Raising the *Titanic*: Rescuing Social Work Documentation from the Sea of Ethical Risk

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Abstract

One of the most contentious issues in social work practice concerns what should be written about people who access social work services, how comprehensively, and in what format social work assessments, interventions, and outcomes should be documented. The present paper describes a structured approach linked to an action research project that was undertaken by hospital-based social workers to identify and minimise problems associated with documentation in the medical record. The Social Work Ethics Audit provided social work staff with a risk-management tool that highlighted documentation as a key area of ethical risk. Through a process of evaluating existing recording practices, social workers were able to meet the challenge of improving social work recording in medical records, returning it to its proper place as a vital component of clinical and ethical practice rather than an administrative task submerged beneath competing priorities. It was anticipated that the social work documentation proforma that resulted from the ethics audit process would have applicability in other health care settings.

Keywords: Documentation; Social Work Ethics; Social Work Practice

The importance of documentation and the accurate and timely recording of relevant client information is an integral component of social work practice (Ames, 1999; Callahan, 1996; Gelman, 1992; Kagle, 1984; McAuliffe, 2005; Reamer, 2005; Swain, 2002; Timms, 1972). As early as 1917, Mary Richmond concluded that “social casework would have to depend upon recording for advancing standards and new discoveries within the profession” (Richmond, 1917, p. 26). The early social work literature described recording as primarily a mechanism to facilitate theory building, research, and teaching, providing the base for the later establishment of detailed and...
sophisticated documentation standards for clinical settings (Reamer, 2005). Initially informed by a psychodynamic framework that emphasised lengthy psychosocial histories and assessments in the narrative style, standards of documentation evolved over time and were influenced by brief problem-oriented approaches that required assessments to be written in behaviourally specific concrete terms (Callahan, 1996). There is unequivocal evidence that documentation is a vital aspect of clinical social work practice, particularly with the use of the medical record in multidisciplinary health care agencies, which would include hospitals (Queensland Health, 2003).

**Documentation in the Context of Risk Management**

Within the 21st century health care context, it is the medical record that remains the primary means of communication among members of the medical, nursing, and allied health care teams. Health professionals use the medical record to document events, critical incidents, thought processes, actions, and outcomes. The medical record is one means through which staff members communicate assessments, diagnoses, and prognoses while coordinating care during an episode of illness (Bernstein & Hartsell, 2000; Johnson, Kicklighter & Para, 2000; Kagel, 1984a; Luepker, 2003; Purtilo, 2005; Young, 1979). In considering the organisational context of multidisciplinary teamwork and the team framework in which documentation often occurs, it is important to acknowledge that the medical record is the central point of communication between team members who may otherwise have infrequent or no verbal communication with one another (Mickan & Rodger, 2000). Social workers regularly share clinically relevant patient information with the multidisciplinary team through case discussions and conferences, family meetings, and through documentation in the patient’s medical record. The present paper focuses on written entries in medical records. Despite general advances in electronic recording, at the time of writing, Queensland Health hospitals were not planning to implement electronic medical records corporately (Manager, Health Information Management Systems, Princess Alexandra Hospital and Health Service District, personal communication, 2006).

The notion of social work risk assessment and the vital nature of documentation is however relevant and applicable to all social work recording, irrespective of the medium being a paper or an electronic medical record. In hospitals and health care facilities, it is expected that social workers record psychosocial assessments, interventions, and outcomes in accordance with organisational and professional procedures and standards. When these procedures are not followed or standards are not met, the social workers, patients, their families, and the organisation potentially enter the domain of risk. Examples of the implications of poor documentation and the resultant risk to clients are presented. The identification and management of risk is an integral obligation for any organisation and there is little doubt that the contemporary environment in which social workers practice is increasingly characterised by a culture of safety and risk management (Chenoweth & McAuliffe, 2005; Parsloe, 1999; Queensland Health Systems Review, 2005; Reamer, 2003). It is when risk intersects
with issues of rights, responsibilities, accountabilities, and integrity that it enters the realm of ethics and takes on a new shape within a framework that is generally well understood by social workers and those working in clinical allied health practice.

**Documentation as an “Ethical Risk”**

The Social Work Ethics Audit (Reamer, 2001) was designed within the context of North American social work to enable practitioners and organisations to systematically examine practices, policies, and procedures in 17 important areas defined as potentially exposing social workers and clients to “ethical risk”, including ethics complaints and litigation. These areas are (a) client rights, (b) confidentiality and privacy, (c) informed consent, (d) service delivery, (e) boundaries and conflicts of interest, (f) documentation, (g) defamation of character, (h) client records, (i) supervision, (j) staff development and training, (k) consultation, (l) client referral, (m) fraud, (n) termination of services, (o) practitioner impairment, (p) evaluation and research, and (q) ethical decision making. Of the two areas that are the subject of the present article, documentation (the primary focus) covers what information should be recorded and who should access information in client records, as well as how records should be stored, retained, and disposed of. In considering the clear link between ethical risk management and documentation practice, social workers should be familiar with two important documents published by the Australian Association of Social Workers (AASW). These are the *AASW Code of Ethics* (AASW, 1999) and the *Practice Standards for Social Workers: Achieving Outcomes* (AASW, 2003). One of the main purposes of the *AASW Code of Ethics* is to provide guidance and standards for ethical conduct and accountable service and the code includes a comprehensive section outlining ethical responsibilities in relation to records (AASW, 1999, Section 4.2.6). This section has seven subclauses that cover impartiality and accuracy of recording, sharing of information and authorization for use of client records, client access to records concerning them, and protection and disposal of records. The *AASW Code of Ethics* forms the basis for the practice standards document that has sections specifically related to recording and record keeping (Standard 1.6) and report writing (Standard 1.7).

