

Case Note Writing and Client Files (one day)

ABACUS Counselling, Training & Supervision Ltd.



Welcome and Introductions

- Opening of workshop
- What is your place of birth (town/city and country)
- Think of a river or body of water, mountain or place of special significance for you
- Introduce yourself, starting with the places above, then your work role, and rate your knowledge about 'best practice' case note writing/client files (scale 1-10)



Good example of a Case Note?

6/8 Shane Shawn came for assess.
Appeared to be drunk and nearly
fell off chair. Did screen (25)
Definitely alcoholic. Asked if he
had any mental health problems,
said no. Was in jail 5 years
- out 3 months and nowhere to
live, no money, wants residential.
Don't think he is ready to stop
but will see if he turns up to
next app first. Probably just looking
for somewhere to live! Jace

Case Notes / Client Notes / Progress Notes

- AOD, PG and mental health and social services vary in approach to writing case notes
- Problems: lack of time, lack of understanding of legal issues, clinical use/value, training and support, agency policies and guidelines, no consistency among practitioners, auditor expectations, confidentiality concerns about client information.
- Improving case notes can improve client outcomes and clinical practice

Is it important to have Client Notes?

- Purpose of client notes is to provide the 'what, why, where and how' of the client's interaction – they are *different* from assessment
- Client notes often not **clinically** valued (they are a record of treatment or client care!)
- Staff concerns: no training/guidance, seen as a 'necessary evil', not enough time to write client notes, not sure what to put in or how long they should be

Is it important to have Client Notes?

- Practitioners often value client work, but dislike the 'paperwork' that represents what happened in client contacts
- Poor client notes can result in poor decision-making and adverse outcomes – rely on 'guesswork' and memory; inaccuracies; others don't know what has been done or what outcomes achieved
- The challenge is to achieve quality documentation that minimises legal and ethical risks (and passes audits)

Legal Basis for Client Notes

- Purpose of client notes: part of the overall obligation to provide good health services & client support – client notes are tangible evidence of this & accurate record of treatment progress/lack of.
- ‘What is the role of personal opinion?’ - OK but needs to be acknowledged & supported with objective rationale
- Consent forms should be as specific as possible in relation to the health information being collected, who it might be disclosed to and why; include any specific parties requested not to disclose to
- Is there a legal requirement to write client notes? **‘Duty of care’**; required by common law & professional codes of conduct; expectation of statutory reporting for ‘medical’ practitioners

What is ‘Duty of Care’?

- Legally imposed obligation or duty (common law) on all people to ‘take care’
- Ensuring neither actions or **omissions** don’t harm anyone else
- Clinical worker has duty of care to prevent harm to clients/patients
- Need to avoid breach of duty of care **through an activity or lack of it** (incl. case notes)

Legal Basis for Client Notes

“Failure to maintain adequate client records could form the basis of a claim of professional malpractice because it breaches the standard of care of a practicing mental health professional”

(Wheeler & Bertram, 2008, pg. 115)

Why do we need good Client Notes?

Not just to ‘tick the box’ (for managers/auditors) – main purpose is to work more effectively with clients, enhance planning and review, for accountability, to help practitioners remember what has been done for their clients, to provide relevant information for other practitioners for action and follow-up in our absence; a record of treatment!

What to record in Client Notes?

- Only what is relevant to the service being provided (including some context)
- Impartial facts, clinical statements not bias, observations and opinion if supported by assessment tools or session information
- Goals, clinical observations, assessment, evaluation of goal attainment & interventions used, plan for next session, other relevant info e.g. test results
- Do not record: emotional reactions/opinions; value judgements; unfounded speculations/assumptions; hearsay; misleading information

Keep in Mind...

- Client notes are legal documents that provide rationale for treatment and documentation of quality care
- Client notes record what worked, what didn't and why
- There is some degree of legal protection from liability for counsellors and organisations by demonstrating planning and rationale
- Case notes establish that the counsellor conducted themselves competently and professionally
- Written records are the only concrete proof regarding client treatment and therapeutic progress
- Organisations must comply with their own written policy related to record-keeping and confidentiality

How much detail should be in the Notes for 'Sensitive Issues'?

Discuss this in the whole group:

- What issues are 'sensitive' for your clients?
- How much of this do you put in your notes?
- If so, why and who is it for? (e.g. client, you, or service)
- Is there anything you don't put in notes now that you are wondering if it should be there?

