Social Work: Documentation

Site Applicability

All VCH sites

Practice Level

Registered Social Worker (RSW) and Registered Clinical Social Worker (RCSW): Basic Skill

Requirements

Social Workers will follow BC College of Social Workers Standards of Practice, organizational policies and program guidelines when documenting in the Client's health record.

Social Workers ensure that records are current, accurate, contain relevant information about clients and are managed in a manner that protects client privacy in accordance with any applicable privacy policies and legislation (BCCSW, 2009).

Need to Know

This guideline provides guidance for Social Work practice and documentation in addition to VCH organizational or local program level direction. This guideline is informed by the Freedom of Information and Protection of Privacy Act, Adult Guardianship Act, Health Care (Consent) and Care Facility (Admissions) Act, BC College of Social Work Code of Ethics and Standards of Practice, and organizational policies and guidelines, including VCH Documentation.

This guideline applies to all Social Workers who document in Clients Health Records in Vancouver Coastal Health (VCH). This guideline applies to paper-based, electronic and hybrid documentation (combination of paper and electronic format).

This document may not address all clinical questions regarding documentation, in which case, consultation with Social Work Professional Practice is expected.

As this document supports *what* to document versus *how* to document, the focus is on providing direction as to documentation content. Please refer to your team/program guidelines for documentation format, workflows and process.

Guideline

The purpose of the guideline is to ensure Social Workers engage in documentation that:

- Is a clear and comprehensive account of the care provided (BCCSW, 2009), as well as concise, consecutive, correct, complete, collaborative, client-centered, confidential and trauma informed.
- Is informed by and aligns with the values, expectations, and goals of the client.
- Is client-focused and based on professional observation and assessment that does not include unfounded speculations, conclusions or personal judgments. Provides a means to understanding the client and plan the social work intervention (BCCSW, 2009).
- Reflects the service provided and the identity of the service provider (BCCSW, 2009).

- Records the client's needs, any actions taken by the Social Worker, and/or the client's response to the care they receive. The health record is limited to the information relevant to the client's care/ treatment.
- Is impartial and objectively considers factors relevant to the client's situation.
- Is grounded in Social Work theory, intervention or guidance.

What to Document

- All contacts with clients, including in person, virtual, email, letters, text and phone
- Client/substitute decision maker consent
- Assessment information including identification of sources of data or collateral
- The client's situation exactly which contains only information that is objective and factual to the understanding of the client's situation and the management of the client's care (BCCSW, 2009)
- The rationale for the Social Worker's assessment and treatment plan, stemming from the documented situation and history.
- A clear distinction between the Social Worker's observations and clinical impressions from the information reported by the client
- Care plan
- Treatment/interventions provided (i.e. system navigation, referrals, counselling, crisis intervention)
- Consultations sought, including with practice leaders/supervisors/Ethics team/ReAct
- Consultation provided to colleagues, when it directly involves or impacts care planning and client care
- Updates, addendums, and corrections as per program requirements
- Potential risks or benefits of Social Work involvement

Documentation will include, at minimum

- Identification of the recipient of services
- The history obtained by the Social Worker,
- Assessment, clinical impressions and plan
- Treatment and other interventions provided, i.e. facilitation, advocacy, referrals, care coordination, supportive counselling
- Outcome or results of evaluation and/or intervention
- Referrals made by the Social Worker, including contact information.
- Clinical recommendations
- Consents, releases or authorizations pertaining to the intervention or the communication of information about the client (BCCSW, 2009)

Consent

Vancouver Coastal Health Consent to Health Care policy directs documentation of consent in certain situations; however, **Vancouver Coastal Health Social Work Professional Practice directs that consent be routinely and explicitly discussed, sought and documented**. Documentation of consent is more than obtaining a client's signature or receiving a verbal "yes" or "no". The process of obtaining consent should "reflect a dialogue between SW and client and…a decision-making process where clients get to make decisions based on discussion and information" (Zur, n.d.).

Documentation of consent should also reflect that consent was *informed*, which requires consent to be given voluntarily by a client who has the capacity to provide consent (Newfoundland & Labrador Association of Social Workers, 2016). Obtaining informed consent is "expression of social workers' respect for clients' rights" (Reamer, 2003) as well as in "keeping with the ethical value of integrity in social work practice" (Newfoundland & Labrador Association of Social Workers, 2016). Additionally, informed consent adheres to the principles of trauma informed care in terms of safety, collaboration, and choice.

