

# Documentation Matters: Tip #11

## What is the link between assessments and documentation?

Documentation and assessment skills are interrelated. The primary purpose of social work recording is to provide a clear statement of social work assessment, intervention, and professional decision-making” (NLCSW, 2020, Standards of Practice, p. 5). The following questions may be helpful when reflecting on assessment and documentation practices.

- Does my documentation accurately reflect my assessment of a client’s situation or needs?
- Does the record contain all the information that is clinically relevant and significant to the services that are being provided in keeping with the assessment?
- Are there any gaps in the information that is documented that could impact continuity of care?
- Does the assessment contain language or information that could be misinterpreted?
- Are client goals clearly communicated?
- Does the record include client information from referring organizations, professionals involved in the client’s care and collateral contacts which informs the assessment?
- Is my decision-making and professional judgement evident?
- Are my professional observations distinguishable from information provided directly by the client?
- Would someone reading the record have a clear understanding of the client’s situation and rationale for the planned intervention?
- Based on the assessment, does the client record contain information on how long the proposed intervention will take, including a clear termination plan?
- Does the record clearly reflect any necessary risk assessments that have been completed?
- Are client outcomes documented? If interventions need to change based on the continual assessment of the client’s needs and goals, is this reflected in the record?



For more information related to social work documentation, visit the NLCSW website [www.nlcsw.ca](http://www.nlcsw.ca).