Ethical Standards in Social Work Documentation: From Process Recording to Risk Management

Produced by the Alabama Department of Public Health Distance Learning and Telehealth Division

Faculty

Renae Carpenter, LICSW, PIP
State Social Work Director
Alabama Department of Public Health

Chapter 850-X-9 Standards of Professional Conduct and Ethics

- (2) The Social Worker's Ethical Responsibility to Clients.
- (c) Confidentiality and Privacy
- (3) The social worker shall keep timely and accurate records detailing problems, treatment plans, scope of services, and dates and content of client contacts for a minimum of three years after the date...

Chapter 850-X-9 Standards of Professional Conduct and Ethics

 ...on which services were last provided to the client. Records shall be securely kept to ensure the confidentiality of clients. Records or other oral or written information which personally identifies the client shall not be released to third parties except in specific circumstances.

The Importance of Documentation

- For many years, the purpose of documentation was to accurately record diagnosis, assessment, planning, and intervention
- Beginning in the mid 1990's, documentation became key in utilization review and managed care

The Importance of Documentation

- More recently, it has become clear that documentation is relevant to riskmanagement
 - Guard clients' privacy
 - Facilitate the delivery of high-quality services
 - Defense against ethics complaints
 - Defense against professional negligence

Contemporary Functions of Documentation

- 1. Assessment and Planning
- 2. Service Delivery
- 3. Continuity and Coordination of Services
- 4. Supervision
- 5. Service Evaluation
- 6. Accountability to clients, insurers, agencies, other providers, courts, etc.

Documentation Considerations

- 1. Is the documentation complete, concise, accurate, and dated/timed?
- If a record is well documented, then it is less likely to become a liability for the employee and/or agency
- 3. Sloppy documentation is equated to sloppy care

Documentation Considerations

- 4. What is written becomes a permanent record
- 5. What isn't written may be questioned forever

Why Timely Documentation is Critical

- · It represents our clients lives
- Accuracy of documentation is directly related to how soon we document after the event
- It allows another social worker to provide services in our absence



Why Timely Documentation is Critical

 It serves as a tool to protect both clients and practitioners in the event of an ethics complaint, a law suit, or even in a criminal investigation

Documentation Best Practices

- Read what you write/type
 - Does it make sense to a lay person?
 - You should assume that your documentation will be read by others; do you want it read out loud in a court of law?

Documentation Best Practices

- · Use proper grammar and spelling
 - Your credibility and the credibility of the agency are at stake
- · Do not use 'auto-correct' functions
 - Too often, the wrong words get used with serious consequences

Documentation Best Practices

- Use abbreviations that are understandable in context
 - -DD (developmentally disabled or dual diagnosis?)
 - -SA (Substance abuse or sexual assault?)
 - AKA (above knee amputation or also known as?)

Documentation Best Practices

- -PT (Patient, Physical Therapy, or Pregnancy Test?)
- -Pt = patient, PT = physical therapy, pt = pregnancy test
- -DO (right eye or once daily)
- PSA (public service announcement, psychosocial assessment or prostate-specific antigen?)

Documentation Best Practices

 Too much content, too little content, or the wrong content can harm the client, the practitioner, and the agency

Commonly Misused Words

- Quite or Quiet?
 - -Quite = almost
 - -Quiet = low volume of noise
- There, They're, or Their?
 - -There = a place
 - -They're = they are
 - -Their = possessive

Commonly Misused Words

- · Set or Sit? Lay or Lie?
 - Set or to lay = to place something
 - Sit or lie = to seat yourself or to recline
- · Its or It's
 - Its = possessive
 - It's = it is
 - **if you can replace "its" with his or hers, then there is no apostrophe

Commonly Misused Words

- · Except or Accept?
 - -Except = to exclude
 - Accepted = to receive
- · Breath or Breathe?
 - Breath = the air that is inhaled or exhaled
 - Breathe = the action of inhaling or exhaling

Commonly Misused Words

- · Then or Than?
 - -Then = time
 - -Than = to compare
- · Affect or Effect?
 - Affect = to influence (verb)
 - Effect = the result of (noun)

Commonly Misused Words

- · Irregardless?
 - No such word exists
- · Ain't?
 - No such word exists
- · Supposably or undoubtably?
 - Do not exist
- Correct words are Supposedly or undoubtedly

Points to Remember

- · Subject and verb agreement:
 - Incorrect The documents was printed
 - Correct The documents were printed

Points to Remember

- Southern lingo is inappropriate for documentation:
 - Incorrect Care Coordinator done the home visit
 - Correct Care Coordinator has done the documentation
 - Best professional practice Care Coordinator made the home visit and completed the documentation

Resources

- · www.socialwork.alabama.gov
- www.crozerkeystone.org/healthcareprofessionals/medicalstaff/physicianinfo/cme/articles/documentation/