Consent does not need to be in writing. However, any written consent form, if present, must be added to the client's health record (i.e. consent to release information, consent to be referred to a particular service).

Social Workers must document:

- That informed consent has been obtained
- Specifics of the consent, such as limits of confidentiality, Social Work interventions consented to, potential risks and benefits of Social Work intervention, and/or consent to release information (except as directed by legislation)
- When the involvement of a Temporary Substitute Decision Maker (TSDM) is necessary, the details of the identification of the TSDM, including those who have been ruled out, and the TSDM acknowledgement to act on behalf of the client.
- How consent was obtained (verbal or written), as per program standards.
- Refusal of consent, if any.
- For clients under 19 years old, the child's ability to consent and, where appropriate, the explanation that was provided to the child and the child's parents/guardians regarding the nature of the Social Worker's relationship to the child (CASW, 2005, Infants Act).

Documentation when the client does not provide consent:

- Social Workers must document situations that do not require client consent (for example, Child Abuse or Neglect, Adult Guardianship or Temporary Substitute Decision Maker involvement) or require the disclosure of confidential client information without the consent of the client (for example, when required or authorized by law to do so).

Language

- Use inclusive language that is client-centered and person-first, being mindful of unconscious bias, cultural labels, in-group terms, marital or family status, disability, sexual orientation, gender identity or expression, pronouns, and age. i.e. 'client with diabetes' vs 'diabetic', client-referred pronouns. (BC Public Service, nd).

- Clearly identify who is being referred to (i.e. when using gender neutral language, when referring to a family member where there are multiple family members with the same relationship to the client, such as "Nargis, client's sister")
- Objective, observational, and non-judgmental
- Explicit (i.e., answer the question 'what does that look like'. For example: 'the client responded by raising their voice and abruptly getting up out of their chair, shouting and swearing" vs "the client became upset/escalated")
- Easily understandable. Avoid vague, unclear or obscure language, symbols and acronyms.
- Written in an objective, professional tone, particularly those relating to substance use, sexual activities or other sensitive matters.

Abbreviations

Use of abbreviations and acronyms is discouraged (VCH Documentation Policy, 2018). If acronyms are used, a supporting reference must be included in the current documentation entry (i.e. when used for the first time, the term is spelled out in its entirety, followed by the abbreviation or acronym in brackets).

Timeliness

Documentation occurs

- At each event of care, transition in care, or whenever there is a change in client status or plan.
- As close as possible to the time of the event of care. Same day, whenever possible.

Degree of detail

Details should include precise, sufficient, and necessary information to inform care planning process and team decision-making about the client's care and treatment. Only include details relevant to understanding and managing the situation.

The detail of documentation is determined by considering:

- Client complexity (i.e. medical stability, number of factors impacting function, capacity to consent, ability to understand or provide accurate information, funding sources),
- Environmental factors (i.e. program policies and procedures, the interdisciplinary team's need for information),
- The Social Worker's professional judgment
- The degree of risk posed to the client or others (consider probability and consequences).

Late Entries

If the documentation is not completed at the time of care or at the latest on the same day, the note will be identified as a late entry (i.e. "*Late entry from (date that care was provided)*"). If this occurs, the time and date of the actual assessment/intervention must be clearly indicated.

Down time

Follow program procedures to meet standard for timely and complete documentation.

Addendums

Addendums should only be used to ensure the accuracy and completeness of the health record. They can be added to the health record when the information is incorrect and/or incomplete, and when the report is already published. This process will vary, depending on electronic documentation system.

Do not add addendum to another Social Worker's note. (Exception: students – see Student Documentation)

Entries written in error

As applicable, corrections to documentation may be required for a variety of reasons (i.e. documenting on the incorrect client). Please follow your program process or seek direction from your supervisor.

In the event an error in documentation completed by another team member is noticed, the Social Worker should notify the author to correct the error. If they are not available, the Social Worker should notify a manager or designate to follow-up.

Referrals not clinically indicated

When a Social Worker receives a referral that is not clinically indicated, follow the clinical documentation process related to your team/program.

Adult Guardianship investigations and interventions

Additional documentation guidelines related to the documentation of Adult Protection cases can be found in the Decision Support Tool: Responding to Abuse, Neglect or Self-Neglect of Vulnerable Adults: For Designated Responder (DR) and Designated Responder Coordinators (DRCs).

Child Abuse and Neglect reports

Documentation related to making child abuse or neglect reports may be used to help solve legal issues and should be consistent with direction outlined in this document. See Decision Support Tool: Duty to Report: Child Abuse and Neglect (Community).

