Documentation And Record Keeping

A Guide for Service Providers

Serial No: 037/SDD24/MAR07
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Feedback

NCSS welcomes feedback on the contents of the guide. Please write in to:

Strategy and Specialisation Department
National Council of Social Service
170 Ghim Moh Road #01-02 Singapore 279621

A copy of this guide can be downloaded from NCSS’ website.
http://www.ncss.org.sg/
(Go to VWO corner, resources, service guides)

Other guides available in this series are:

- Intake and Assessment
- Care and Discharge Planning
- Safety and Protection of Service Users

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Foreword

Purpose

a. This guide is part of a series of guides\(^1\) on good practices for service delivery. These guides compliment the Service Standards Requirements\(^2\) checklist for Voluntary Welfare Organisations (VWOs) and Non-Profit Organisations (NPOs) to conduct self-assessment of their organisational practices and processes.

b. It is hoped that the guide will help improve processes to achieve the programme’s outcomes for its clients. This guide is designed to provide a reference on documentation and record-keeping practices for community-based social service agencies in Singapore. It also serves to highlight the minimum standards that agencies should strive to achieve. The minimum standard for documentation and record keeping and as outlined in the Service Standards Requirements are:

   (i) **Up-to-date client records, including details of assessment, re-assessment, care and discharge planning are maintained for at least three years; and**

   (ii) **The programme ensures that service user records are kept in a secure manner, so that the privacy and confidentiality of service users are protected.**

c. Organisations are expected to develop and customise their documentation policies and procedures using pointers from this guide.

Target audience

d. This guide is designed primarily for organisations that provide social services for persons with disability, seniors, children, youth and families in the community, in Singapore. This guide is intended for the following programmes:

   - Aftercare Case Management Service

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\(^2\) The Service Standards Requirements (SSR) is a set of 16 service processes that have a direct impact on client outcomes.
- Befriender Service
- Caregiver Support Service
- Client Re-integration and Family Services
- Community Case Management Service
- Social Work Services
- Counselling Centres
- Early Intervention Programme for Infants and Children
- Family Service Centres
- Home Help Service
- Home Therapy
- Hostels – Disability and Mental Health
- Integration Support Programmes
- Production Workshops
- Mentoring Services
- School Social Work programme
- Sheltered Workshop (employment services)
- Training and Transition Programme
Chapter 1

THE IMPORTANCE OF DOCUMENTATION AND RECORD KEEPING

**Why keep records?**

1. Documentation and record keeping are important to ensure accountability, facilitate coordination of care between providers and for service improvement. However, the importance of documentation and record keeping may be overlooked/overshadowed by the focus on direct services to clients. As such, proper documentation and record keeping may be neglected.

2. The following section provides three reasons why it is important to document and maintain proper records:

   2.1 **Continuity of care.** Records provide a case history and a more holistic picture in order to follow-up on services or try different approaches to assist the client. This is especially for clients with long-term or complex needs, or who require multiple services. Accurate and up-to-date recording is important especially when there is an emergency and the staff-in-charge is not available (due to illness, vacation, resignation, etc.). Good records and documentation will facilitate communication between service providers to ensure coordinated, rather than fragmented, service.

   2.2 **Accountability.** It is important to be able to provide relevant client information at any given time and the organisation’s response to their needs. The information may be needed to respond to queries from stakeholders, who may include the client’s family, funders, donors or the courts. One important source of information is the client records. Documentation forms the nature of the professional relationship with the client. Information on problems encountered and the agency’s response would assist in the event of a crisis or investigations.

   2.3 **Service improvement.** Well-documented records can also lead to improved services to the clients by helping the staff organise his/her thoughts. Aggregated client information can also facilitate service
planning, service development and service reviews. The information can also form primary data to conduct evidence-based research.

3 Having established the importance of documentation and record keeping as essential elements of professional practice and service to clients, Chapters 2 and 3 will provide guidelines and best practices of documentation respectively. Chapter 4 will elaborate on record-keeping and Chapter 5 will highlight the importance of having good records for service improvement.

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<td>Record-keeping and documentation are important processes that facilitates:</td>
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<td>▪ Continuity of care</td>
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<td>▪ Accountability</td>
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<td>▪ Service improvement</td>
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Chapter 2
GUIDELINES FOR DOCUMENTATION

What should be documented?

4  Given the diverse nature, size and complexity of client needs and intended client outcomes, there may seem a myriad of information to document and store. What then should be documented?

4.1 History and needs of client. At the point of admission, detailed information on the needs and background of the client is documented during intake assessment. Refer to the Guide on Intake and Assessment, NCSS (2006) for more information.

