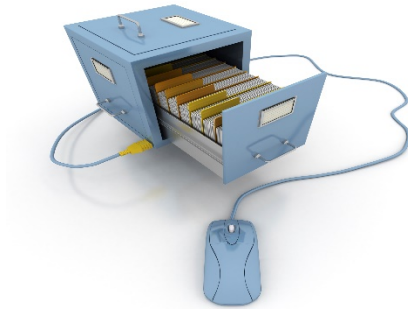


Newfoundland & Labrador

College of Social Workers

SOCIAL WORK RECORDING *(Explanatory Document)*



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Note: Social workers have a responsibility to be aware of and adhere to the Newfoundland and Labrador College of Social Workers (NLCSW) (2020) Standards of Practice for Social Workers in NL, the Canadian Association of Social Workers (CASW) (2005) and the CASW (2005) Guidelines for Ethical Practice.

This explanatory document is a companion document to the NLCSW (2020) Standards of Practice.

INTRODUCTION

The Newfoundland and Labrador College of Social Workers (NLCSW) regulates the practice of social work in Newfoundland and Labrador (NL) under provincial legislation titled the [Social Workers Act, SNL 2010, c.S-17.2](#). The vision is Excellence in Social Work.

Social work documentation is a vital and integral component of professional, ethical, and competent practice in clinical, organizational, community and private settings. The purpose of this document is to:

- a) Inform social workers, employers, and the public on best practices for social work recording,
- b) Highlight awareness of the practice standards, considerations, and ethical responsibilities in social work documentation, and
- c) Support social workers in their documentation practices.

The terms recording and documentation are used interchangeably throughout the document.

BEST PRACTICES FOR SOCIAL WORK RECORDING

- 1.** Documentation in social work practice is grounded in the ethics, values, and principles of the social work profession.
- 2.** Social workers maintain records of social work intervention(s).
- 3.** Social workers ensure records are in a format that facilitates monitoring and evaluation of the social work intervention (s).
- 4.** Social work documentation shall include a clear assessment, intervention strategy and termination plan.
- 5.** Social workers protect client confidentiality and ensure that clients are aware of the limits of the confidentiality of social work documentation before initiating the social work relationship and throughout the relationship as needed.
- 6.** Social workers ensure electronic communications are documented in keeping with best practice guidelines, standards, and policies.
- 7.** Social workers engage in continuing professional education to strengthen documentation competencies.

DEFINITIONS

Social Work

The *Social Workers Act* (2010) of NL defines social work as: the assessment, remediation and prevention of psycho-social problems and the enhancement of the social, psycho-social functioning and well-being of individuals, families, groups and communities by using social work knowledge, theory and skills to

- (i) provide direct counselling and therapy services to a client,
- (ii) develop, implement, manage or deliver human service programs, including those done in collaboration with other professions,
- (iii) contribute to the development and advancement of health and social policy, and,
- (iv) conduct research in the science, technique and practice of social work.

Social Worker

To refer to oneself as a social worker or to practice within the scope of practice of the social work profession in NL, an individual must meet the criteria for registration as outlined under the *Social Workers Act* (2010) and be actively registered. Registered social workers are granted the RSW designation. Use of the RSW designation affirms an individual has met the criteria for registration and has been granted use of the title and right to practice social work in NL.

Clients

Clients include a “person, family, group of persons, incorporated body, association or community on whose behalf a social worker provides or agrees to provide a service or to whom the social worker is legally obligated to provide service” (Canadian Association of Social Workers, CASW, 2005a, p. 10). The word, “client,” acknowledges the power differential that exists between giver and receiver of service.

Social Work Recording

The *Social Work Dictionary* (2014) defines recording as “the process of putting in writing and keeping on file relevant information about the client; the problem; the prognosis; the intervention plan; the progress of treatment; the social, economic, and health factors that contribute to the situation; and the procedures for termination or referral” (p. 358).

