
A Guide to



Record Keeping

for Adult Services Social Workers

A Companion to
A Model for Excellence
in Adult Services Administration and Social Work Practice

A collaborative project of
Adult Services Staff Members from County Departments of Social Services
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of the North Carolina Division of Social Services
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Foreword

Accurate, up-to-date-recording is an important part of social work practice. There are a number of reasons for this. When an emergency arises and the worker on the case is unavailable, an important clue to the client's problem is of no value if it is locked in the worker's brain. As my supervisor used to say when I let my recording wait for a while, "What will we know about Mr. X if you're run over by a taxi on your way home tonight?" Then again, in this world of malpractice suits there is the question of accountability. What did the worker actually do or not do? Good recording is also necessary for research, but what is sometimes not understood is that good recording can actually lead to better practice by helping a worker organize her thoughts and her data. Recording isn't just paperwork or something social workers have to do, alas. It is an integral part of a social worker's responsibility.

I was brought up in the era of process recording, in which everything that either I or the client had said had to be included in the record. This was great for teaching, but it was a weariness of the flesh. We hated it, partly, I think, because it tended to disclose as much about us as it did about our clients. I made a study once that showed that emergencies occurred twice as often during workers' scheduled time to record as they did at other times.

Some of us can remember, too, the three-inch-thick record from which it was almost impossible to find important data. I once found a medical diagnosis that might have saved a client's life sandwiched between two lists of clothing. We later turned to summaries, which were more helpful in finding data, but which

weren't much good for accountability. Summaries were often too brief and too selective.

The authors of this guide seem to me to have arrived at a method of recording that meets all criteria. They provide a series of "tools," which they insist are not forms, only two of which are more than a front and back of a page, beginning at inquiry and ending at transfer or closing. They reflect *A Model for Excellence in Adult Services Administration and Social Work Practice*, issued in 1992, and to me their great value is that while their use can be flexible and allow for the worker's initiative, they ask all the necessary questions and help the worker organize her or his thinking. They are also nothing like so time-consuming as some previous methods. As forms, which in one sense they are, they are well designed and allow adequate space for answers. Although at first sight this method may look to be impersonal because the tools do look like forms, this is, I believe, a real breakthrough in the often-neglected art of recording.

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Many other social workers, supervisors, and administrators contributed their ideas, energy, and support to this project. We particularly appreciate the contribution of those staff members of county DSSs throughout the state who saw and tried the tools and suggested refinements that helped make this guide more effective. Their feedback to APRs and staff members of the Branch and CARES on the phone, at meetings, and in training events helped us reflect the needs and preferences of county adult services workers. Thanks, too, to members of the Adult Policy Review Committee and Joint Services Steering Committee, who reviewed and supported development of this work.

Introduction

Introduction

“The hard part isn’t the writing; the hard part is the thinking.” This is William Zinsser’s reflection on the everyday writing that most people must do as part of their jobs (1988, p. 56), and it certainly applies to the writing social workers do to record their work with clients. Clear thinking and a sound practice model will not make record keeping completely painless, but they will go a long way to making it quicker, easier, and more useful to the social worker and the client.

This guide seeks to make record keeping both more understandable and easier. It does this by developing a function-oriented model that wraps itself around and reinforces the thinking associated with the Family Assessment and Change Process, which grew out of the central stages outlined in *A Model for Excellence in Adult Services Administration and Social Work Practice* (CARES 1992; hereafter called *A Model for Excellence*). The record-keeping method presented in this guide is designed to capture both the social worker’s “reflective thinking and professional judgement,” as well as provide a concise, usable account of why adult clients come to the agency or are referred for services, what the presenting problem is, what goals are developed, what interventions are planned and implemented, how the interventions worked for the client, and what if any aftercare is provided (Kane 1974).

This guide does not describe state and local

policies or issues of compliance in record keeping. While admittedly important, such issues as record retention and confidentiality can be better addressed through state and local policy and procedural manuals. The purposes of this guide are to teach and promote the kind of documentation that supports excellent adult services social work practice.

