Tautoko Tāne
Male Survivors Aotearoa

PRACTICE NOTE 23.1

GUIDANCE FOR THE MANAGEMENT OF PEER SUPPORT CASE NOTES

CONTEXT

The purpose of this Practice Note (PN 23.1) is to clarify and advise best practice for the management (preparation or capture, composition, filing and reviewing) of client case notes.

Case notes provide an essential record of the client's interaction with our peer support service, and in recording them it is important that peer workers are always mindful that they may be read by others (whether the clients themselves, or in some circumstances by legal practitioners and courts). Therefore, case notes should always be written as though this *will* happen, not *might* happen.

While the ultimate purpose of case notes is to enable and support the clients journey towards wellbeing, they also serve other purposes:

- Provide professional accountability by providing evidence of services and support being provided to clients;
- Assist with service planning and progress review by providing a record of interactions with clients;
- Help jog peer workers' memories about their client interactions and progress;
- Assist in client handover;
- Demonstrate an appropriate duty of care and considered responses to risk;
- Provide a resource for responding to client and/or third-party queries and/or complaints about service provided;
- Meet the requirement of the funding body.

Because there are multiple and varied sources of client case note information (session notes, emails, significant phone calls, and/or texts, reports, applications etc.), it is important to have a clear set of guidelines for how we should decide what is important case note information and how and when it should be captured and recorded.

Wherever possible and practicable, case notes should be filed within the electronic case management system. This provides additional case note security and is the most efficient way to enable quick and complete access to case histories and client progress information. However, there may be some circumstances where subsidiary document files are maintained to amplify or support case note information, but this practice should be the exception and not the norm.

PRACTICE

CONTENT

In general, the following questions provides a guiding prompt when considering what to include in a client case note file:

*"Is this information important for me to recall, and/or for a third-party reviewer to understand, the client-service interactions and/or to appreciate the client's progress on their journey towards wellbeing?" ***

Some more specific guidelines follow.

Face to Face Interaction

The content of a face to face (local or remote) service interaction record should include:

- **Session details**: date, time, client's name, service/session /record type. *(These details are typically input or drop down selected in an electronic case management system)*
- **Brief description of client presentation** *(how the client has presented in this interaction highlighting deviations from usual for existing clients)*
- **Session record**: (local or remote) – entered or copied (scanned and uploaded) handwritten notes as relevant – refer Compilation principles below)
    - Main themes discussed;
    - Progress towards wellbeing goals;
    - Plan for next session or service interaction
- **Disclosures:** of any ethical and/or confidentiality issues encountered
- **Risk factors:** record any risk factors including detailed record of actions taken in response to recorded risks.

Other Interactions

In considering what content, other than face to face interactions, should be retained on a client case file the same prompt question** posed at the beginning of this section should provide a useful guide. However, the following comments may be helpful in considering what content is considered important and how it should be captured.

Communication records – significant emails, text messages, and telephone conversation summaries should be captured into case notes with a descriptor that categorises them as an **email, text, or telephone** record.

These communications can contain content that is essential to informing and /or understanding the client service interactions and their progress towards wellbeing. Assuming they qualify as significant/important content, then suggestions for capturing this content are as follows:

- **Emails** should be copied and pasted into a case note file record being careful to also capture the email header to record the date, email addresses etc. *(Many case management systems do not provide email system interfaces for security reasons)*

- **Text messages** should be treated the same as emails perhaps using message forwarding to your email address to enable a copy capture as an image or text.
- **Telephone calls** present more of a capture challenge. With permission they may be recorded in confidence with the client but usually they are often unplanned and require a response during the call. The suggestion is that you record a bullet point summary of the main points of the conversation using the Face-to Face content guide above as a broad template – date and time, client presentation, brief record, disclosures, and risks.

Reports - client or third-party reports can take many forms and come from multiple sources. Again, assuming they qualify as significant/important content, they should be captured in full by uploading and attaching them to a case note with a reports descriptor.

Ideally the reports case note will include a short description of the report with any significant fundings or outcomes.