Despite the fact that documentation has been established as an ethical responsibility, the reality of practice is that rigorous documentation and recording of assessments, interventions, and outcomes are viewed by many social workers as boring, of low status, and a routine chore that takes them away from the real work of helping people (Prince, 1996). In certain settings (e.g., child protection agencies, the Family Court of Australia, and Guardianship and Administration Tribunals), social work documentation is critical in the decision-making process, despite the prevailing attitude minimising its importance. Paperwork, including documentation of practice, is often perceived as an administrative task and an unnecessary burden or bugbear (Carrilio, 2005; Prince, 1996; Swain, 2002). Gelman (2002) endorsed the belief that recording is rarely approached with enthusiasm by practitioners and is often not viewed as a high priority.
Among multidisciplinary team members, a considerable amount of information is conveyed by all disciplines verbally in the hospital setting. This can facilitate effective service to patients. However, the risk is that the absence of accurate and skilled social work documentation reduces transparency and accountability and, therefore, can blur the assessment and intervention profile. It was within this framework of risk management that social work staff at the Princess Alexandra Hospital (PAH) identified documentation as an area of “ethical risk”, taking proactive steps to raise awareness and introduce a documentation proforma designed to minimise this risk and better reflect best practice. The structured approach that follows builds on the work of McAuliffe (2005), whose exploratory action research study engaged 11 agencies in trialling the Social Work Ethics Audit (Reamer, 2001). Three of the agencies were major hospitals with established social work departments, but only one explored the complex issues associated with documentation.

The PAH Experience

The PAH, located four kilometers from Brisbane's central business district, is a major tertiary referral center and one of Australia's leading teaching and research hospitals. The Social Work Department (the Department) forms part of the Division of Clinical Support Services and, in 2002, maintained 27.7 full-time equivalent social work positions. Social workers work mainly within multidisciplinary teams providing services to patients, families, and carers throughout the hospital. Multidisciplinary teams enhance the quality of patient care and clinical outcomes by incorporating the contributions and perspectives of many health care professionals via regular and clear oral and written communication among team members (Mickan & Rodger, 2000).

As a means of evaluating the ability to deliver quality services, the PAH Social Work Department responded to an invitation in April 2002 from The University of Queensland's School of Social Work and Applied Human Sciences for expressions of interest to participate in a research study (McAuliffe, 2002). That study was designed to test the applicability of The Social Work Ethics Audit (Reamer, 2001), a risk management tool, in an Australian context while examining practices, policies, and procedures in the hospital Social Work Department. This prompted the formation of an Ethics Audit Group (EAG).

The Social Work Ethics Audit (Reamer, 2001) guides practitioners through a systematic process of auditing policies and procedures in the 17 areas mentioned above. Each area is assessed against four degrees of risk, from absence of risk to minimal, moderate, and high risk. Using these guidelines, the Department collectively identified and confirmed Documentation and Client Records as high priority areas of ethical risk. Despite the existence of policies and procedures about documentation practice standards in the Department, and expectations that these would be followed, there were no prescribed or standardised documentation formats, or audit processes, in place. An Action Plan, consistent with Reamer's (2001) recommendations for
implementing strategies to minimise ethical risk, was developed to assist the EAG to work with staff to address problems and harness strengths.

As part of the Action Plan, the EAG consulted all the staff in the Department and designed an uncomplicated documentation proforma (see Figure 1). Although *Documentation* and *Client Records* had been identified as areas of high ethical risk, the introduction of the Summary Contact Sheet proved unpopular with staff. The

**Princess Alexandra Hospital**

**SUMMARY- CONTACT SHEET**

<table>
<thead>
<tr>
<th>Contact Details:</th>
<th>Patient ID Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ New Referral</td>
<td>Name:</td>
</tr>
<tr>
<td>☐ Review</td>
<td>Address:</td>
</tr>
<tr>
<td></td>
<td>Phone:</td>
</tr>
<tr>
<td></td>
<td>Ward:</td>
</tr>
<tr>
<td></td>
<td>UR:</td>
</tr>
<tr>
<td></td>
<td>DOB:</td>
</tr>
<tr>
<td>Date of Contact:</td>
<td></td>
</tr>
</tbody>
</table>

