Documentation: Case Note Writing

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Learning Objectives

- Understand the dos and don’ts of writing case notes.
- Learn how to identify, label and describe behavior.
- Tips for writing effective case notes / coaching progress notes.
Top 10 Challenges with Documentation

10. ____________________________________________________________

9. ____________________________________________________________

8. ____________________________________________________________

7. ____________________________________________________________

6. ____________________________________________________________

5. ____________________________________________________________

4. ____________________________________________________________

3. ____________________________________________________________

2. ____________________________________________________________

1. ____________________________________________________________
Case Noting:

- Documentation: The case note records important details about services provided to the customers.
- Case notes should record the customer’s participation in activities and his or her progress.
- Sometimes case notes serve as documentation of factors affecting eligibility or other important information.
- Case noting is a way to let the next reader know what is going on with the customer.
- Poor case notes cause confusion and potential lack of services to customers.
- Case notes reflect service continuity
- Provide a justification for reimbursement
- Case notes help maintain quality control / quality assurance
- Case notes are a valuable source to gather statistics
- Case notes justify counselor’s actions / decisions
- Litigation protection, and prevention

*Documentation in Counseling Records, Robert W. Mitchell*
Case Notes: The Basics

Should **always** include:

- The complete date: 01/15/2014 or January 15, 2014
- Method of contact: In person, phone, email, text, letter, etc.
- Legal Name, Title and Credentials of the staff member.
- Written in pen or typed. **MUST BE** legible.
- Never white out anything.
- Description of the event
- Description of how the customer will benefit from the activity / impact / consequences
- Follow-up plan and who is responsible.

Who? What? When? Where?

- Who did you speak with?
- What happened today? What is next?
- When are actions due? When did you speak with the customer?
- Where did the contact occur? Where is the activity supposed to be completed?

Timeliness:

- Update case notes frequently and promptly.
  - While information is fresh in your mind
  - Case note any and all interactions with the customer
Making Corrections / Altered Documentation:

- If you make a mistake, the most universally acceptable method to make a correction is to use a pen and draw a line through the entry. Do not obliterate words; they must remain legible.

- Above the correction write “error´ and somewhere on the page write “corrected entry,” and initial.

- If you discover an error several weeks after the entry, above the correction write “error,” enter the date of change, and initial it. Again, somewhere on the page write “corrected entry,” and initial.

- If you are correcting more than word or two, write the correction on the original note and cross-reference with the original note.

  Documentation in Counseling Records, Robert W. Mitchell

Professionalism:

- Avoid slang: Street language, clichés, or jargon. Use professional language.

- Use correct spelling, complete sentences, capitalization and punctuation.

- Do not use abbreviations or text type writing.

- Do not write cryptically.

- Address the behavior and the plan.

- Do not state client is a “victim of domestic violence.” Describe the situation with facts and behaviors.

- Omit details of the client’s intimate life that does not have an impact on the plan.
Recommendations:

- Write in a style that is:
  - Factual
  - Objective, unbiased
  - Specific
  - Clear and to the point

Quality Assurance:

- Supervisors and Quality Assurance officers will review your notes.
- Auditors will review your notes for compliance with state and federal policy and procedure.
- Case notes are legal documents.

Be Warned!

- Liability issues
  - Recording a “to do” item in the case file and not following through
  - Negative, biased or prejudicial language

*Documentation in Counseling Records*, Robert W. Mitchell
The Individual Plan for Employment:

The client’s IPE is the roadmap of their services.

They outline goals and objectives for the participant and the agreed upon activities and services that will be provided to meet those goals and objectives.

**Goals:** Long-term, general, desired results. Often open-ended and may be difficult to measure.

**Objectives:** Specific, concrete and measurable outcomes to reach in moving towards our goals. Generally have dates connected to them. There may be several objectives (steps) for each goal. Objectives identify specific activities and services.
Language Matters

Use Strong Verbs:

Advised
Assessed
Assisted
Clarified
Confronted
Counseled
Discussed
Directed
Encouraged
Focused

Identified
Recommended
Redirected
Referred
Reflected
Structured
Summarized
Supported
Urged
Offered

Words to avoid:

Abnormal
Abusive
Anxious
Attitude
Dangerous
Demanding
Difficult
Disturbed
Hysterical
Immature

Impulsive
Irrational
Obnoxious
Overwhelmed
Resistant
Suicidal
Threatened
Troubled
Uncooperative
Unfit
DIFFERENTIATE BETWEEN LABELING BEHAVIOR AND DESCRIBING BEHAVIOR

1. Identify the type of behavior [i.e. hostile, aggressive, impulsive, super-agreeable, indecisive, etc.].

2. Focus on the person’s behavior and not their personality.
<table>
<thead>
<tr>
<th>Label</th>
<th>Difficult / Positive Behavior</th>
<th>Describing the Behavior</th>
</tr>
</thead>
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