Some of the tools and instructions presented in this guide will surely look familiar; others may represent a substantial change in your social work practice and record keeping method. This method is not meant to be an additional chore for you, but rather a new approach that supports excellence in adult services social work practice.

This introductory chapter sets the stage for understanding and using the record-keeping method outlined in this guide. It begins by discussing various uses associated with the adult services record, followed by a brief description of the Family Assessment and Change Process for Adult Services, to highlight the social work practice behind the record. It is in relation to the Family Assessment and Change Process that this function-oriented record-keeping method provides a step-by-step, chapter-by-chapter discussion of social work practice, tools and the guidelines for completing them, case applications, identification of frequently asked questions, and summaries of key points associated with each step. This chapter concludes with a discussion of the physical organization and potential automation of the record and a summary of key points.

The Practice Method behind the Record-Keeping Model

The cornerstone of *A Model for Excellence*’s approach to social work practice with adults and their families is its focus on the functioning of adult clients, and specifically, on making changes in functioning that improve the quality of their lives. Social work interventions focus on preventing new losses in functioning, maintaining current functional abilities, or rehabilitation as the best avenues

Goals for the New Record-Keeping Tools in Adult Services Social Work

For line social workers the tools should:

1. support the steps of practice recommended in *A Model for Excellence*
2. prompt social workers to gather information in a holistic manner
3. demonstrate social workers' reflective thinking and professional judgment
4. capture important information and decisions clearly in as little space as possible and with a minimum of burden to client/family and the social worker
5. provide case continuity and an historical context for chronic problems.

For supervisors, the tools should provide a basis for:

1. supervising appropriate practice steps and interventions
2. identifying skills and competencies needed by social workers
3. giving consultation at critical decision points
4. evaluating the effectiveness of adult services practice (including quality and timeliness) and programs.

for improving the client's well-being. The Family Assessment and Change Process used here does not try to deal with remote or historical origins of problems in functioning (Reid 1978); rather, it addresses those factors both external and internal to the individual that are contributing to the problem. As an adult services social worker, you concentrate on those factors that you and the client together can change.

Although the empowerment of adult clients includes the recognition of each client's autonomy, the Family Assessment and Change Process also

recognizes that adults, like children, function within a family system. Adult services workers have long relied on family members as resources for the client and have also sometimes seen them as contributors to the client's problems. The family-centered approach asks them to look beyond these ideas to see the complex interaction between the client and all parts of the family—both involved and absent. It recognizes that families have unique histories, values, manners, roles, and functions that shape the lives of their members, and that changes that affect one member have repercussions for all.