**PRESENTING PROBLEM:**

**ASSESSMENT:**

**ACTION TAKEN:**

**PLAN/OUTCOME:**

<table>
<thead>
<tr>
<th>Social Worker:</th>
<th>Summary Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>☐ Review</td>
</tr>
<tr>
<td>Extension:</td>
<td>☐ Ongoing Contact</td>
</tr>
<tr>
<td>Pager:</td>
<td>☐ No further Contact</td>
</tr>
<tr>
<td></td>
<td>☐ Final Contact</td>
</tr>
</tbody>
</table>

Note: Please file report within the Correspondence Divider

**Figure 1** First attempt at standardised documentation proforma.
EAG noted the disparity between staff recognition of the risk of current documentation practices and their expressed discomfort with the idea of implementing changes to the present system. It was recognised that firm evidence regarding the risk of current social work documentation practices was required in order to progress the minimisation of this identified risk.

Despite the groundswell of evidence within the Department recognising high levels of ethical risk about current documentation practices, there were various responses to the prospect of significant change. These responses ranged from palpable resistance to keen embrace. Some staff claimed to be “too busy” to effect change and believed that the EAG was not au fait with the realities of the work environment and pressures. Other staff felt threatened, overwhelmed, and concerned. There was a pervasive sense of “if it ain’t broke, don’t fix it”, “leave well enough alone”, and “don’t look and you won’t find”. Further, the orientation to documentation practices among new students, cadets, and locums at the hospital was well intentioned, but lacked standardisation and required reform. Finally, despite reservations about practice standards, the Department had no hard evidence to assess these reservations. The EAG was galvanised into further action.

It took considerable courage and leadership to openly acknowledge the failings of the current documentation system and to address the challenge of risk minimisation. Using the Allied Health Integrated Information System (AHIIS), a database system that captures allied health patient activity information, as the first indicator of social work intervention, the EAG devised a checklist for auditing individual medical records based on Queensland Health Procedures (60012/v4/07/2003) on documenting in the medical record. This allowed the EAG to assess a number of key features, including an indication of social work contact, the format of the notation (including the use of headings), and characteristics of the entries observed. The checklist provided a framework for an audit of social work documentation practices in medical record keeping.

A retrospective audit of 156 of a potential 200 medical records for the months of September and October 2003 was conducted. Each member of the EAG was randomly assigned a number of medical records to audit. The EAG conducted weekly meetings in order to discuss and crosscheck findings, which enabled a fair and consistent evaluation process. Of the 108 records that indicated social work contact, the results were summarised into those that reflected good-to-excellent, mediocre, or decidedly poor evidence of documentation standards. Good-to-excellent recording encompassed the checklist criteria and demonstrated high-quality assessment, analysis, and intervention. Mediocre recording reflected less capacity for encompassing the checklist criteria and demonstrated a lower overall quality of assessment, analysis, and intervention. Records that were decidedly poor failed to meet the majority of checklist criteria and were of an inadequate quality.

Examples of the difference between good-to-excellent, mediocre and decidedly poor recording can be seen in Figures 2, 3, and 4, respectively. On each occasion, the
Table 1

<table>
<thead>
<tr>
<th>SOCIAL WORK: 0/0/0 0930am</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral:</strong> Mr J, a 49-year-old truck driver was referred on 0/0/0 for assistance with a Centrelink Form by nursing staff.</td>
</tr>
<tr>
<td><strong>Admission:</strong> Mr J was admitted on 0/0/0 after suffering severe visual disturbances and headache while on the job. He was able to divert the truck and call for assistance.</td>
</tr>
<tr>
<td><strong>Provisional diagnosis:</strong> Stress related; dismissed–transient ischaemic attack (TIA), cerebrovascular accident (CVA–stroke), migraine, allergic reaction.</td>
</tr>
<tr>
<td><strong>Past Medical History:</strong> Mr J confirmed the history documented on his admission.</td>
</tr>
<tr>
<td><strong>Employment:</strong> Mr J works for B and B Transport who are currently paying him sick leave. This runs out tomorrow. Mr J’s job is being held for him.</td>
</tr>
<tr>
<td><strong>Finances:</strong> Mr J is very worried about money as he has no more sick leave, has used his holidays and needs to support his family. His partner, Ruth, recently was involved in an MVA, has written off their car, which was uninsured, and is currently unable to work because of soft tissue damage. She was employed casually as a cleaner and currently has no income. The couple are up to date with their rent. Mr J also pays child maintenance.</td>
</tr>
<tr>
<td><strong>Accommodation:</strong> Mr J and Ruth live in a rented unit through a friend. The rent is modest in exchange for some gardening/maintenance duties, which Mr J and Ruth share.</td>
</tr>
<tr>
<td><strong>Family:</strong> Mr J is divorced and has no contact with his 1st wife and occasional contact with his two high school-aged children. Mr J pays maintenance and is currently “slightly” in arrears. Ruth has adult children from her 1st relationship.</td>
</tr>
<tr>
<td><strong>Legal:</strong> Mr J has made a will but has no Enduring Power of Attorney. He does not want anyone else controlling his finances or making decisions about him.</td>
</tr>
<tr>
<td><strong>Current Problems:</strong> Mr J acknowledged that he has been working extra and sometimes double shifts to help Ruth’s recovery and to meet his financial commitments. He said that he has not been sleeping well and felt like a rat chasing his tail. He admitted to drinking alcohol daily to help him relax and was smoking more than usual. Discussion about financial/budgeting services to assist—Mr J appeared receptive.</td>
</tr>
<tr>
<td><strong>Assessment:</strong> Mr J is a 49-year-old man who has faced significant increased financial pressures recently. He has coped in ways that have not been successful for him and he is prepared to consider other options.</td>
</tr>
<tr>
<td><strong>Action:</strong> 1. Provision of Centrelink Sickness Allowance application forms. Medical certificate (on front of chart) to be completed by RMO (Resident Medical Officer) please. Liaison with Centrelink re intention to lodge application.</td>
</tr>
<tr>
<td>2. Information given about XYZ Counselling Services, which offers financial reviews and budgeting advice, and stress management courses.</td>
</tr>
<tr>
<td><strong>Plan:</strong> 1. Ruth to assist Mr J with completion and lodgement of Centrelink forms.</td>
</tr>
<tr>
<td>2. Mr J to consider self-referral to XYZ after discharge.</td>
</tr>
<tr>
<td>3. Mr J or Ruth to initiate further sw contact if required.</td>
</tr>
<tr>
<td>S Smith (Smith), SW, #00</td>
</tr>
</tbody>
</table>

