Effective Notes for Case Management

Presented by Victoria Pivnik, LCSW

National Association of Social Workers Guidelines

Social workers should take reasonable steps to ensure that documentation in records is accurate and reflects the services provided.

Social workers should include sufficient and timely documentation in records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future.

Social workers' documentation should protect clients' privacy to the extent that is possible and appropriate and should include only information that is directly relevant to the delivery of services.

Social workers should store records following the termination of services to ensure reasonable future access. Records should be maintained for the number of years required by state statutes or relevant contracts.

Why Is It Important to Document?

"Case Notes are legal documents which may be viewed by judges, attorneys, clients, etc. They provide a measure of protection and substantiate compliance with auditors."

Accurate record keeping provides accountability to the

Client	Organization	Funder

IF YOU DID NOT DOCUMENT IT, THEN IT DID NOT HAPPEN

Purposes of Record Keeping

- Accurate record keeping supports the case manager in planning, implementing, and evaluating services for each client
- Illustrates patterns of in/effective interventions
- Enhances quality of service – especially with heavy case loads/crisis
- Follows the agency/funder/state or other governing body protocols
- Reflects any significant client, family, or secondary service provider contact
- Measures outcomes

Purposes of Record Keeping (continued)

Reminds Case Managers of services to be provided

Serves as support for insurance coverage purposes

Presents accurate history of crisis patterns

Progress Notes

Must prove “delivery of service” with information which is:

- ✓ Accurate
- ✓ Timely
- ✓ Objective
- ✓ Specific
- ✓ Concise
- ✓ Descriptive
- ✓ Consistent
- ✓ Substantive
- ✓ Pertinent

Progress Notes (continued)

ALWAYS INCLUDE

WHO: the name, qualifications and/or title of the qualified staff providing the service or intervention

WHAT: what was done, the specific interventions/services provided

WHERE: the physical site where the services were provided (office, client's home, etc.)

WHEN: date, length of service (in units and time) and time of the day

WHY: why the services were provided – the intended goal, objective and outcome related to the service

HOW: how the intervention was completed (concrete, measurable, and descriptive) along with client's response and progress

General Professional Guidelines

- Highlighting client's strengths, supports and coping mechanisms
- Specification of where the information is coming from (ex: client reports/states, as per POA)
- Client's identification on each page
- Documentation of the link of success and failure to the service plan
- Tracking of client's activities (assessments, goals, etc.)
- Tracking of program/agency monitoring activities (services provided, contact with client, etc.)

General Professional Guidelines (continued)

THINGS TO AVOID:

- Casual abbreviations
- Taking shortcuts at the cost of clarity (re-reading notes out loud)
- Generalization or over-interpretation
- Grammatical errors
- Negative, biased, and/or prejudicial language
- Details of client's intimate life unless it is relevant to the care plan
- Use of medical diagnosis that have not been verified by a medical provider

General Professional Guidelines (continued)

Tips and Suggestions

- Stay organized
- Carry notepad/laptop
- Maintain encounter log
- Account for “case noting” time
- Save time to document
- Utilize staff resources to improve

Self Check

Did your note prove “delivery of service” with information which is accurate, timely, objective, specific, concise, descriptive, consistent, substantive and pertinent?

- Give a reason for your interaction with the client
- Indicate client needs
- Indicate any changes in client’s status since last assessment/encounter
- Address client’s current issue(s)
- State action taken on client’s behalf
- Document follow up plan

Example 1

- Poor example: SW left msg w/clt
- Better example:
- 5/1/2021 10:35 am (duration 5 minutes)

SW called client's cell phone with the purpose of inquiring about recent hospitalization. Client did not answer the telephone, SW left a brief voicemail asking client to call SW back. If SW does not hear from client by 5/4/2021, SW will call client once again.

Victoria Pivnik, LCSW 5/1/2021

Example 2

- **Poor example**
- 8/1/2021 9:45 am
- SW met with client who was angry about losing his business. Client is depressed and anxious. He wants to see a therapist and SW referred him out. He is scared about losing his insurance, so SW spoke to him about govt' benefits.
- **Better example**
- 8/1/2021 9:45 am (duration 45 minutes)
- SW completed an initial assessment with the client in the office. Client is concerned about their business possibly closing soon. Client expressed feelings of anxiety caused by current financial situation as exhibited by statements "I can't sleep at night because I don't know how I will pay my rent" and "If I can't provide for my family, they will think I'm a failure." SW and client explored counseling options, as client expressed interest in mental health services. SW provided referrals to Wilshire/Valley Group, Department of Mental Health, and Blue Moon Therapy. SW also began talking about available government benefits based on client's income/assets. Follow up meeting is scheduled for 3pm on 8/7/2021 at Pico office to review client's budget and develop a care plan.

  Victoria Pivnik, LCSW 8/1/2021

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Case Notes

What to include in case notes?

Contact: email, phone call, office visit, home visit etc

Content of contact: discussion of rent, review of documents needed, notice to quit, referral to therapist etc

Plan: client to call ABCD, will facilitate referral to Family Table, to review with supervisor.

Additional important information: if client's presentation is noteworthy (rambling, disordered thinking, yelling), Spanish is primary language/using translator, conflicting information given etc

What not to include in case notes?

Details that can be found in other parts of the record: no need to repeat what is in application, notice to quit, lease etc, unless there is a change from what is documented

I said, she said: It doesn't need to be a verbatim recording of a conversation. If quoting client for a particular reason, it should be in quotes.

Subjective descriptions: client was anxious, paranoid, etc. Instead, what were the behaviors, tone of voice, content of conversation?

Examples of possible notes:

*TC to client. Discussed EFA application. Client will send missing bank statement.

