that is helpful and applicable to the current case/care of the client.
- Description of the facts, decision-making process and actions taken so that if needed, another professional providing coverage for the registrant's cases could easily understand the file, including what steps had been taken and what still needs to be done.
- Understanding that others, including the client, colleagues, or lawyers, may see the record.

The registrant agreed to reflect on these questions and considerations and discuss with their supervisor what information was essential to the record given the context of their practice setting. Ensuring that the record contains clear, concise information that is helpful to client care saves time and enhances clarity, which will positively impact client outcomes.

The Professional Practice Department has also received inquiries about how registrants should document in cases where information in the record may expose an individual to a serious risk of harm. Specifically, the College has encountered inquiries about documentation in the context of intimate partner violence. The following scenario provides an example in the healthcare setting, where registrants may support clients and their families, and where a careful approach to documentation was employed.

SCENARIO 2 – A TRICKY EXCEPTION - DOCUMENTING MINIMALLY

Warning: Intimate Partner Violence Content

A registrant who works in a hospital rehabilitation unit contacted the Professional Practice Department about a client who was admitted to their unit. The client's spouse visited regularly, and with the client's consent, the registrant regularly updated the spouse about the client's progress. The spouse was also in the process of preparing the client's home for discharge. On one visit, the spouse asked to speak with the registrant privately and disclosed experiences of intimate partner violence from the client. As a result, the spouse voiced fear about the client's discharge home. The registrant provided support and referrals to community agencies and professionals who could assist the spouse. The registrant contacted Professional Practice because they were uncertain how to document this interaction. The client was the hospital's patient; as such, only the client had a patient record. The hospital did not permit opening files for individuals who were not hospital patients. However, the registrant was concerned that if they documented in the client's record that the client's spouse disclosed abuse, the client might one day see it and pose a threat to the spouse.

The registrant queried how to minimize a potential threat to the spouse while being accountable for their services and ensuring their record is accurate.

Professional Practice staff suggested that in this unique instance, the registrant may want to consider documenting the support offered to the spouse in the client's record, but with limited detail to minimize any potential risk of harm.

Depending on the specific facts of the case and the practice setting, registrants may determine that the details of support offered to a client's spouse should be documented in the record because they are relevant to the client's care. In very exceptional circumstances, however, like this one, the registrant may determine that they only need to provide a high level of detail. In this scenario, the registrant determined that they would document in the client record that they provided support to the spouse about the client's discharge and offered them information on community resources.

The registrant felt that this accurately captured the overall service and support offered to the spouse while documenting information in the record relevant to the client's care. The registrant also committed to working with their team and manager to advocate for organizational policy change regarding opening separate files for family members. Professional Practice staff reminded that providing services to the spouse in an ongoing way could be a conflict of interest, as discussed in the Practice Notes: Navigating Conflicts of Interest, and if the spouse were to continue to seek support from the registrant, to direct them to the referred community agencies.

CONCLUSION

Documenting in the client record is a practice requirement, and registrants must make many decisions daily about what information to include in the record. Information in the record must offer evidence and accountability for the registrant's services, be current and accurate, and be relevant to the client's care. Registrants apply their professional judgment to discern the appropriate contents of the client notes and ensure their professional obligations to the record are met.

While registrants often gather interesting and important information from clients, which is essential to rapport and trust-building, registrants are not required to produce transcripts of their encounters. In a direct care clinical setting, the client's record must explain the factors and decisions that went into treatment plans and interventions. In an indirect non-clinical setting, the record must articulate why specific recommendations are being made over others.