RATIONALE

Social work is a regulated profession with a high degree of legal and ethical accountability. Social workers adhere to a code of ethics, standards of practice, legislative mandates, and organizational policies.

A social work record is a written or electronic document that contains client information, professional observations, clinical decisions, intervention strategies, and outcomes generated throughout the delivery of social work services.

The purpose of social work recording is to provide:

- A clear statement of social work assessment, intervention, and decision-making.
- Professional accountability and transparency to the client and organization and in keeping with relevant legislation.
- Opportunity for critical thought and reflection on professional practice and service delivery.
- Relevant information to facilitate service delivery, continuity of care and termination of services.
- Information for the purposes of supervision.
- Documentation for the purposes of research and program evaluation.
- Information for risk management and quality assurance.
- A record to facilitate inter-disciplinary communication and collaboration.

Given the significance and importance of social work recording, it is imperative that social workers have the appropriate knowledge and skills to ensure timely and effective documentation that meets best practice guidelines and legislative requirements. This document has been developed to highlight some of the ethical, best practice, and professional issues that need to be considered in to ensure high quality social work documentation.

BEST PRACTICES FOR SOCIAL WORK RECORDING (ELABORATED)

- 1.** Documentation in social work practice is grounded in the ethics, values, and principles of the social work profession.

Documentation is an integral component of social work practice. It is therefore important that social workers document all interventions in an ethical and competent manner. The Canadian

Association of Social Workers (CASW) (2005) [Code of Ethics](#) outlines the values and principles that guide professional social work practice:

- 1) Respect for the Inherent Dignity and Worth of Persons
- 2) Pursuit of Social Justice
- 3) Service to Humanity
- 4) Integrity in Professional Practice
- 5) Confidentiality in Professional Practice
- 6) Competence in Professional Practice

These values provide an ethical framework social workers can use when reflecting on documentation practices across all areas of practice including clinical, community, management and supervision, research, education, and policy development.

Social workers document in keeping with one's ethical responsibilities, organizational policies, and legislative obligations, and consider issues pertaining to informed consent, client privacy and confidentiality, integrity, best interest of the client, and technology use in social work practice.

2. Social workers maintain records of social work intervention(s).

Social workers have an ethical and legal responsibility to maintain social work records. Documentation of social work interventions with clients should be contained in one file. The records may be electronic, paper or both. Social workers should not maintain client information that is not relevant to the service delivery, or client information that is not recorded in the client file. Social work documentation should only include information that addresses the clients' needs and meets legislative, ethical, and organizational requirements.

It is the responsibility of the social worker to inform clients about what information is being recorded, how it is being used, and who will have access to this information as part of the informed consent process. Social workers should also be aware of organizational policies and legislation respecting client access to the professional record and rights of appeal. Social workers in private practice are responsible for developing these policies.

Informed consent is defined by the CASW (2005) Code of Ethics as a "voluntary agreement reached by a capable client based on information about foreseeable risks and benefits associated with the agreement (e.g., participation in counselling or agreement to disclose social work report to a third party)" (p. 10). In keeping with the Newfoundland and Labrador College of Social Workers (NLCSW) (2020) [Standards of Practice](#), social workers document informed consent in the client record at the beginning of the social work relationship, and throughout the

duration of the relationship as necessary (e.g., change in service delivery or treatment modality, referral to another service, reassessment of client capacity, disclosure of client information). NLCSW's [Self-Assessments Tools for Informed Consent and Documentation](#) provides checklists social workers can use to reflect on and evaluate their practices pertaining to informed consent and documentation, and identify areas for continuing professional education.

Access to supervision is an important part of professional practice and records of supervision are essential. While the frequency in which social workers should have access to supervision may depend on a number of factors (e.g., one's education, knowledge, experience, risk in the practice activity, stress experienced by the social worker), it is the responsibility of the social work supervisor to keep records of the supervisory sessions and ensure that client confidentiality is maintained. This is in keeping with the NLCSW (2020) Standards of Practice which states "Social work supervisors keep accurate and timely records of supervision" (p. 14).