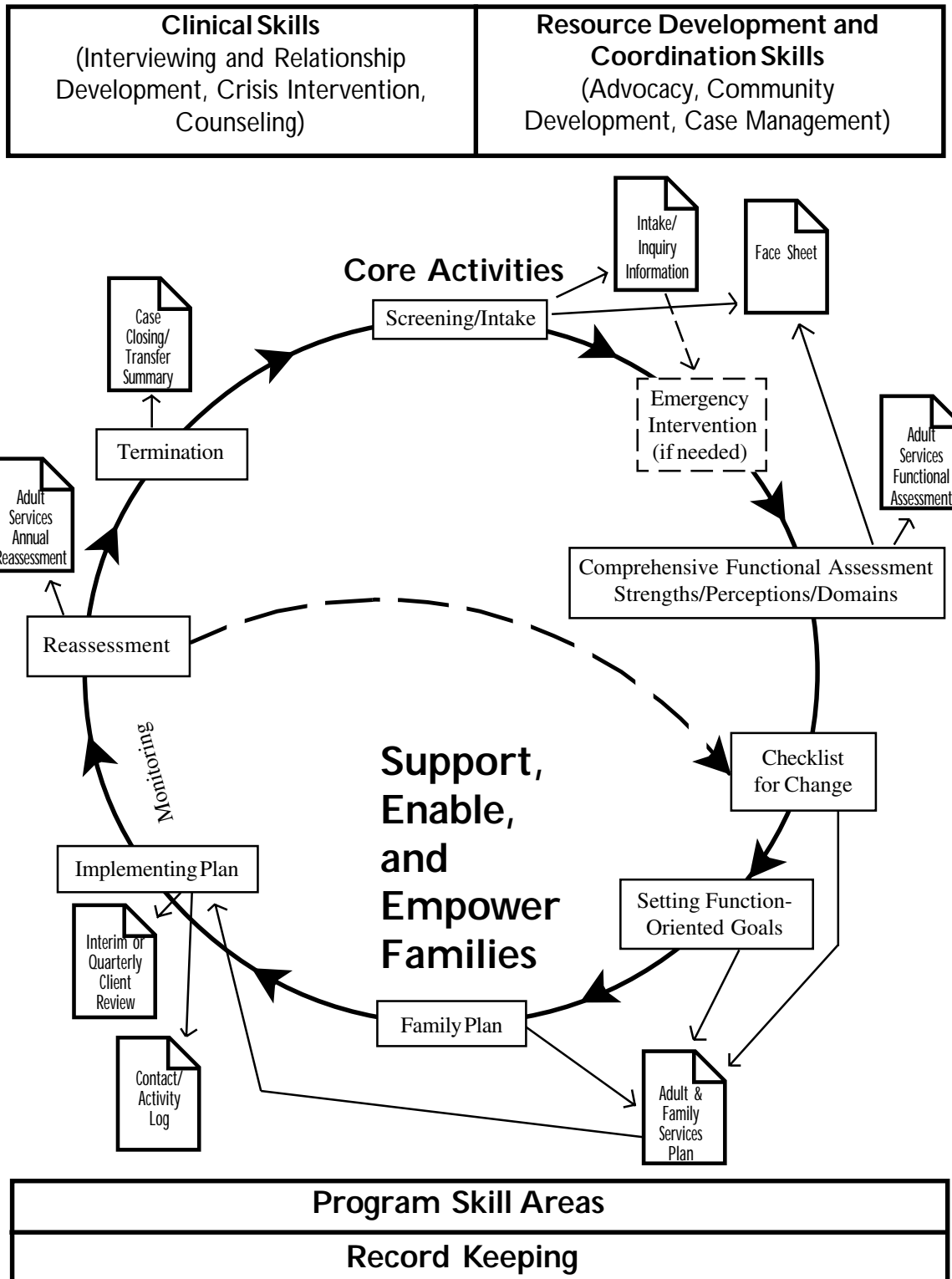
The core activities of the Family Assessment and Change Process start with intake and screening, followed by a comprehensive functional assessment, development of a checklist for change and establishing goals, planning for interventions and services, implementing the service plan, monitoring and reassessment, and case closing. Other competencies included in the process are clinical skills, resource development and coordination skills, program-specific skills, and record-keeping skills. (Figure 1 shows the Family Assessment and Change Process, and the tools used to document each of the core skills).

Elements of Function-Oriented Record Keeping

The function-oriented record-keeping method in this guide builds on, records, and documents the principal steps in the Family Assessment and Change Process for adult services practice. The major elements of the function-oriented record include: (1) the collection of necessary intake and functional assessment data to identify problem areas and areas of strength; (2) the identification of a Checklist for Change stemming from the intake and assessment; (3) the development of goal statements and service plans to address desired changes; (4) the monitoring of day-to-day activities, quarterly reviews, reassessments, and finally, (5) case closing or transfer.

Function-oriented record keeping provides social workers with a structured approach to documentation by highlighting the linkages be-

The Family Assessment and Change Process and the Record-Keeping Tools That Support It



Family Assessment and Change Process adapted from *A Model For Excellence in Adult Services Administration and Social Work Practice*, a collaborative project of The Adult Services Branch and the Adult Programs Representatives of the N.C. Division of Social Services and CARES, School of Social Work, UNC-CH.

tween the various steps in the Family Assessment and Change Process. In the absence of a structured approach, social workers run the risk of jumping from presenting problem at intake to recommending a service intervention without fully exploring the intervening steps. A comprehensive functional assessment may point to different problems, goals, and service packages than you and the client and family originally believed appropriate. It calls on you to help them think more critically about the nature of the problems and strengths, the best obtainable goals, interventions to reach those goals, and evaluation of those interventions against the outcomes all of you were anticipating.