Use of Interpreters

When interpreters are used to communicate with clients, indicate the following:

- Which language (i.e. ASL, Cantonese) and specific dialect, if applicable
- Who provided the interpretation
- The modality used to provide interpretation (i.e. in person, virtual, phone, online type to voice augmentation, CART, or alternative communication device)

Signature Requirements

All entries must be signed (including electronic) or initialed by the authoring healthcare provider (BCCSW, 2009), including designation (RSW or RCSW).

If the Social Worker is under the Provisional Class of Registration, the Social Worker must use the title 'Provisional RSW' when signing documentation.

If your electronic signature does not reflect the signature requirements, type designation/title below completion of your documentation content, and before your name/date/time stamp.

Direct Quotes

From healthcare providers

When directly quoting documentation of another healthcare provider in Social Workers own documentation, Social Workers must:

- Use exact words used; avoid paraphrasing.
- Clearly document the author of the information, including name and reserved title or designation, as well as the source and date (if applicable, i.e. “Cerner, April 5, 2023).
- Ensure the integrity of the documentation is maintained.
- Use quotation marks to indicate the start and end of the original documentation.
- Include the date and time of the original documentation.

From clients/family members

Where clinically indicated, direct quotes from clients/family members can be used within the health record (i.e. Client’s partner reported that they “are barely hanging on, haven’t slept more than 2 consecutive hours a night in the past month… (and) ready to call it quits”). In the event a healthcare provider needs to directly quote from clients/family members in their documentation, Social Workers must:

- Clearly identify the author of the information (unless Adult Guardianship related; refer to Responding to Abuse, Neglect or Self Neglect of Vulnerable Adult – for DRs and DRCs DST)
- Use quotation marks to indicate the start and end of quotation

Group Sessions

When documenting information on a member within the group (therapeutic group, family meeting), the Social Worker will record on the individual client’s health record and only information as it pertains to that individual.

Involvement of Family Members/Others Involved with Client

When providing education and other forms of support to family/caregivers, Social Worker should indicate in the client health record what intervention was provided to the family/caregiver, and any collateral relevant to the care of the client.

Social Workers are to maintain the privacy of the family/caregiver, and must ensure no detailed personal information disclosed by the family/caregiver is recorded in the client health record. (i.e. Instead of “Mother reported she was diagnosed with metastatic breast and brain cancer, will start intensive treatment soon, and is devastated with the diagnosis and unable to leave her house”, document “Mother is unable to continue providing physical and practical support to the client as she starts treatment next week for a serious health issue”.)

In situations where the Social Worker becomes aware of a situation requiring the Social Worker to directly intervene to maintain the health and safety of the family member, (i.e. family member expressed active suicidal ideation and the Social Worker supported the family member to go to Emergency), the Social Worker should document relevant information only in the family member’s health record.

If information, data or collateral about a person other than the client is obtained under Adult Guardianship Act authority, this forms part of the adult protections investigation. Upload this information in the ReAct Reporting System. Do not document personal information about another person in the client's health record.

Draft Documents, Standardized Assessment/Screening Tools, Applications and Forms

Any collateral materials must be placed or uploaded into the client's health record. Collateral information should not be kept outside of the client's health record (i.e. ghost chart). If documents are not placed in the health record, they must be shredded or returned to client/family as appropriate.

Information that informs the clinical decision making process should be included in the health record. A summary of the assessment may be adequate to support your clinical impression.

Applications and other forms, as well as original copies of standardized tools (i.e. Standardized Mini-Mental State Examination, Client Health Questionnaire, Subjective Global Assessment) completed by the Social Worker must be included in the health record.

Student Documentation

As per the guidelines of the BCCSW, students will document under the supervision of their preceptor. (BCCSW, 2009).

If the preceptor has been present for the client interaction and agrees with the note, the preceptor may co-sign the note. If the preceptor has not been present for the client interaction, the preceptor reviews the documentation and documents a brief note (i.e. "read and agree") to indicate that they have read and agree with the plan or the preceptor adds an addendum.

Documentation of Text, Email, and Video Communication

Summarize the contents of electronic communication including text and emails, into the health care record (similar to telephone conversations).

Copying and pasting of texts or emails should occur by exception, and only when the entire content of the text/email is relevant to the care of the client.

Professionalism

Documentation should be reviewed for spelling and grammatical errors prior to adding signature.

