Clinical Record Keeping

This fact sheet was developed by the Clinical Innovation and Governance Directorate of Ageing, Disability and Home Care in the Department of Family and Community Services, New South Wales, Australia (FACS). The aim of this fact sheet is to provide guidance to FACS practitioners on clinical record keeping.

Purpose of record keeping

It is the legal, ethical and professional responsibility of all FACS practitioners to keep current and accurate records of the services they have provided. A record is any document or other source of information created or stored in written form, on film, by electronic process or by any other means (State Records Act 1998 NSW). This can include but is not limited to; a progress note, an email, record of a telephone conversation, a report or an intervention plan. Staff has an obligation to keep and preserve full and accurate records.

It is important to keep comprehensive records to:

- ensure the safety of people with disability
- record the sequence of events in chronological order
- provide written evidence that services have been delivered
- document why a decision was made
- provide evidence of care in any legal proceeding.

For further information on record keeping, accessible information and CALD, ATSI considerations please see section 7 in the Service Delivery Approaches Practice Guide.

Progress notes

Progress notes should:

- be recorded on Client Information System (CIS)
- be factual, objective and accurate
- be non judgmental and respectful of the person with disability and all people mentioned
- contain a chronological history of all actions undertaken during the course of the relationship between the person with disability and the FACS practitioner
- document consent from the person with disability, parent or person responsible
Progress notes continued

- ideally be entered on the day of the interaction with the person with disability or their carers. If that is not possible, the practitioner should enter the progress notes the following day but document the date the entry is being made and the date of the actual session
- contain the date of each contact, details of what took place who was present and the duration of the contact
- document any assessments and/ or observations that were undertaken and clinical findings
- outline intervention goals, proposed intervention and any risk or alternatives (if any) that are discussed with the person with disability and their family/ carers
- detail the intervention that is provided including training or education given to family and/ or carers
- outline the clinical reasoning behind decision making for assessment and intervention
- document intervention progress and outcomes
- outline any risks or ‘flags’ which might impede service delivery or future service delivery
- document if the intervention is not able to be implemented or an offer of intervention was declined, and outline the reasons why this occurred
- contain a simple plan for the next session
- document any offer of training progress and outcomes or if training is not able to be implemented or an offer of training was declined and outline the reasons why this occurred
- include any other correspondence with the person with disability, their carer or other service providers e.g. phone calls, emails, reports received
- contain the TRIM reference number for any document that is referred to in the progress notes and attached to TRIM
- include the meaning of an abbreviation. If an abbreviation is used it should not make the progress note hard to read.
Progress note structure

Progress note formats may vary, especially across disciplines.

One example is a descriptive/ narrative format. It does not have a specific structure but information is presented in a logical manner. A descriptive note must follow the guidelines provided above about what should be contained in a progress note.

An alternative format to the descriptive note is the SOAP format:

**S** = subjective or symptomatic examination. Information such as what the person with disability, their family/carers say in regards to their current status or outcomes from previous intervention. Include social, medical history and informed consent prior to assessment and intervention.

**O** = objective examination. Report on the observation and assessment. Objective data about what the person with disability, their family/carers did, what was measured and observed.

**A** = assessment. Interpret and analyse the information from the ‘subjective’ and ‘objective’ section and make comments on the person’s progress and performance e.g. activities completed, support required.

**P** = plan. Outline the next steps to support the person with disability to achieve their goals. Include timeframes and specific actions to be taken.

Document Writing

All documents that are created as part of service delivery should:

- have a clear purpose, be delivered in a timely fashion and be provided to relevant agreed parties (with formal consent)
- be written so that the person with disability and/ or their family and carers can easily understand them, taking into account cultural and linguistic diversity and/or the need for alternative presentation of information
- not contain abbreviations or jargon
- be on departmental letterhead
- be stored on TRIM e.g. assessment report, intervention plans, programs, summary letters
- contain the TRIM number and be cross referenced in the CIS notes
- be dated and signed.
Relevant FACS policies and procedures

Records Management Procedures for Community Clients (2011)
Accessible Information Checklist (2013)
Community Support Team Practice Package (2013)
Code of Ethical Conduct (2013)
Language Services Guidelines (2012)

Discipline specific documents

Each practitioner should be familiar with their own discipline specific Code of Ethics provided by their professional association. Some professional associations may also have position statements specific to clinical record keeping.

References and Resources