Figure 2 Example of good-to-excellent documentation.
provided a strong sense of analysis, assessment, planning, and consultation on the
part of the practitioner.

As shown in Figure 3, a mediocre record demonstrated a moderate sense of
analysis, assessment, planning, and consultation, even though all may have been
performed by the practitioner concerned.

The example in Figure 4, assessed as a decidedly poor recording, demonstrated a
poor or nonexistent sense of analysis, assessment, planning, and consultation, even
though all may have been conducted.

The EAG asserts that good social work recording should document reflective
practice and that social work practice should be documented. Although social work
as a profession must continue the avid debate about what constitutes the core
components of “good social work” or “good practice”, rather than focus on all of
these, the PAH Experience contemplates the linkage between documentation and
practice. Without any framework for documentation, there is a limited base point
from which to start analysing and reflecting upon practice. Good documentation is
not the only indicator of good overall practice; however, absent or substandard
documentation substantially reduces the opportunity to gauge good, bad, or
indifferent practice.

All members of the treating multidisciplinary team, including social workers, share
the professional responsibility of risk identification and achievement of the best
possible patient health care outcomes. The importance of communication and
documentation of risk cannot be underestimated, particularly when team members

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**Figure 3** Example of mediocre documentation.

**SOCIAL WORK: 0/0/0**

*Referral:* Mr J referred re Centrelink form.

*Assessment:* Mr J has no sick leave from his truck driving job and needs to apply for Sickness Allowance.

*Action:* Application form given. Medical certificate (on front of chart) to RMO to complete please.

*Plan:* No need for further action.

S Smith SW #00

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**Figure 4** Example of decidedly poor documentation.

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rely on one another’s professional assessments and written records for communication on patient care, progress, and outcome. In considering this, the EAG concurred that some of the key criteria for good documentation practice included (a) evidence of social histories, assessments, and case plans; (b) contacts with clients (type, date, and time); (c) contacts with third parties; (d) consultation with other professionals; (e) critical incidents; (f) failed and cancelled appointments; and (g) a final assessment (Reamer, 2001). An amalgam of professionally identified criteria, organisational tensions, and requirements ratified the development of the three-tier classification system (good-to-excellent, mediocre, decidedly poor) that the EAG used to assess social work documentation practices.

As illustrated in the following case examples, the poorer the social work communications, including those inherent in documentation, the greater the potential for contributing to an adverse, ambivalent, or confused outcome:

1. An inpatient with a known history and a diagnosis of severe depression failed to attend a social work appointment in the social worker’s office. The social worker assumed that the patient must be too unwell to attend or was undergoing a medical test. The social worker neither checked the patient’s whereabouts nor communicated, verbally or in the medical record, the patient’s failure to attend the appointment. Later that night, the patient was found dead, having jumped from a nearby building. Because there was no documentation or any other communication to advise hospital staff that the patient had not attended the social work appointment, staff did not search for the patient until several hours later, because they thought that the patient was attending a lengthy social work appointment. The lack of communication compounded police attempts to piece together the patient’s last moves and was a factor in why the search commenced as late as it did.