4.2 Services rendered. When the client is participating in the service/programme, information on services rendered is documented in the client’s care plan. Refer to the Guide on Care and Discharge Planning, NCSS (2007) for more information. Other key information to document, accompanied by supporting documents, is fees charged and subsidies received (for e.g., qualifying information for subsidies under means testing or other sources).

4.3 Client outcomes. Agencies should document client outcomes achieved or not achieved during periodic reviews, discharge or follow-up. Additional information may be derived from milestones achieved by the client or caregiver satisfaction surveys. The ability to produce documentation of clients’ achievements further enhances the accountability of the programme.

4.4 Programme information. Minutes of meetings, case conferences and email exchanges towards critical decision making are important to record. Such documentation, in addition to other sources of information, could provide a background to the reasons why certain proposals were accepted or rejected.
**How can the information be used?**

5 Client-related information are usually aggregated periodically (for e.g. quarterly, half-yearly or annually) to provide information on outcomes. The consolidated reports are often provided to stakeholders, such as current and potential clients, funders, donors, media, accreditation bodies, etc. The information on client outcomes and programme effectiveness (or the lack of it) could be used for service planning and improvement, needs assessment, cost-benefit analyses, marketing and publicity, as well as other purposes where necessary.

### Summary

Important information to record includes:

- History and needs of client
- Services rendered
- Client outcomes
- Programme information
Chapter 3

BEST PRACTICES FOR DOCUMENTATION

What do I have to bear in mind when documenting client information?

6 Different staff would have unique writing styles according to individual preferences. To ensure consistency, it is best to bear in mind the following when documenting case notes:

6.1 Concise. Client notes should include only relevant information in appropriate detail, i.e. only provide information that is directly relevant to the delivery of services for intended client outcomes. Staff should try to ensure minimal burden to the client and his caregivers by asking only required information and not asking for them repeatedly. With the client’s consent, assessment history should be transferred and verified from a referring provider to the current provider instead of subjecting the client to repeated assessments.

6.2 Accurate. Besides providing accurate information, direct quotes from the client, caregivers or other professional staff (such as comments from psychologists or doctors) could be reflected if necessary to provide a full picture of the client. As the information may be shared with other agencies, the records must be legible; the reference terms used must be consistent and the records free from jargon (meaningless words).

6.3 Up-to-date. Progress notes, crisis intervention or incident reports should be written as soon as possible after an event has happened to prevent loss of information due to time lapse. All significant facts should be recorded. Such reports should not assign blame on individuals and be free from irrelevant speculation or offensive, subjective statements.

6.4 Meaningful. The notes should capture thoughtful reflective thinking and professional judgement of the intervention and services provided. Notes should distinguish clearly between facts, observations, hard data and opinions. Where opinions or professional diagnosis or
recommendation of a particular intervention is made, these should be properly acknowledged, dated and signed. Records requiring validation and authorisation must be properly completed and signed.

6.5  *Internally consistent*. Notes should be structured according to a preset format that may be unique to each organisation or professional group within the organisation (for e.g., use of standard care and discharge plan templates). Acronyms used should be meaningful to all within the organisation. Consistency and standardisation helps to bring clarity to staff and reduces the time taken to search for vital information amidst the huge amount of client information available.

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<td>Notes and records should be:</td>
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<td>- Concise</td>
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<td>- Accurate</td>
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<td>- Internally consistent</td>
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Chapter 4

GUIDING PRINCIPLES FOR RECORD KEEPING

How do I store and maintain records?

The following section provides some guiding principles for good record keeping practices in terms of record retention, transmission and destruction.

8 Record Retention

8.1 Storing records. Records can be stored as case files, log books, softcopy databases, etc. Agencies should take reasonable steps to ensure that client’s records are stored in a secure location and are not available to others who are not authorised to have access. Agencies need to also have a policy on backing up of soft-copy data, access rights and security. Precautions should be made to protect soft copy records from electronic viruses or technical failure, and written records from damage due to fire, water or even rodents (e.g. termites).

8.2 Protecting records. Agencies should develop its own confidentiality policy to protect the client’s written and electronic records and other sensitive information, and the obligations of all workers to abide by them. Agencies should seek to balance an individual’s right to confidentiality with their right to services, care and protection.

8.3 Access to records. When providing clients with access to their records, staff should take steps to protect confidentiality of other individuals identified or discussed in such records. Both client requests and rationale for withholding records should be documented in client’s files. Sensitive and confidential information must be released only to authorised parties; with client consent, wherever applicable.
9 Transmission of information

9.1 Maintain confidentiality. Agencies should take precautions to ensure and maintain confidentiality of information transmitted to others through the use of computers, electronic mail, fax machines, telephones and telephone answering machines.