3. Social workers ensure records are in a format that facilitates monitoring and evaluation of the social work intervention(s).

Social work documentation must be completed in a timely and chronological order to ensure accuracy, clarity, and credibility of the information. Recordings should be completed following the intervention or as soon as reasonably possible afterwards. Social workers use professional judgment to determine if records need to be completed more expeditiously. The need to document a record more immediately may depend on the complexity of the case, degree of risk, impact on service delivery, and/or legislative requirements. Where organizational standards or policies exist, social workers should be aware of and adhere to policies and timelines for documentation to be completed.

Social work records should contain all information that is clinically relevant and significant to the service delivery. At a minimum, records should include the following:

- Client's name and contact information
- Presenting issue and description of professional service requested
- Client's informed consent
- Copy of relevant documents (e.g., referrals, letters, court documents, etc.)
- Professional assessment, goals, interventions, and outcomes
- Progress notes
- Communication with other professionals and collateral contacts
- Clear statement of when and why the professional relationship is terminated
- Fee for service agreements (for those in private practice)

Records that are not clinically focused should contain at the minimum contact information for relevant partners and stakeholders, assessments, planning and implementation notes, records of meetings and communication with stakeholders, appropriate consent forms, pertinent research, and evaluations.

The nature of the intervention or service delivery and organizational policies will shape the format and content of the social work record. When organizational policies pertaining to documentation practices are not developed or are vague and unclear, social workers advocate for documentation policies that are in keeping with the best interest of the client and standards for the profession.

Social work records are to be dated the day they are written. Records completed on a different date from which the intervention occurred must clearly identify when the intervention or client contact occurred in the case note. Issues pertaining to workload, personal circumstances, leave and absences from work that are impacting social work documentation should not be included in the client file. Social workers discuss issues impacting their ability to meet professional and organizational standards for social work documentation with their manager/supervisor and to identify potential strategies address these issues.

Social workers sign all records using their name and professional designation (social worker, Registered Social Worker, or RSW). Social workers should not sign records, reports, or letters authored by another social worker or professional. Social workers may co-sign documents where appropriate (e.g., advocacy letter by collaborative team on behalf of a client, progress note from co-therapy session).

Social work records should be free from jargon and emotive or derogatory language. Abbreviations should only be used after the term is explained the first time it is used in the record. This is important to avoid ambiguity and misunderstandings. Errors must not be erased or deleted. If corrections need to be made, they should be noted as such and dated and initialed by the social worker. To ensure the credibility of the note, social workers should also ensure that they use accurate spelling and grammar (Reamer, 2005).

Consultations with a supervisor, colleague, or consultant that is relevant to the service delivery should be documented in the client's record. Clients should be informed that information may be shared with a supervisor or internal consultant as part of the social work service delivery when appropriate. Informed consent is necessary when client information is released to an outside consultant.

Reamer (2005) notes that staffing issues, disagreements amongst staff, supervisors, managers, and administrators (e.g., about a policy), and opinions about the competence of a colleague, should not be documented in the client file. Social workers may explore other organizational mediums to document these issues (e.g., administrative files).

4. Social work documentation shall include a clear assessment, intervention strategy and termination plan.

Documentation and assessment skills are interrelated. As noted by Leon & Pepe (2010), “how one interviews and assesses a client will determine how informative the client contact will be and consequently how much essential content one can include in the client documentation” (p. 365). Incomplete or inaccurate records can lead to inadequate services for the client.

Assessments are based upon facts that should be clearly documented in the client file. Only facts that are essential and relevant to the assessment or service delivery should be recorded. The type of information considered relevant will depend on the context of practice and professional judgment of the social worker. All professional opinions need to be supported with facts, and professional observations must be distinguished from information provided directly by the client.