2. Further to the social worker’s assessment, a relatively frail patient was deemed unable to return home, because high risk was identified. The patient had been hospitalised for 2 weeks, lived alone in a house with 20 steps, had no reliable or available family support, and home services were unable to commence for 7 days. The social worker communicated the information to nursing staff, but failed to document the assessment, including the severity of the identified risk. On Saturday morning, the patient was seen by a consultant doctor who, with no helpful written information to the contrary, assumed that family support and community services had been arranged for the patient. The weekend agency nursing staff received no specific handover from the permanent week staff about the patient’s home situation and discharge plan. The consultant doctor ordered the patient’s discharge on that same morning owing to a significant bed shortage resulting from an influenza epidemic. The consultant assumed that the people who had visited the patient during the week were “supportive family”. The patient, in fact, had no food in the house and the telephone had been cut off. Soon after arriving home, the patient tripped and fell down the steps, sustaining a hip
fracture, and was found the next day by a neighbour. The patient was readmitted to hospital, developed an infection, and died on Day 93 after readmission.

3. The social worker was asked to provide an assessment of a previously unknown patient who had been referred for an urgent transplant. The social worker discussed the assessment with a few of the nurses, but failed to document a significant history of noncompliance, poor social support systems, and patient ambivalence about transplantation. The net result was that because the medical indication became the paramount reason to perform the transplant and there was no significant or helpful psychosocial history or contraindication documented, the transplant proceeded. The patient’s identified behaviour patterns and past history entwined to contribute towards the patient’s posttransplant noncompliance and eventual failure of the transplant. The medical team was unhappy that it had been poorly informed and, hence, had provided a scarce resource to someone who was a high-risk transplant candidate. Other potential transplant candidates missed out on a transplant and two such candidates died while on the transplant waiting list. Although it was probable that the transplant would have proceeded, albeit cautiously and with some trepidation, had the full psychosocial history been communicated and documented, the outcome may have been different. It is known that the availability of such information can play a significant role in the transplant decision-making process, especially in the context of a severe community donor organ shortage.

In considering these case examples in relation to criteria identified in the Social Work Ethics Audit and used by the EAG, it can be seen that the repercussions of poor or nonexistent documentation can be significant within a chain of events involving multidisciplinary team members and in the final evaluation of patient care. Although a considerable number of social work entries seen by the EAG were assessed as mediocre or excellent, there were still an unacceptably high number of records demonstrating poor documentation standards. In several cases, there was a total absence of social work recording, which completely contradicted the AHII registered patient activity information. The audit results were significantly worse than the EAG’s expressed reservations and personal fears. There was clear demonstration that, despite a commitment to high standards of social work practice, documentation practices generally did little justice to the known calibre of social work practice in the Department. Overall, practice was inadequately reflected and recorded, creating a regrettable legacy and an unacceptably high degree of future risk.

Following the results of the first documentation audit, the hospital’s Health Information Management Services (HIMS) authorised the EAG to develop a contemporary, yet simple, two-page proforma to record the social worker’s case assessment that was different from the original one previously presented (see Figure 5). The key advantages of such a proforma were expected to be increased accountability, much improved consistency, and greater visibility of social work activity within the
patient’s medical record and, therefore, in the hospital at large. The EAG believed that a more measurable link between social work assessment, intervention, and the notion of outcome was needed (Nicholas, Qureshi, & Bamford, 2003) following on a separate and prior study that examined social work outcomes in the hospital clinical setting (Shapiro et al., 2001–2004). The Shapiro et al. study examined the impact of implementing an outcome-directed practice model on outcomes for clients. It was undertaken by The University of Queensland and the social work departments of the PAH and another major Brisbane hospital.

In devising the assessment proforma, the EAG examined social work proformas that had been developed by several local, interstate, and overseas hospital social work departments to identify commonalities in frameworks for documentation, minimal standards and guidelines for social work report writing. The proforma incorporated a number of nationally agreed upon social work interventions, such as crisis intervention, discharge planning, and referral, in keeping with terminology that was familiar to staff. The EAG drew on the work of the AASW and the National Allied Health Casemix Committee (NAHCC). The latter had developed a Minimum Data Set, a Health Activity Classification Hierarchy, and a set of Activity and Intervention Codes based on the Allied Health International Classification of Diseases Codes (NAHCC, 1997). The EAG explored their potential applicability and usefulness in hospital psychosocial assessments and the documentation thereof. However, there is, as yet, no nationally standardised or AASW-prescribed method of psychosocial assessment or documentation. Rather, documentation and recording practices are agency or context specific.

A social work professional development session was conducted 4 months after the first audit. Each staff member was presented with an information pack outlining the audit process and results. A Queensland Health video on documentation was viewed and the new proforma and its guidelines for use were introduced. A 3-month trial of the proforma commenced 2 weeks later. It is important to reflect on the significance of introducing a new documentation proforma to the Department, with a mix of full- and part-time practitioners, each carrying differing professional experiences and representing a wide generational span. The challenge of effecting organisational and cultural change was not to be underestimated and required deep sensitivity, respect, and open communication.

Ongoing formal and informal feedback was sought by the EAG from the social workers. Comments received included:

It’s made me think a lot more about what I write.

It’s a great guide.

Who determines outcomes (i.e., is it us, the patient, the family, the doctors)?