Farewell to Open-Ended Narrative

Under the record-keeping system demonstrated in this guide, everything essential that would traditionally have been recorded in narrative form or dictation will appear on one of the tools. For most social workers, this represents a large change—welcome for some and uncomfortable for others. Even for those who have never liked doing narrative, the process of recording on tools may seem awkward at first. As with any new skill, you probably won't feel entirely comfortable until you have had a little practice.

On the other hand, this is not an entirely new skill for you. The abilities of observation, description, and deduction that you used to create good narrative are the same ones you will use to do good documentation on the tools. The structured nature of the tools should allow you to cover the points important to you and your supervisor in a consistent, easy-to-find, and less time-consuming manner. In most cases, you will need fewer words to do a complete job. However, if your style is to write very detailed dictation, you can still add as much as you desire by using the “additional comments” sections of tools and by attaching additional pages as needed.

Organization of the Guide

Drawing upon the Family Assessment and Change

Process, Chapters 2 through 9 of this guide address the social work practice behind each step in the function-oriented record-keeping method. Each chapter presents recommended tools, shows you the use of these tools with a case example, identifies frequently asked questions in relation to the particular step in the process, and summarizes with key points.

Chapter 2 addresses client intake and necessary identifying data collected on the face sheet. Chapter 3 details the data collection and assessment process. Drawing on assessment findings, Chapter 4 demonstrates some ways to summarize them. Chapter 5 shows how to document two steps prerequisite to planning services: the client and family's Checklist for Change and the function-oriented goals that go with each item on the Checklist. Based on those goals, Chapter 6 addresses service planning. Chapter 7 covers day-to-day monitoring activities and quarterly reviews, while Chapter 8 describes annual reassessments. Chapter 9 concludes with case closing or transfer. The appendix provides full-sized copies of all tools, which can be duplicated for use in your agency. However, tools can also be ordered from the Forms and Supplies Branch of the Division of Social Services. In addition, the appendix provides copies of additional screening and assessment tools that you might sometimes use as part of the assessment process. These include the genogram, ecomap, economic assessment work sheet, Geriatric Depression Scale, and six-item Blessed Scale.

The chapters are written in an informal style that we hope you will find clear, practical, and “user-friendly.” A single case example runs through all of the chapters, showing the entire record-keeping scheme for a single client. The text also briefly discusses some alternate examples in instances where the sample case is not very typical.

This manual can stand alone as an instructional tool. Nevertheless, if more than one social worker in an agency is learning to use this method, it may be more efficient for a supervisor or other

trainer to teach the materials. For that reason, a separate set of trainers' notes giving suggested lesson outlines, additional examples, sample transparencies and handouts, and group or individual exercises is provided to each agency.

Physical Organization of the Record

The task of record keeping is made easier when it is informed by clear thinking. It is also made easier when it is organized in a manner that is both understandable and accessible. The uses of the case record are multiple. Essential to effective practice, you need a record in which it is easy to find information such as:

- the presenting problem
- involvement of family members and collateral service providers already helping the client
- important assessment findings
- goals established by the client, family, and social worker
- service plans that have been developed
- monitoring notes and reviews
- reassessment data.

Your supervisor needs to review records to provide ongoing supervision to you and to engage in administrative planning and reporting. Administrators need to access information to identify presenting problems and through them the community's perceived need for services. Administrators also use case record information to obtain a census of clients and to measure service use and the costs associated with it, in order to plan for the short and the long term.