Related Documents

Documentation Policies and Standards

Community Mental Health and Substance Use Documentation Standard (D-00-15-30005)

Documentation Policy (D-11-11-41002)

Health Record Policy (D-11-11-41003)

Interdisciplinary Documentation Protocol (D-00-05-30194)

Paper/Electronic Documentation Standards (D-00-05-30023)

Consent to Health Care (D-00-11-30016)

Trauma Informed Practice (BD-00-07-40107)

Documentation Practice Standards

BC College of Social Workers Code of Ethics and Standards of Practice (see Principle 4 Social Work Record)

BC College of Social Workers Technology Standards of Practice (see Section 5 Records and Documentation)

Virtual Health Policies

Texting Policy

Emailing Policy

FaceTime Use- Clinical

Zoom Application Use

Forms

Authorization for the Release of Health Records

Help links

Profile EMR User Help

PARIS Website/Guidelines

PARIS User Help

CST Cerner Help

Emailing Guide for Home Health Clinicians

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Definitions

"Assessments" assessments are something that is continuous and ought to be part of a cycle (Payne, 2008). Assessments are underpinned by a broad knowledge and skill base, as well as a series of guiding principles that support practitioners in their role.

Assessments are a professional task of working with client systems to gather and analyse information about the client situation and context with the goal of care planning (Taylor, 2017). Assessments are a critical part of social work practice and guide the social work intervention. Assessments are continuous, cyclical and based in broad professional knowledge, skills and guiding principles.

"Client" refers to any person or body that is the recipient of social work services. The term 'client' includes 'patient', 'resident' and 'participant'. In defining the client or client system a member could ask the question: "To whom do I have an obligation in respect to the services I am providing?" (BC College of Social Workers, 2009).

"Down time" refers to periods when a system is unavailable and includes both scheduled and unscheduled events.

"Health Record" is a confidential compilation of an individual's health history, including all past and present medical conditions, illnesses and treatments, with emphasis on the specific events affecting the patient during the current episode of care (Health Information Management).

"Family Members" may be a person or persons, including immediate relatives and other individuals in the Person's support network. Family may include the Person's extended biological, spiritual, and cultural family, partners, friends, and other individuals as determined by the Person (BC Provincial Health Care Social Work Working Group, 2022).

"Informed Consent" is the client's granting of permission to the Social Worker and agency or other professional person to use specific intervention procedures including diagnosis, treatment, follow-up, and research. This permission must be based on full disclosure of the facts needed to make the decisions. Informed consent must be based on knowledge of the risks and alternatives (CASW, 1995). Informed consent includes informing clients that digital and electronic communications will be included in client records.

"Interventions" in Social Work are purposeful actions Social Workers undertake which are based on knowledge, understanding, acquired skills learnt, and values adopted. Therefore, interventions are knowledge (including theoretical), skills, understanding and values in action. Intervention may focus on individuals, families, communities, or groups (micro, meso, and macro) and be in different forms depending on their purpose and whether directive or non-directive.

Social work interventions are selected on the basis of the issues, needs, and strengths of the client. These are determined as a result of a psychosocial assessment conducted by the Social Worker. Interventions are implemented for the purpose of reducing symptoms, resolving problems, enhancing adaptive capabilities and improving the overall psychosocial wellbeing of the client (Boihtlung, 2017).

"Social Work" refers to the assessment, diagnosis, treatment and evaluation of individual, interpersonal and societal issues through the use of social work knowledge, skills, interventions and strategies, to assist individuals, couples, families, groups, organizations and communities to achieve optimum psychological and social functioning; "Social Worker" means a person who practices social work.

(Social Workers Act BC, 2008)

"Trauma informed" begins with understanding the physical, social, and emotional impact of trauma on the individual, as well as on the professionals who help them. Trauma informed care takes the client's experiences of trauma into account; utilizing therapeutic approaches that validate the person's experience. It understands the symptoms of trauma to be coping strategies that have developed in reaction to a traumatic experience(s). Core principles of trauma informed care includes safety,

trustworthiness, transparency, peer support, collaboration, empowerment, humility and responsiveness. It is not necessary for someone to disclose trauma to receive trauma informed care (BC Provincial Mental Health and Substance Use Planning Council, 2013).

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	VCH: (Regional DST Endorsement - 2nd Reading) Health Authority & Area Specific Interprofessional Advisory Council Chairs (HA/AIAC) Operations Directors Professional Practice Directors Final Sign Off: Vice President, Professional Practice & Chief Clinical Information Officer, VCH
Owners: *(optional)*	VCH
	Social Work Practice Lead, Vancouver Acute Social Work Practice Lead, VC