Who is the “client” (i.e., is it the patient, the family, the organization)?
### Figure 5 (Continued)

<table>
<thead>
<tr>
<th>Referral details and date:</th>
<th>Interviews with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date/Time of Interview/s</td>
<td></td>
</tr>
</tbody>
</table>

**REASON FOR REFERRAL:**

1. Social Work Review
2. Counselling / Support
3. Discharge Planning / Referral
4. Respite / Res. Care
5. Palliative Care
6. Sudden Death
7. Major Trauma
8. Anger / Grief & Loss issues
9. Acute Onset of Illness / Disability
10. Unanticipated Major Surgery or Diagnosis
11. Adjustment to Illness Treatment / Trauma / Rehab
12. Established Non-Compliance
13. Rape / Sexual Assault
14. Domestic Violence
15. Suspected Child / Elder Abuse and Neglect
16. Conflict Resolution
17. Mental Illness
18. Relationship Stressors
19. Alcohol and Drug
20. Main Carer Hospitalised / Ill
21. Cultural Challenges
22. Legal Matters / Referrals
23. Insurance / Workcover / CTP
24. Income Support
25. Home Safety / Support Issues
26. Transport and Access Issues
27. Accommodation / PTSS / IPTAS
28. Homelessness

**FAMILY SITUATION:**

**MARITAL STATUS:**

- Single
- Married
- De facto/Unmarried Partnership
- Divorced
- Widowed
- Separated
- Other

**SIGNIFICANT SOCIAL SUPPORTS AND GOVERNMENT SERVICES:**

- Family / Friends
- Church / Group / Associations
- Colleagues / Employer
- Interests / Hobbies
- None Identified
- Home Help
- MOW
- Domiciliary Nurses
- CAPS / COPS
- In Home Respite
- Centre Based Respite
- Other / Additional Information

**EMPLOYMENT / OCCUPATION:**

- Employed (FT / PT / CAS)
- Self-Employed
- Occupation Type:
- Unemployed
- Home/Parenting
- Retired
- Carer
- Student
- Other

**CURRENT FINANCE:**

- Wage/Salary
- Self-Funded / Retiree
- Private Means
- Insurance / Workcover / Comcare
- Other
- Centrelink (Benefit Type: ____________)
- Veteran Affairs Pension (Card Type: ____________)

**LEGAL:**

- EPQA: Y/N
- AHD: Y/N
- GAAT: Y/N

Name of Attorney: ____________________________

Appointed For: Financial / Personal/Health / Both

**HOUSING:**

- Own
- Renting
- Dept of Housing
- Unit / Flat
- House
- Boarding
- Caravan
- RVillage
- Residential Care Facility
- Other

**ACAT APPROVAL:**

- High / Low
- Respite / Permanent
- Awaiting Placement
- Mt Olivet
- Listings
## Australian Social Work

### SOCIAL WORK ASSESSMENT

**PATIENT IDENTIFICATION LABEL**
- Name:
- Ward:
- UR No.:  
- D.O.B.:  

### OTHER RELEVANT FACTORS OR DETAILS:

### EMOTIONAL STATE / AFFECT:

### OVERALL ASSESSMENT:

### INTERVENTIONS

<table>
<thead>
<tr>
<th>Action Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Crisis Intervention</td>
</tr>
<tr>
<td>- Counselling</td>
</tr>
<tr>
<td>- Case Management</td>
</tr>
<tr>
<td>- Information Provision</td>
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<tr>
<td>- Liaison</td>
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<tr>
<td>- Discharge Planning</td>
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<tr>
<td>- Advocacy</td>
</tr>
<tr>
<td>- Resourcing</td>
</tr>
<tr>
<td>- Education</td>
</tr>
<tr>
<td>- Other</td>
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</table>

### OUTCOMES:

<table>
<thead>
<tr>
<th>Reduce (patient/family):</th>
<th>Enhanced (patient/family):</th>
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<tbody>
<tr>
<td>- Anxiety</td>
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</tr>
<tr>
<td>- Grief</td>
<td></td>
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<tr>
<td>- Isolation</td>
<td></td>
</tr>
<tr>
<td>- Sadness</td>
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<td>- Vulnerability</td>
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<tr>
<td>- Stress</td>
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<tr>
<td>- Sense of failure</td>
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<td>- Uncertainty</td>
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<td>- Role strain</td>
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<tr>
<td>- Frustration</td>
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<td>- Anger</td>
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<tr>
<td>- Positive feelings</td>
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<tr>
<td>- Emotional relations</td>
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<tr>
<td>- Economic environment</td>
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<tr>
<td>- Dignity</td>
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<tr>
<td>- Assertiveness</td>
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<tr>
<td>- Home environment</td>
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<td>- Negotiation skills</td>
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<tr>
<td>- Adaptation to change</td>
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<tr>
<td>- Ability to plan</td>
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<tr>
<td>- Social environment</td>
<td></td>
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<tr>
<td>- Personal development</td>
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<tr>
<td>- Physical safety and security</td>
<td></td>
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<tr>
<td>- Autonomy</td>
<td></td>
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<tr>
<td>- Purposeful activity</td>
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<tr>
<td>- Independence</td>
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</tr>
</tbody>
</table>

### ADDITIONAL OUTCOMES:

### FUTURE ACTION:

<table>
<thead>
<tr>
<th>Name of Social Worker/Student:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
</tr>
<tr>
<td>Report Completed (Date/Time):</td>
</tr>
</tbody>
</table>
| Extension:  
| Pager: |

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**Figure 5**
It doesn’t always reflect the story of the contact (i.e., the context seems lost).