We recommend that all case records be indexed using a system of tabs and/or alternating color codes. At a minimum, each case record should contain the following sections: (1) face sheet and intake; (2) assessment; quarterly reviews; and reassessment tools; (3) service plans including goals; (4) case closing and/or transfer, (5) policy compliance documentation, (6) correspondence, and (7) a section or sections for other pertinent materials as your agency determines

necessary (for example, sections related to guardianship orders or financial data for payees). In addition, there should be a *separate* section containing all confidential reports and correspondence.

In addition, we suggest a front clamp or other arrangement to help keep your temporary Contact/Activity Log sheets, which serve as a record of day-to-day activities on the client's behalf, but which can in many cases be discarded after relevant information is recorded on the quarterly reviews. Information in each section should be organized chronologically, with the most recent information first. Figure 2, on the next page, presents a graphic illustration of this organization scheme.

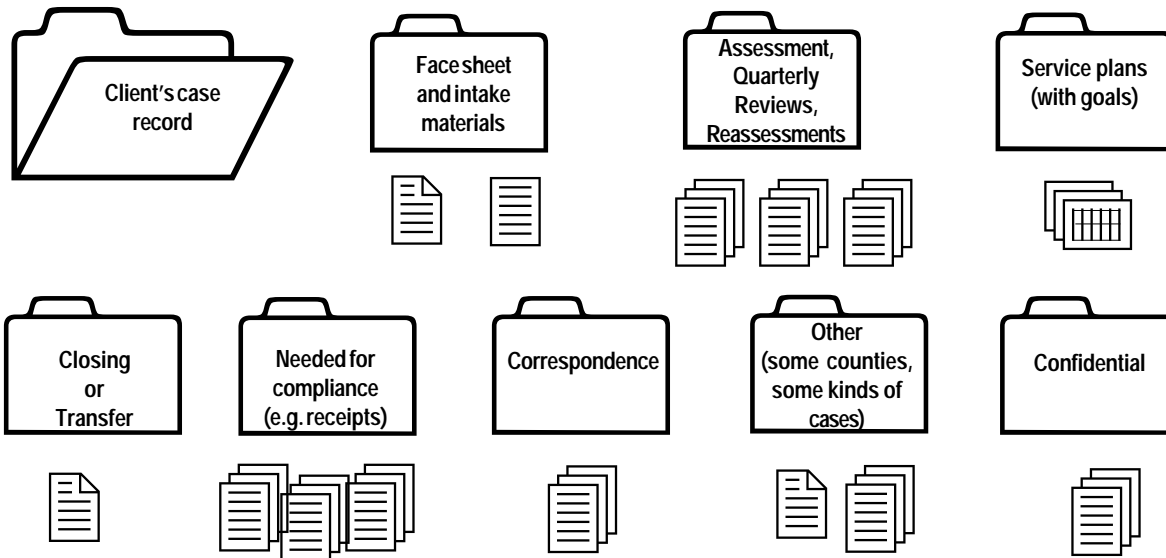
Automating Case Records

The information contained in clients' records, whether it is identifying data such as the client's name and case number or more substantive information about the client's problems and strengths, goals, and outcomes, can be quite a burden to record and maintain. Workers usually lament the amount of time spent on finding and keeping records current. Automation can be a partial solution to this problem.

Repetitive tasks and information lend themselves especially well to automation. For example, you write some or all of the identifying information—the client's name, case number, ID number, social security number, address, etc.—on every tool, report, and piece of correspondence about the client. It is possible through automation to enter this information only once and have it automatically entered into subsequent tools.

Automation also helps in finding information. You may file information in your filing cabinet by a client's last name, but if you only had his/her social security number, case number, or address, you would not be able to find the file quickly. By using a computer, you can search for any discrete piece of information that may be in a person's record.

Case Record Organization



You can also sort or organize your information in different ways. Using the filing cabinet idea, you can rearrange the files from alphabetically by last name to numerically by zip code, case number, or date. You could find groups of records that fall into a certain category or combination of categories, such as age, sex, race, urgent need, specific problem, or goal. Automation also provides different ways of viewing and printing information, which may provide new insights into relationships between different information that is usually physically separated (located on different tools). For example, you could print out a client's progress on one particular long-term goal from the three quarterly reviews and the reassessment to get a clearer picture of how work in this area was progressing.