Appropriate level of detail: physical, mental, sexual abuse; HIV, Hep B, C

- Is the information offered or collected relevant to the service being provided? If in doubt, seek client's consent to record the information if you believe it is relevant, or if the client requests you record it

Is it intrusive:

- 'Sensitive issues': sexual (orientation, sexual practice, abuse, pregnancy/terminations, births outside marriage, STDs, sexual dysfunctions)
- HIV status (unless safety issues); hepatitis, mental health history; addictions; or diseases/problems with 'social stigma'

‘Mandatory Reporting’ in Notes

- Obligations in relation to domestic violence? No statutory obligation to disclose unless there is significant risk to others (also refer to Health Code of Privacy Act in regard to collecting information)
- Obligations in relation to child protection? Medical practitioners, nurses, youth/welfare workers in public service, psychologists; Vulnerable Children Act, 2014

Vulnerable Children Act, 2014

- Applies particularly to direct providers of children’s services (e.g. screening and vetting checks); government funded organisations
- Agencies providing health and social services to adults also need to have child protection policies to guide frontline staff to identify and report child abuse/neglect
- Examples: AOD use where children’s safety at risk (e.g. family violence, intoxicated others); problem gambling (e.g. family violence, neglect: financial deprivation, left alone in car while parent gambling) – advise CYFS
- Case notes would reflect risks, actions, outcomes

Case Scenario

You are a counsellor in an alcohol and drug treatment service and Carmen has come in for help to deal with alcohol and drug use problems. She tells you she is a sex worker and she is a great storyteller and obviously has lots of sexual issues she is willing to discuss (her sex change, sexual practices, client stories, STDs, 'sexual misadventures' etc – all of which are interesting). She makes a lot of money at times and also has gambling problems. She says she has nothing to hide as she is 'well known' so tells you not to worry about consent forms.

How far do you go in listening to and 'exploring' the sexual issues and behaviours and recording them in notes?

- To what extent do you follow up 'gambling' in the notes?
- Is a consent form necessary, since she doesn't care?
- Discuss with person next to you (10 min) and feed back to group.

Client Notes should....

- Reflect that clients are aware of rights (informed consent)
- Reflect that confidentiality is not absolute (safety overrides) and client has been informed of these
- Reflect what information has been collected directly from clients and others; 'tools' used and results; what happened in counselling/treatment; when case reviewed; any changes in approach/plan; outcomes; follow-up – 'if not on record, it didn't happen!'
- Include case note alerts if safety issues identified + rationale
- Never be altered/changed retrospectively (line through words if 'corrected' and note reason)
- Be kept 'up-to-date' (and file closed if 'fully discharged')
- Connect actions and interventions to the purpose of client attendance at the service (e.g. addressing AOD, PG and mental health issues)

How to record Client Notes

- Typed, or if handwritten, completely legible; data base
- Can use different models/templates for structure
- Ground what you write in what your client tells you
- Use specific, definite, accurate, unconfusing language
- Be succinct and avoid professional jargon, slang or abbreviations
- Organise your notes so it's easy to find information
- Write for a wide audience – yourself in the future, colleagues, client, auditors, or even potentially a judge!
- When to record client notes: ASAP or at least within 1 week of client contact; ideally, allocate time for case note recording...

Recording Client Notes

- Discuss in groups of three: How do you record what happens in your client sessions? Do you...
- Write as much as possible while the client is talking?
- Try to remember what was said, what was done and what is planned, and write notes immediately after the session? Write the notes when you have time?
- Write a few key points to trigger your memory?
- Concentrate on interactions with your client, as that is most important, and write very little in the notes, to protect their confidentiality?
- Feed back to main group (5 minutes).

Privacy Act and Client Notes

- When is a client note NOT confidential? Always confidential; governed by Privacy Act. Notes can be shared e.g. among clinicians, where informed consent has been given by the client. Less sensitive: workplace confidentiality agreements
- When access is formally requested e.g. subpoena
- Always document disclosure: who to, why, when, what health information is disclosed?
- Can my client access their notes? Client entitled to request from case manager/service (Privacy Act). Clients can request that information be corrected if inaccurate, incomplete, out of date, or misleading.

Practical examples for Notes

'Omit needless words'

- 'During the session, the client said that she had never attended to see an AOD service or attended for AOD counselling before'.
- The client said she had no previous AOD treatment.

'Choose your words carefully' (do these all mean the same?)

- Client denied any use of drugs or alcohol.
- Client said she does not use any drugs or alcohol.
- Client does not use drugs or alcohol.

Practical examples for Notes

Try not to use vague terms:

- “appeared”; “seemed”; “possibly”. Try: “shown by”; “demonstrated by”; “supported by” (behaviour/statement) – more evidence-based

Avoid judgemental or stigmatising language:

- “scruffy”; “dirty”; “lazy”; “loser”; “crazy”

Avoid negative speculations/assumptions:

- “dysfunctional”; “rude”; “obnoxious”; “abnormal”

Not: “Client appeared to be drunk and was rude and ignorant to staff and couldn’t get his act together for counselling so he was sent home”.

Better: “Client smelled of alcohol, and was verbally abusive to staff, so his counselling appointment was rescheduled”.