*Left VM for client asking about completion of EFA application.

*TC from Stanetsky's funeral home (Jane) asking about pending payment. Told her that EFA still needs itemized invoice. She will send it.

*Email exchange with Brookline Mental Health about help they will provide for client's arrears. They will email back to EFA when decision is made whether to assist.

*Client's EFA application received by fax. Left VM for client explaining that application is incomplete, requested that client contact EFA to discuss.

*Email sent to Newton Housing Authority (Jane Smith) requesting updated housing ledger for client. Stressed that this is required before check can be authorized.

*TC from client, who said that she had applied for SNAP and SSDI. Encouraged her efforts, and asked that she call back if she needs help or when she receives decision about those applications.

*TC from client asking for additional oil delivery. Explained that client needed to first complete EFA application, including updated bank statement, before request could be considered. Client angry with response, raising his voice and demanding immediate help, then threatened to jump off bridge if request is denied. Asked client about plans to hurt himself, client denied any active thoughts or plans of suicide, said "that's just how I talk". Stressed to client that any comments like that would be taken seriously and mental health providers to be called for assessment. Client strongly denied any intent for self-harm and will complete EFA application as requested.

*TC from Yad Chessed staff Cindy Cohen to discuss client Joe Shmoe. YC is unclear about who is the lead agency with this client. Reviewed EFA's history of assistance with client, and it was decided that EFA staff will remain lead CM. YC will continue to provide food cards. Updated supervisor.

*Exchange of emails during past week with client, Newton Housing Authority and Newton Social Service. Cousens Fund to pay $1000 toward client's arrears, client to pay $500, and EFA to pay $1000. NHA in agreement and eviction process halted. NHA to send letter to client and EFA confirming tenancy preserved.

*Office visit with client and husband to discuss budget. During discussion, client remained focused on her phone, while husband repeatedly criticized and blamed client for her spending habits. Several attempts made to engage both in discussion about mortgage arrears, with client continuing to ignore conversation and husband becoming increasingly angry, as seen by louder voice. No clear information was gained to be able to assist them. Finally, husband got up suddenly from his chair and left the room, leaving client behind with staff. Client then looked up from the phone and asked why husband why invited to meeting? Client urged to address mortgage issues together with husband, but client refused. Meeting ended with client agreeing to work on resuming SNAP benefits.

*Walk in visit, met with client in reception area for lack of room. Previously unknown to agency, although has had contact with other JFCS agencies around the country. Client is 37 year old divorced Jewish man with long history of homelessness. He recently relocated to this area from Seattle, "just because". He says he has no family or friends in the area. He was working prior to his move as computer consultant but currently has no income, benefits, or health insurance. Client is now living in his car and seeking assistance with food, gas, benefits, job. He presents as disheveled, poor eye contact, rambling narrative. He denies any connection to local agencies. Provided client with emergency food, gas card, and together completed EFA application. Appointment scheduled for client to return on xxxxx to complete SNAP application.

*TC from client around 1 pm, saying that she has no food in the house, no money to purchase food. Oldest children reportedly went to school but youngest two, ages 4, 2 are home with her and per the client, "Haven't eaten all day". Mother's voice slurry, and she blames her boyfriend for her current situation. "He took all the rest of my money to fix his truck" she says. Asked client if anyone could loan her money for food, or if family member could bring any to her. She says no. Client reports that her SNAP will not be replenished for another 6 days. Expressed concerns to client and need to get her assistance. Client in agreement. Ended call and consulted with supervisor. 51A filed, incident report written. Received updated call from DCF later in the afternoon that an emergency visit was planned to the home within the next hour.

Case Notes: The Job We All Love to Hate

Case Notes are

An on-going, written record of our professional involvement with clients.

Case Notes are NOT

A record of supervision, process recordings or clinical evaluations.

Considerations when writing case notes:

Accuracy of reporting: Basic truth telling – days, times, hours

Objectivity of language: certain words are loaded, subjective or overly general
"manipulative", "out of control", "anxious"

Confidentiality: Does this piece of information need to be here? Is it relevant to our work or goals with the client?

Inclusion of important information

Job responsibilities: What is expected through program mandates or guidelines?

Thinking about your possible reading audience:

Your supervisor

Do your notes document that you are doing your job? Are you including all the work that you have done? Do your notes reflect the quality of your work?

The client

Do your notes use strength-based language? Do they reflect a tone of respect and collaboration with the client? If someone were writing this about you, how would you feel?

Courts

Are statements attributed accurately to the source? Are opinions recorded as facts? Are the words "allegedly" and "reportedly" used when needed? Written notes are potentially a legal document.

A New Worker

If you left the agency tomorrow, would a new worker be able to pick up where you left off by reading the chart? Would that person have a clear idea from your notes as to what work had been done with the client, and what remained to be done?

Agency/Program

Are agency and program expectations being followed in the documentation?
Are there outside stakeholders or funders looking for particular information?

YOU!

Documentation is a valuable log of your work with your clients, and a reminder of tasks to be completed in the future.

CHIP notes:

Contact
Happening
Information
Plan

Contact: ***How was contact made?***
Telephone call from client
Email from attorney
Exchange of emails with Housing Authority

Happening: *What was the focus of our interaction?*
Updated client on check request
Completed EFA application together
Requested recent housing ledger

Information: *Any additional information to enhance understanding of contact*
Client expressed worry that check will not arrive in time
Client was unable to recall rent or SNAP amounts, and changed the subject when asked about spending habits
Property manager described client as "a great tenant"

Plan: *Next steps*
Check for rental arrears to be requested
Will send client list of recent housing lotteries
Client to follow up with RAFT for assistance