It’s not useful in short contacts.

As part of the Action Plan, a re-audit along identical lines to that of the first audit was undertaken during the second, third, and fourth months after the new proforma documentation tool was implemented. The EAG could now observe both occasions of usage and implementation of the new proforma. Comparisons became possible.

There were several noticeable differences between the first and second audits. The most significant difference was the marked improvement in recording practices. The introduction of the new proforma can, in part, explain this improvement. There must be acknowledgment of the genuine and concerted efforts across the Department to reflect upon and improve documentation practices. There was also a decline in the number of decidedly poor entries following the introduction of the new assessment proforma, resulting in a more equal distribution of the number of entries across each of the categories. The results indicated that social workers were moving along the ethical risk continuum; that is, from a position of high to minimal risk. Despite this positive movement, the continued high number of poor results indicated that further professional development and training sessions were required to enhance the social workers’ competencies and skills in the areas of psychosocial assessment and outcomes.

Discussion and Implications

The PAH Experience illustrates the cultural shift that is needed to bring a staff group on board in a collaborative way within a process of change designed to minimise risk for all. Anecdotal accounts of problematic documentation standards were not sufficient to improve the quality of recording: hard evidence was needed that could then form the foundation for the development of new systems (in this case the documentation proforma). In serving as an “effective means of exchange” within a multidisciplinary team (Young, 1979), it is clear that documentation in the contemporary health care and social work context has developed a range of purposes and outcomes. Predominantly, the rationale for sound documentation practices that are highlighted in the literature (Baumhover & Beall, 1996; Reamer, 2005; Swain, 2002) include:

1. Provision of continuity of care and communications between practitioners.
2. Assistance in clinical decision making and subsequent service delivery.
3. Assistance with preparation of reports.
4. Refreshment of memory.
5. Provision of one basis for accountability to clients, insurers and other providers, and stakeholders.
6. Provision of a basis for professional supervision.
7. Assistance in research and the generation of new knowledge.
8. Risk management.
The experiences of this hospital social work group illustrate that, despite endorsement within the literature about the essential and valuable nature of documentation, there is compelling evidence of a profound dissonance experienced across a range of social work agency settings between this endorsement and the actual implementation of sound documentation practices. This may, in part, relate to what Ovretveit (1985) identifies as “record alienation” and how much of social work recording is irrelevant to task and purpose. Ovretveit’s (1986) research found that provision of a standardised recording system allowed practitioners to reduce the amount of irrelevant documentation, assisted them to distinguish facts from opinions, and facilitated definition of objectives and planning in their social work practice. However, despite new recording technologies, not all social workers embrace changes to recording practices and are criticised if they fail to meet new standards (Kagle, 1993).

In addition, Gelman (1992) has described the process of “professional protectionism”, whereby records are structured and entries made to protect the actions or lack thereof by the practitioner or agency. Social work records are known to have been flawed and to contain information not relevant to a client’s situation, including contradictory opinions, value judgments, rumors, and allegations that are unsubstantiated by fact and often do not do justice to the work that was done (Gelman, 1992). The implications of relationships between documentation practices, ethical standards, and risk-management frameworks are significant (Chenoweth & McAuliffe, 2005; Gelman, 1992; Johnson et al., 2000; Kavaler & Spiegel, 2003; Kemshall, 2002; Reamer, 2005). What is recorded is equally as important as what is not recorded when this is likely to bear upon the client’s future treatment by the organisation and upon the defense of social work actions and outcomes (Bernstein & Hartsell, 2000; Jones & May, 1992; Kennedy & Richards, 2004; Luepker, 2003; Purtilo, 2005). Themes that have gained clear momentum over time, many of which are controversial in legal terms, include “if it isn’t written, it did not happen”, “no documentation, no defense”, and “truth versus evidence” (Bernstein & Hartsell, 2000; Callahan, 1996). Chenoweth and McAuliffe (2005) argued that advice often given to social workers not to keep case notes because “if there are no records they can’t be disputed” is not responsible and does not make for accountable practice.