These automation tools are known as databases. Examples of database software packages are dBase 5.0, Microsoft Access, PerFormPro Plus, and Claris FileMaker Pro. Dramatic improvements in database creation, operation, and maintenance makes using these database tools easier than ever for the novice. With some initial effort devoted to setup, this software offers exciting possibilities for the future of adult services

record keeping. If you are interested in this technology, ask your instructor/supervisor if you have access to database software. (We hope to provide more guidance on the use of this technology to you and your agency in the future.)

Even if your computer system is limited to word-processing software, you can produce a "list processing file" of your clients (the same way you keep a mailing list) and then use "field names" to insert names, addresses, and numbers from these fields into your word-processing documents. You can also automate many of the standardized tools and forms and record the information on screen rather than sending it to a clerical worker to be typed. One person in your office could create a blank or template version of the tool and then make it available through your computer network, if you have one, or by "sneaker net" (taking it from machine to machine on a diskette). Then for each new client, you simply bring up a copy of the template, enter your data, and save it under a new file name.

You may use any word-processing program instead of the contact/activity log discussed in Chapter 7. However, because computer file names are restricted to eight characters, you need to let

your supervisor and at least one colleague know your file-naming and subdirectory conventions so that they can find the log for any given client in your absence. If you do not have or like to use a computer for your notes, you never need to computerize your log. The log is a tool for you.

The types of information requested on the tools can be separated into two categories: discrete information and open-ended information. Checklists and checkboxes represent discrete information on each of these tools and provide data that can be easily aggregated in a centralized computer system. However, some of the most important information on these tools is open-ended or free-form, where the reply to a question cannot be easily categorized and the content is left to the writer. The functional assessment tool introduced in Chapter 3, the quarterly review tool introduced in Chapter 7, and the functional reassessment tool introduced in Chapter 8 have many examples of both checklists and open-ended questions.

Open-ended questions can create an automation dilemma. Long sentences can be entered into most modern databases, but it may not be practical to use that information in any way other than reading it from the tool. One way to approach this potential problem is to answer these questions in a somewhat structured fashion, working from general to specific information. When describing the general information use consistent wording. For example, if some of your clients are recovering from heart attacks, decide whether you are going to write “MI” (myocardial infarction) or “heart attack.” It doesn’t matter which one you use, but it does matter for automation whether you are consistent. It will enable you to look up all related information and may help in developing strategies for common problems. You can then work toward the specifics and not leave out any important information that shows the client as a unique individual.

Computers and automation are not meant to dehumanize your work but to assist you and

provide you with needed information to make your job easier.

Conclusion

Whether you are a brand new social worker, or have many years of experience behind you, we hope you will approach this Guide with a spirit of adventure. Both the Guide and the system of record keeping it teaches were designed to empower you and help you assist your clients in becoming empowered.

Although this system is highly structured, it will support your flexibility and creativity. It prompts you for the information you need to document and reminds you of the core activities in the family assessment and change process, leaving your mind free for the advocacy, solution finding, resource garnering, and relationship building that are the most important and rewarding parts of your job.

Key Points

- Record keeping is a small part of good social work, but careful record keeping can support your creative thinking and supplement your ability to help clients make desired changes.
- Good record keeping helps the client and family, the social worker, and the supervisor meet the client’s goals more efficiently.
- Good record keeping helps the social worker and supervisor meet their professional goals more effectively.
- This guide is concerned with documentation that supports good adult services social work practice as described in *A Model for Excellence*.
- This guide introduces a system of documentation tools that we recommend to replace standard narrative/dictation.
- A record divided into sections, dividers, or color-coded folders is a more effi-

cient tool for social workers and supervisors.

- The automation options range from word processing to the exciting potential of database programs.
- The structure of the approach taught in this guide should support your creativity, not limit it.

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