Practical examples for Notes

• Avoid using clichés in notes:

- “Client had the light on, but nobody was home”; “Client is running his own race”;

• Avoid ‘meaningless’ statements that don’t provide useful information:

- “No change”; “Client was useless in group”;

• Avoid too much use of Acronyms in notes:

- DNA; client caught DIC; LOL; Client was like OMG.

Client Note Models – SOAP & DAP

SOAP

- Subjective – what the client tells you/others tell you about client; concerns, problems, attitudes
- Objective – what you clinically observe; screen & test results; other documentation; mental state examination
- Assessment info – analysis of problem, explanations, hypotheses, diagnoses
- Plan – interventions used/ planned to achieve goals, treatment progress, goals for next session; prognosis, follow-up

DAP

- Data – info from session e.g. current issues or problems, signs & symptoms, behavioural concerns, current interventions, etc.
- Assessment - assessment of client progress/setbacks, goal attainment etc.
- Plan - review of treatment plan, objectives by session, or over cumulative sessions; where to from here

Which Model?

- **What is good about SOAP?**
AOD/PG friendly, especially for one-on-one contacts; Lots of literature on SOAP – medical ‘gold standard’. Well utilised by medical practitioners; systematic – provides credible and professional approach for clinical notes
- **What is good about DAP?**
Possibly useful for outreach/family services. Provides structure/ template; might save time
- **What is not good about using models?**
Some practitioners prefer ‘eclectic’ approach. Not as useful for short client contacts; danger of being a checklist; takes time to learn how to use them; may be confusion with terms (e.g. subjective/objective information).

'SOAP' examples

- **S** (subjective): "Client said that counselling has helped reduce depressive episodes. She states that she has much more energy since attending."
- **O** (objective): "Client maintained good eye contact and filled out AOD screens with no difficulty."
- **A** (assessment): "Completed Beck depression screen again and the score has dropped from 32 to 18, indicating an improvement in her mood, as stated."
- **P** (plan): "Arranged another appointment to monitor her mood state. We will also start relapse prevention work to help her maintain her current abstinence from alcohol."

Writing a Case Note from a scenario

- Read the scenario on the handout
- Circle or underline what you think is important and relevant that you would enter in client notes
- Write a brief case note for the client covering these points (using SOAP model), that you would be happy for anyone to read and that the client would agree is accurate
- Pick a partner to compare your notes with and make any changes if needed
- Feed back to the whole group how the exercise went

Case Note exercise

Use the SOAP model to guide your session notes:

- Subjective: (What you have been told by others/client)
- Objective: (What you observe; mental state; motivation)
- Assessment: (What you think the problem is; findings)
- Plan: (Interventions, goals, plans, follow up)

Sample Case Note

- Open discussion on sample case note supplied
- How does this compare with your case note in the exercise?
- How does this compare with your usual notes?
- How well would this suit your service?
- Any questions or suggestions?

Case Note exercise

- Watch the DVD of a counselling session (Liam – AOD)
- As you watch, consider the most important and relevant points to record in your notes – jot down key words
- After the session, consider the following: what to include or not; level of detail; type of language to use; structure of the notes; who may read it – evaluate
- Form into groups of three (different partners): discuss, compare and feed back to group

Storage of Notes, Files, Client Records

- Physical storage of notes/files – locked in cabinet, unless ‘in use’. If working on notes/files, shouldn’t be left on desk/in drawers overnight where cleaners/others could access them – consider where keys kept/access
- Electronic storage of notes/files – need to be ‘password protected’. If forwarding to others (with consent) ensure security at recipient end by checking email addresses and who else may have access/ beware ‘reply all’. If faxing client information, receiver should have consent
- Health regulations (‘retention of health information’) require records be retained for a minimum of 10 years.

Paper-based Client Files

- These should be clearly identified with name/client identifier and contain information specifically related to only that client. Good to have common order so that information (e.g. demographics) can be found easily
- Double-check the right information for right client is entered (e.g. cross check with DOB if same/similar name)
- If there are two sets of client records (computer/paper), is one considered 'more important' than the other? Both need to be complete/up to date. Auditors look at files!

What should be in Client Files?

- Personal Information (name, DOB, contact details etc)
- Risk assessment/risk alert, risk/crisis management plan
- All consent forms or comment if no consents given
- Assessment (presenting problem for intervention and any co-existing/other problems: history/current status)
- Any screens, diagnostic tools used, results and interpretation/ diagnosis; medications (current/prescribed)
- Individual treatment plan; how, when, where, who; referrals
- Ongoing case notes re counselling, interventions and response; case reviews; discharge planning; follow-up

Acknowledgements

- Health Information Privacy Code (NZ), 1994 and commentary, 2008
- 'The Counselling Practicum and Internship Manual: A resource for graduate counselling students (ebook), Shannon Hodges, 2010
- Cameron, Jacqui, 2012: 'Case notes for AOD services' (Turning Point AOD Centre)