The use of medical records in defending practitioners against accusations of unethical conduct or professional negligence, as well as the pervasive use of computerised records with the attendant concerns about privacy and unauthorised access, are among the substantial reasons cited for the increased focus on documentation for risk management purposes (Reamer, 2005). Risk management is defined as “the process of managing an organisation’s potential exposure to liabilities, preventing them, or providing for funds to meet the liability if it occurs . . . to ensure that liabilities are not limited to physical risks, but also include risks arising from requirements, financial and moral or ethical issues” (McGregor-Lowndes, cited in Fishel, 2003). Kemshall (2002) provided an additional insight into risk management by stating that “individual and organizations charged with getting risk right are required to defend these decisions, often from litigation, and formalized
assessments methods are used to replace the vagaries of professional judgment”. Although the common theme in these definitions may appear to be one of defensive practice, risk management can also be an excellent strategy for focusing on challenges and searching out opportunities for improving the quality of practice (McAuliffe, 2005).

Given the risk culture in which most professionals work, many employer organisations and professional associations have developed detailed policies, procedures, and codes of ethics to help ensure that client records adhere to rigorous documentation standards. Examples include the Australian Medical Association (2006), Australian and New Zealand College of Mental Health Nurses (2006), Australian Nursing and Midwifery Council (2006), Australian Psychological Society (2003), and Australian Society of Occupational Therapists (2006). The PAH developed the Patient Record Procedure, in keeping with the current Australian Standards (AS2828; 2001), to ensure that (a) patient records and documentation of treatment conforms to standards of optimum patient care and amenability to evaluation of the care provided; (b) in appropriate and restricted circumstances, patient records be made available for patient care but also remain confidential and accessible to the hospital for coding, research, quality management, and medicolegal activities; (c) consistent and complete patient records are maintained to allow for ease of access when needed; and (d) continuity of care is maintained through the provision of efficient and confidential access to patient records.

The assertion in the present article is that social work documentation in the medical record, as an area of potential ethical risk if not conducted according to professional and employer-mandated standards, should be an integral part of clinical practice and not an administrative side-task. The foundations for good documentation and recording practices lie in the domain of social work education and it has been argued that changes to recording practices have not been incorporated in a systematic way into either undergraduate or graduate education (Ames, 2002). These changes include standardisations of the narrative style of documentation to different formats for the electronic storage and dissemination of social work assessments across multiple databases. Tebb (1991) stated that education for social work recording should occur in the classroom, during field instruction, and at the workplace. Further, Tebb (1991) concluded that documentation and recording should be part of the curriculum in every school of social work, thus exposing students to the link recording provides between practice, theory, and policy. Certainly, the AASW (2000), in setting eligibility standards for membership, expects graduating social work students to have “demonstrated capacity to communicate effectively orally and in writing”. It is reasonable to expect that written communication and documentation of assessment and intervention should be an integral part of social work education. This is supported by Trevithick (2005), who notes that documentation is “a crucial learning tool because record keeping provides an opportunity for analytical reflection and evaluation, particularly in relation to decision-making, to formulating hypotheses and evolving collaborative ways of working”.

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Conclusion

The opportunity presented to social workers at the PAH to identify and examine potential areas of ethical risk resulted in a reality check that documentation and client records had been submerged for too long in the murky waters of clinical practice. A key component in the salvage effort has been the positive partnership with and support from The University of Queensland as a means of assessing and conceptualising social work practice within a complex hospital environment. The development and trial of a new Social Work Assessment Proforma has strong potential to reduce the identified level of “high” ethical documentation risk to one that is “minimal”. The Social Work Department is well underway towards the implementation of a structured approach that aims to project and reflect quality practice. Such written documentation has the potential to meet, exceed, and futuristically become the benchmark for medicolegal, Queensland Health, and social work professional requirements.

In considering recommendations, the Social Work Ethics Audit (Reamer, 2001) was found to be well applicable to the Australian hospital social work setting. The need to provide stronger documentation education commencing in the tertiary setting was confirmed by the PAH Experience. With new communication technologies, greater accountabilities, and Medicare funding of Allied Health Practitioners, the capacity for structured, justifiable, meaningful, and relevant documentation will take on even greater significance. Within the Social Work Department, there is the ongoing requirement for orientation, professional development, and training around the documentation and patient record areas while reviewing the proforma itself. It is likely that within 12 months there will be a new style of proforma, or a range of proformas, to better meet needs of the different social work teams, enhance flexibility, and to more accurately capture and emphasise the notions of risk and assessment. Regular audits of medical records conducted by groups of staff from across the Social Work Department would confirm the value placed upon documentation while enabling all staff to gain a perspective on social work documentation and contribute towards its development. It is recommended that documentation be a standing item for supervision. Overall, there needs to be a framework of cultural shift where report writing is valued in and for itself and is considered more than an administrative task. The responsibility to update and incorporate recording practices in the hospital and other social work settings has potential well beyond the scope of the present article. Although challenges in recording practices can feel akin to raising the Titanic, these are required for the social work profession to rescue documentation from the sea of ethical risk.

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References


The Central Medical Illustration Unit, Royal Brisbane and Women’s Hospital, Brisbane (Producer). (2003). Clinical documentation [Booklet/video]. (Available from Organisational Improvement Unit, Royal Brisbane and Women’s Hospital, Butterfield Street, Herston, Queensland 4029, Australia).