9.2 Consent. Human interest stories are essential for publicity or fund-raising. However, agencies should inform the clients on the purpose of the publicity, whether it is an interview or profiling clients in magazines or annual reports (including sharing of photographs). After giving the information, the agency should seek the client’s permission. The client should be given the right to decline without being deprived of service.

9.3 Release of information. Agencies should not disclose sensitive information when discussing clients, whether with the media or to external consultants unless there is a compelling reason to do so.

10 Record Maintenance and Destruction

10.1 Update of records. Agencies should develop its own internal policy on time frames for update of records, including care plans, progress reports, incident reports, etc.

10.2 Termination of service. Agencies should store records following termination of services to ensure reasonable future access. As a general guide, case records should be kept for at least three years, and financial records, seven years. Agencies need to ensure that their record-keeping practices comply with all contractual, regulatory or legal requirements.

10.3 Deceased clients. Agencies should protect the confidentiality of deceased clients with the standards mentioned. The transferring or disposing client records should be conducted in a manner that protects client confidentiality and is consistent with government, contractual and any other regulation.
11 Electronic or hard copy records?

11.1 Electronic records. Keeping client records in soft copies allows for easy access, transfer and saves storage. However, keeping records via an electronic tool such as the Personal Digital Assistant (PDA) whilst conducting intake assessment of new clients, for e.g., may seem impersonal and inappropriate. If documentation and records are stored electronically, it is important for the organisation to develop its policies and procedures for information management and technology, including system maintenance, monitoring access and staff training.

11.2 Written records. Written records are common and more personable to client, especially in the business of human and social services. However, they are at times difficult to read due to varying and unique handwriting. In addition, duplicate copies have to be made for transmission to other parties or agencies.

11.3 Electronic Case Management System (eCMS). NCSS has developed the eCMS, a software system that allows for comprehensive and systematic documentation of clients’ particulars, intake assessment and care plans. The eCMS also allows for sharing of information across agencies that have access to the software, accompanied with privacy and confidentiality safeguards. The eCMS is thus one mode of documentation for agencies to record client information.

11.4 Agencies could consider all factors and choose a system that meets their needs, to ultimately benefit the clients served.

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<tr>
<td>When storing, transmitting or destroying any information pertaining to the client, whether in written records or “live” interviews, agencies should:</td>
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<tr>
<td>▪ Protect client confidentiality</td>
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<td>▪ Seek client consent before sharing sensitive information, or profiling or interviewing clients in any media</td>
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<tr>
<td>▪ Inform the clients about their right to decline for being interviewed or featured</td>
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Chapter 5

REVIEWS OF RECORDS FOR SERVICE IMPROVEMENT

Why review records?

12 It is good practice to review records so that service improvements can be made. Hence, records should be reviewed periodically to establish:

12.1 Whether assessments conducted were thorough, complete and timely.

12.2 Whether clients were actively involved in making informed choices regarding services received.

12.3 Whether clients were given appropriate services to achieve client outcomes.

12.4 Whether the achievement of client outcomes could be improved upon.

Records for continuous improvement

13 Records will provide the primary data source for many uses. These include:

13.1 A study of the data of client outcomes to assess the impact of intervention and analyse areas for improvement.

13.2 Further research in the area of evidence-based practice, to study the proven methods for the myriad and complexity of issues presented by clients.

13.3 Demonstrating of accomplished standards of practice for possible accreditation.

14 The research findings could be used to advocate for clients, expand proven programmes, achieve accreditation as a hallmark of quality service, as well as share best practices with other providers.
**Summary**

Periodic reviews of records are important for continuous improvement initiatives. The aggregated primary data could be used to:

- Analyse areas to better meet client outcomes
- Conduct evidence-based research to document proven and most effective intervention strategies
- Seek accreditation as a hallmark of quality
Chapter 6

CONCLUSION

15 In conclusion, writing proper assessments, care and discharge plans entails in-depth professional judgment and reflection. Having to prepare proper documentation serves an important role of helping to ensure quality care by making staff think about their clients, as well as review and reflect on their interventions.

16 With periodic reviews based on information systematically gathered from client records, social service staff and agencies could objectively consider the effectiveness of their service. Findings from evidence-based research could also lead to new perspectives and innovative approaches and programmes. Achievements could be celebrated and distinguished by seeking accreditation to demonstrate a hallmark of quality to clients and other stakeholders.

17 Thus, rather than viewing documentation as tedious and time-consuming, social service professionals should view it in the light of it being an essential element of professional practice to deliver successful outcomes for clients.
Appendix

REFERENCES


Note: All links are last downloaded in March 2007.