On-going records and documentation should clearly identify the services to be provided, the client goals for intervention, and outcomes. The client is considered the primary source of information for the file. In circumstances where the client is not able to provide information to guide the intervention, social workers seek guidance from provincial statutes and organizational policies on who should be speaking on behalf of the client (e.g., power of attorney, substitute decision-maker). Client information from referring organizations, professionals involved in the client’s care, and collateral contacts should also be included in the social work record.

Social work is a complex profession fraught with ethical and practice dilemmas. It is important that social workers document ethical decision-making processes when working through an ethical dilemma or issue with a client or client system in the social work record. Examples of ethical issues that may be important to document in the client record include conflicts of interest, professional boundaries, dual and multiple relationships, and professional self-disclosure. NLCSW’s [Ethical Decision-Making in Social Work Practice](#) provides a model that can be used to guide one’s ethical decision-making and documentation.

When social work relationships are terminated, the record should include a clear statement to indicate the end of the professional service. Social workers follow organizational policies and best practice guidelines regarding the retention of social work records after the professional relationship has ended. Social workers in private practice are responsible for developing policies pertaining to the retention of social work records. As outlined in the NLCSW (2020) Standards of Practice, “Client records must be kept for a minimum of seven to ten years from date of last entry, unless otherwise specified by legislation or organizational policy. If the client is under the age of 18 when the last entry is made, the client file should be kept for a minimum of 7 to 10 years from the date that the client turns or would turn eighteen. Social workers use professional judgment in deciding if records are needed to be maintained beyond this time frame” (p. 7). This may depend on the nature of the work and future need for the record. Social workers are responsible for informing clients of the length of time in which records will be stored, security measures, and how clients can access them if needed during this time period.

5. Social workers protect client confidentiality and ensure that clients are aware of the limits of the confidentiality of social work documentation before initiating the social work relationship and throughout the relationship as needed.

The CASW (2005) [Guidelines for Ethical Practice](#) speaks to the importance of informed consent and privacy and confidentiality. It is important for social workers to reflect on these principles when preparing social work records.

Social workers must be aware of organizational policies pertaining client confidentiality, and take steps for protecting the confidentiality of a client's written or electronic record. According to the CASW (2005) Code of Ethics, it is important that social workers "take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access" (p. 8). Where policies are lacking or are unclear, social workers advocate for policies that meet professional standards in the best interests of clients.

When social workers provide services to more than one individual in a client system (e.g., families, couples and groups), it is important that all parties are informed of each person's right to confidentiality and the confidentiality of information shared by others, and how records are being maintained. This information should be clearly documented in the client file. Clients being seen individually, in addition to the family, group or couple's work, should have their own social work record.

As outlined in the CASW (2005) Guidelines for Ethical Practice "social workers ensure that clients have reasonable access to official social work records concerning them" (p. 10). Client access to personal information in clinical social work practice is also a right under applicable legislation (e.g., *Personal Health Information Act*). The benefits of allowing clients to access their records may include a) opportunity for clients to correct inaccuracies contained in the record, b) client can see where change is possible, and c) increase in trust of services being provided. Social workers have a responsibility to ensure that clients are aware of organizational policies pertaining to client access to records. "If there are compelling professional, ethical or legal reasons for refusing access, social workers advise clients of their right to request a review of the decision through organizational or legal channels" (CASW, 2005b, p. 10). Social workers also take steps to protect the confidentiality of others when providing clients with access to their records (e.g., masking third party information, information about group members). When clients articulate complaints with regards to their records, social workers advise clients of appropriate complaints mechanisms.

The disclosure of client information and records to persons or organizations is permitted:

- a) With the informed consent of clients. This consent, written or verbal, should be documented in the client record.

- b) When disclosure is necessary to prevent serious, foreseeable, and imminent harm of the client or others. Social workers use their professional judgment to determine how much client information needs to be disclosed to prevent harm.
- c) When required by federal and provincial laws or regulations. The CASW (2005) Guidelines for Ethical Practice states that where the “consent of clients is not required, social workers attempt to notify clients that such access has been granted, if such notification does not involve a risk to others” (p. 9).