COMPILATION PRINCIPLES

Client case notes should be:

1. **Person-centred**

   Remember the case note is about, and **for the benefit of, the client**. While it also has a function in recording and remembering the interaction for the peer worker, it should essentially be a progress record for the client on their journey towards wellbeing.

   It may also be written to enable understanding by a third party, but it is not written primarily for that purpose.

2. **Informed**

   Review previous case notes to make sure that you are familiar with the client interactions to date, their progress and any risks that have been noted for management.

3. **Accurate, reliable and evidence based.**

   Report **facts and observations**. Any interpretations should have supporting evidence ("the client appeared anxious as demonstrated by…").

   Acknowledge **the sources of information** ("The client reported that …or the (name) report indicated that") and include important and/or referenced service information (e.g., reports, emails etc.) in the case note file.

   If you need to **change or update** an existing case note you should record the change as a new case note, including an explanation of the error or omission in previous case note (do not alter the original case note).

   If **new information** comes to light after the session, it should always be included in a new case note, not added to the original case note.

Always **review** the case note with a client lens – "if the client read this note, would they agree with it?" and if not are you happy that areas of probable difference could be justified?

4. **Relevant and targeted.**

   Simple, succinct, and complete - include only information relevant to the service being provided and do not omit information that is relevant. Bullet point recording is acceptable provided the final note passes the 'third party test' see below.

   Avoid using other people's names in your case notes (use wife, partner, brother etc. or first names only)

   "Stay in your lane" – don't offer advice or opinions about things you are not qualified to advise on. Instead, you may choose to suggest a suitably qualified person that your client could consult with. Record these suggestions in your case notes to evidence appropriate ethical practice.

5. **Legible and clear.**

   Type notes, or if handwritten, ensure they are legible.

   Avoid biased language, emotional language, value judgments, opinions, and street language / jargon (unless quoting the client).

   Apply the '**third party test'** – if another person read this case note, would they understand the relevance of the interaction or information record?

   NEVER use white-out on a case note. Ensure any hand-written corrections are legible (original information should still be readable), signed and dated.

6. **Recorded promptly.**

   Make time for case notes. Build case note recording into your daily routine so that you are organised to record client interactions as soon as possible after the service interaction - but always within two working days. This is important to ensure an accurate and timely record that is not diminished or confused by other client interactions and/or memory fade.

7. **Kept in a chronological order.**

   Always time and date stamp your case notes. Understanding the sequential order of client service events can be important to a review of service provided. Once completed it is good practice to review your case note within the context of previous case notes on file – does it make sense as an entry in the 'client-service story' so far?

8. **Consistent within the organisation.**

   While content styling may be differ between peer workers, general adherence to the five principles above will help to ensure that case notes are compiled in a consistent manner across the organisation.

INFORMATION MANAGEMENT

Security & Confidentiality

Case notes are a confidential record of a client interaction and are governed by the **TTA Confidentiality Policy**, which is focused on assuring the confidentiality of all client information.

Management of client information is subject to the **TTA Records Management Policy**, which deals with assuring the security and confidentiality of client records. All case notes management systems, whether electronic or manual, are required to comply with this policy.

For electronic systems, careful management of system access controls and the use of system audit features to review access control compliance will typically provide adequate security. And system backup protocols provide good assurance that case notes can be recovered in the event of system failures.

For manual systems, physical security must be assured through file access locking etc. However, there will not be the same backup and recovery security in the case of fires or other natural disasters destroying file systems. This is why best practice endorses the use of electronic systems that include ALL relevant client case note information.

Information Access

Always be aware that case notes may be read, in certain circumstances, by other parties – e.g., legal practitioners or the courts.

And remember that your clients have the right to access case note information and to require you to amend or remove any incorrect or misleading information.

> *"Therefore, case notes should always be written as though this will happen, not might happen".*

Freedom of Information

Freedom of Information (FOI) requests are usually received from current clients, from lawyers when clients receive new charges, or when clients are released on parole.

In most cases, the document MUST be provided. You can argue to restrict release, or redact aspects of the document, only if their release will pose a significant safety risk to the client or others.

FOI requests are becoming more common – therefore you should always keep this in mind in everything that is documented in a client file (including case notes, reports, assessments, etc.)