

Case Notes

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Case notes are an integral and important part of practice for many Social Workers. Research has shown that record-keeping practices have an impact on client outcomes such that poor case notes can result in poor decision-making and adverse client outcomes (see Preston-Shoot 2003, Cumming et al. 2007).

A 'case note' is the term applied to a chronological record of interactions, observations and actions relating to a particular client.

What information should be included in a case note?

The guiding principle for deciding what information should be included in a case note is whether it is relevant to the service or support being provided.

The type of information that is considered relevant will clearly depend on the context of practice, however the *AASW Practice Standards 2013* provide some broad guidance. This may include:

- a range of biopsychosocial, environmental and systemic factors impacting on the client. This includes consideration of an individual's culture, religion and spirituality
- risk and resilience factors
- facts, theory or research underpinning an assessment
- a record of all discussions and interactions with the client and persons/services involved in the provision of support including referral information, telephone and email correspondence
- a record of non-attendance, either by the Social Worker or client, at scheduled and agreed meetings or activities
- evidence that the Social Worker and client have discussed their respective legal and ethical responsibilities. This may include:
 - client rights, responsibilities and complaints processes
 - the parameters of the service and support being offered and agreed to
 - issues relating to informed consent, information sharing, confidentiality and privacy
 - efforts to promote and support client self-determination and autonomy
 - specific responsibilities to clients in particular settings such as private practice or rural settings as per the *Code of Ethics 2010*
 - professional boundaries and how dual relationships may be managed
 - record keeping and freedom of information
 - discharge planning
 - relevant legislative requirements and their possible implications for practice
- details of reasons and any related actions or outcomes leading up to or following the termination or interruption of a service or support.

How should this information be represented in a case note?

There are a number of case-writing models available to Social Workers. Some of them provide general guidance for writing case notes, such as the 'Summary Style', while others are specific to a service type or context, such as the STIPS model.

In addition, many organisations have policies and procedures around case recording.

The AASW does not recommend the use of one model or policy over any other, however the *Code of Ethics* 2010 points to some general principles for good record keeping.

Information recorded about a client should be **impartial**, **accurate** and **complete** with care taken to ensure that:

- only details relevant to the provision of a support or service to which the client has consented are recorded (see sections 5.2.5 (a) and 5.2.4 (b))
- when working with involuntary clients this means recording information relevant to statutory practice (see also 5.2.2)
- notes are free from derogatory or emotive language (5.2.4 (a))
- subjective opinions are qualified with relevant
- background information, theory or research (5.2.5 (a))
- relevant information is not omitted (5.2.5 (c)).

When recording information about third-parties, such as information about a client's relationship with significant others, it is equally important to separate fact from opinion.

For more information and for Social Workers in particular settings, such as Private Practice, please see our related Ethical Guidelines on the AASW website at www.aasw.asn.au/whatwedo/ethics-faqs

How and when should case notes be recorded?

Case notes can be recorded manually or electronically and should:

- include on each page the name and DOB or other identifying information of the client. This can be handwritten, typed or constitute an electronic tag where an electronic case recording program is utilised
- be dated
- be recorded as soon as possible after an interaction or event
- be typed or clearly readable if handwritten
- include the name, signature and profession/role of
- the author
- include the time of contact, particularly where there are a high volume of interactions in a day.

Can I change or amend a case note at a later date?

Care should be taken to avoid errors or omissions. In some instances it is illegal to change, white-out or amend case notes after the fact.

If a change must be made to correct an error or omission, the change can be recorded as a new and separate case note. In addition to outlining the error or omission as part of this new case note, it is advisable to provide an explanation for its earlier absence or inaccuracy. You may also add, if possible, a note in the margin of the original case note referring the reader to the additional or amended detail.

A case note should never be amended or changed in light of additional information obtained at a later date. This should always constitute a new case note.

What are my legislative responsibilities with regard to case note recording?

Case notes may be subject to a range of legislative processes and requirements during and following the conclusion of the professional relationship.

The nature of these requirements may differ greatly according to the State and nature or context of practice. Statutory bodies, for example, are subject to Freedom of Information legislation, which may differ slightly from State to State.

In any context, notes can be subpoenaed for any number of reasons. Processes for responding to a subpoena may differ depending on the Court and similarly organisations may vary in their policy and procedure for doing so.

Finally, organisations may have policies and procedures for ensuring these and other legislative obligations are met, in addition to general guidelines for case note recording and management.

For these reasons it is important for Social Workers to:

- be familiar with the specific legal requirements and processes impacting on practice
- consider the implications of Federal and State legislation to the recording of case notes
- understand how these requirements are implemented within their organisation (where relevant)
- understand what policies and procedures may need to be implemented when working in private practice.

How should I plan for the termination of a service or support with regard to case notes?

As noted earlier, Social Workers should include details relating to the termination or interruption of services or supports in case note entries leading up to or following the end of the professional relationship.

However, it is also possible that the termination of service is unanticipated. This might include instances where the Social Worker is incapacitated or unable to continue employment or practice. These are particularly salient issues for Social Workers who are not part of team, work in private practice or are geographically isolated.

It is particularly important therefore to ensure that case notes are maintained and updated as soon after an interaction or event as practicable.

This possibility raises a number of issues in relation to security, confidentiality, storage and sharing of client information in the event of an unanticipated termination of service. These issues are addressed in detail in the Ethical Guidelines on:

- Information management
- Working in Private Practice
- Remote Service Delivery.

Further information on case notes and their management can be found in the following Ethical Guidelines:

- Information management
- Working in Private Practice
- Responding to a Subpoena
- Remote Service Delivery

Ethical Guidelines can be downloaded from the AASW website at <http://www.aasw.asn.au/practitioner-resources/ethics-and-practice-guidelines> or you can contact the Ethics Consultation Service on 03 9320 1044 or at ethicsconsult@asw.asn.au.