When disclosure of social work records is required by a court order or subpoena, social workers should be familiar with the nature of the request, seek consultation, take care not to release more information than is required, inform the client where appropriate, and strive to protect confidential client information from unreasonable public exposure. This may involve applying to the court for some client information to be withheld from the public record; however, consultation with a supervisor, manager, and/or legal advisor would be prudent in this situation.

6. Social workers ensure electronic communications are documented in keeping with best practice guidelines, standards, and policies.

Technology use in the delivery of social work services continues to increase. It is therefore important for social workers to consider how technology impacts on documentation practices as it relates to informed consent, client communication, crisis management, and client confidentiality. As noted in NLCSW’s [Technology Use in Social Work Practice \(Explanatory Document\)](#):

- Social workers discuss with clients policies pertaining to the documentation of electronic communications within the informed consent process. This is in keeping with the clients right to self-determination and allowing clients to decide what information is communicated electronically.
- E-mail, phone, text, or other electronic messages from clients have clinical or therapeutic significance should be documented in the clinical file. Social workers should also have clear policies pertaining to electronic messages and response times that is documented as part of the informed consent process.
- When communicating with clients electronically, having clear policies on how crisis situations will be handled is crucial. Social workers engage clients in conversations about these policies through the informed consent process and discuss the type of information appropriate for electronic communications, particularly when outside of scheduled contact or planned sessions. This information should be clearly documented in the client file.
- Social workers documenting electronically must consider client requests to access their records in keeping with confidentiality standards, organizational policy, and applicable

legislation. Providing clients with information on how long records will be maintained and stored after the professional relationship has ended is also important.

- Social workers have a responsibility to protect the confidentiality of a client's written or electronic record. As outlined in the CASW (2005) Guidelines for Ethical Practice: "Social workers take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access" (p.8). When documenting electronically, risk management strategies (e.g., computer passwords, back up files) is important in the protection of client information.

When sharing client information through electronic mediums (e.g., electronic email, facsimile machines, or other forms of technology), social workers inform clients about the limits of confidentiality and develop risk management strategies to minimize potential breaches such as encrypted emails, firewalls, and passwords in keeping with organizational policy.

When team members or care providers communicate by e-mail or other electronic technologies, reasonable efforts must be made to ensure the protection of client privacy and confidentiality and risk management strategies must be put in place. Clients should also be informed about this method of team communication and documented in the client file as part of the informed consent process.

7. Social workers engage in continuing professional education to strengthen documentation competencies.

Reamer (2005) states "social workers must strive to continually strengthen their record-keeping practices to maintain the integrity of their programs" (p. 327). Social workers are responsible for being familiar with standards and best practice guidelines governing social work practice and documentation. As part of on-going professional development, social workers continue to assess their knowledge of social work documentation through self-reflection and consultation with peers, managers and/or supervisors and to engage in professional development opportunities to foster continued learning and competency. This is in keeping with the NLCSW (2020) Standards of Practice which states: "Social workers seek to ensure they have the necessary skills to carry out their work efficiently and effectively. These skills include, but are not limited to, communication, assessment, interviewing, and documentation" (p. 4).

Social workers engaged in supervision, including those involved in the provision of field instruction to students, ensure that social workers and students are familiar with the standards for social work recording and best practice guidelines for documentation and writing, while seeking opportunities to enhance the competency of supervisees and students in social work documentation.

CONCLUSION

This document highlights best practices for social work recording. It is intended to provide guidance and support to social workers in diverse fields of practice and to raise awareness of the practice considerations and ethical responsibilities. Informed by the CASW (2005) Code of Ethics, CASW (2005) Guidelines for Ethical Practice (2005), and NLCSW (2020) Standards of Practice, these best practices are applicable to direct and indirect social work practice, and can be adapted to specific practice areas. Additionally, the NLCSW has a [Documentation Matters](#) series that provides information and clarification for social workers on professional and ethical issues pertaining to social work documentation. The ultimate goal is excellence in social work practice.

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