

STANDARD FOR DOCUMENTATION

PURPOSE

The purpose of this standard is to provide direction and guidance to the Child and Family Services (CFS) program regarding documentation. This standard is intended to achieve statewide consistency in the development and application of CFS core services and shall be implemented in the context of all applicable laws, rules and policies. The standard will also provide a measurement for program accountability.

INTRODUCTION

From the first moment of contact, a CFS social worker/clinician becomes responsible and accountable to his/her profession, his/her employer, the community, the individual he/she serves, funding sources, co-workers, and a legal system which protects the rights of each individual. The case record serves as the source for fiscal, legal and clinical accountability.

The purposes of documentation include:

- To record decision-making and the basis for the decision;
- To record progress on a case;
- To allow others to understand the case if the social worker/clinician is unavailable;
- To serve as a basis for responding to complaints and lawsuits;
- To become the primary source for quality assurance determinations; and
- To provide verification of the need for services as mandated by funding sources.

TERMS

Contact

Contact is any communication with a family, a child, a resource family, a service provider, or individual involved in a child protection referral or case that is open for services. The method of contact may include face-to-face communication, a telephone call, or letter. When a social worker goes to the home to see the family or child, it is considered a contact, not a visit.

Visit

A visit is defined as face-to-face contact between a child in out-of-home care with his or her family. Visitation is planned and is separate from routine appointments such as family counseling, doctor appointments, and school meetings. Visitation is the primary mechanism through which family relationships are maintained while a child is not living at home. Visitation also provides the context for determining if and when a

parent is willing and able to provide a safe environment for a child. Visits may be with parents, grandparents, relatives, siblings, and other individuals with whom the child has previously established a significant relationship.

IMPLEMENTING THE STANDARD

FOCUS is the electronic file maintained by CFS to document the case records of individuals involved with the agency. However, not all documents can be included in the electronic file. Information that cannot be entered into FOCUS such as court documents, medical evaluations, school records, signed consent forms, correspondence, and critical incident reports must be kept in a hard file and housed in an area that can be locked for purposes of confidentiality.

Information obtained during or considered part of formal safety assessments will be documented on assessment screens in FOCUS to allow the information to be printed on the assessment documents. For example, collateral contacts regarding assessments will be entered on the assessment screens. However, during the assessment period, if there are contacts that pertain to case management functions, those contacts should be documented on the contact screen. Examples of case management functions include meeting with the resource family with placement information or providing the resource family clothing vouchers for the child.

On-going case contact and family visitation will be documented on the contact/visitation screens in FOCUS as described in the following sections.

Contact with Families and Other Parties

All contacts, meetings, phone conversations and other communication must be documented. Documentation of contacts must be recorded on the “Visitation/Contact” screens in FOCUS. In order to complete a contact record sufficient to meet federal and internal reporting requirements for face-to-face contact, the following must be recorded:

- Date of contact;
- Name of individual contacted;
- Participant role – child of concern (coc) or relationship to the child;
- Location of contact – family home, resource family home, office, other, etc.;
- Method of contact – face-to-face, telephone, etc;
- Duration of contact;
- Results of the contact including a notation of failed or cancelled appointments – successfully completed, interrupted, etc; and
- Name and title of responsible party making the contact.

Minimal Content Requirements:

- Each contact with the child has a defined purpose related to monitoring the child’s

- safety, permanency, and well-being, as well as reviewing the child's progress and needs;
- At a minimum, documentation should identify the purpose of the contact and include an observation and assessment of the child's safety, health, and general well-being, as well as an assessment of the adequacy of the home environment, when applicable;
 - Relevant information derived from the contact should be noted, including decisions made and rationale for all decisions made during or as a result of contacts; and
 - All contact descriptions should be written in complete sentences.

Visitation between the Child and Family Members

Documentation for all visitation between child(ren) and their family members, will include the following:

- Date of the visit;
- Type of visit (supervised or unsupervised);
- Staff providing supervision or staff monitoring the visit;
- Children and adults present during the visit and their relationship to the child(ren) of concern;
- Location of the visit;
- Length of the visit;
- Notation of failed or cancelled visits; and
- A brief monthly summary of the visits, including the purpose of the visits and the activities and interactions that occurred during the visits. Documentation will describe the interactions of the parent and child in behavioral terms, rather than making judgments or conclusions regarding the quality of the visit.

Critical Incidents

Critical incidents should be documented on the critical incident report form when there is a death of a child in care, a death of a client, a serious injury of a client, an allegation of a client being abused, neglected or sexually abused by a Department employee, an incident or allegation of a client being sexually abused, neglected, or abused by a service provider, resource family or volunteer, any alleged civil or criminal action, or a missing or runaway foster child.

Time Frames for Documentation

To accurately reflect the details of a referral or activities of a case, documentation should be completed as soon as possible. Established time frames for case documentation are listed below:

- Presenting Issues - Presenting issues should be documented the same day they are received so they can be prioritized and assigned for assessment;
- Safety Assessment - The safety assessment shall be completed no later than

- thirty (30) calendar days after first seeing the child;
- Comprehensive Assessment - A comprehensive assessment shall be completed within forty-five (45) days of a referral of child abuse or neglect if the safety assessment indicates the need for intervention and/or services;
- Service Plan - A service plan must be developed with the family within 30 days of the date the Comprehensive Assessment was completed in all family preservation in-home cases. In out-of-home cases, federal standards and the Child Protective Act require a written service plan to be developed within 60 days of the date of placement;
- Alternate Care Plan - The Alternate Care Plan shall be developed within 30 days after a child has been placed in out-of-home care. A revised alternate care plan will be developed every six months;
- Narratives - Within 30 days of the end of the previous month, all monthly notes shall be documented. Although this is the maximum time frame for documentation, it is recommended that when possible, documentation occur as soon as the event or activity has taken place, in order to accurately capture the details and in the absence of the assigned social worker/clinician, allow other staff to have full knowledge of the case;
- When a child is age 15 or older, an Ansell Casey Assessment shall be completed no later than within 30 days of the child residing in foster care for 90 cumulative days.
- An independent living plan shall be completed within 30 days of the completion of the Ansell Casey Assessment and updated annually.
- Child and Family Social and Medical Information Form should be completed within the first 30 days.
- Information for the child's social history should be one of the early steps of the family's Concurrent Plan and prior to authorization for a TPR (Please see the Standard on Concurrent Planning for additional time frames).
- Adoptive Placement Agreement – The Adoptive or Legal Risk Adoptive Placement Agreement must be developed and signed at the time of adoptive placement.
- Adoption Assistance Agreement – Must be developed and signed prior to adoption finalization.

Principles for Documentation

The credibility of a professional hinges on documentation. All work should be documented as accurately, objectively, completely, and timely as possible.

- The tone of documentation should be neutral and objective. Avoid documenting your emotions or opinions.
- In all documentation, record facts, with clear behavioral descriptions. Avoid judgments or statements that could be misinterpreted or show disrespect.

- Avoid a word by word description of what happened during each contact with an individual. Otherwise it may be difficult to glean important information quickly from the narrative.
- When possible, summarize the activities with a single entry that records the important facts regarding multiple case related events and occurrences for a specified period of time. Record only information that is relevant to the case and be concise. Summary notes are structured to require social workers/clinicians to summarize and synthesize information. When combined with a list of contacts or visitation in outline form, summary narratives provide a complete documentation of case activity. Please see the example following this standard.
- Provide documentation for important case events. This will include but is not limited to:
 - (a) Identifying issues, changes in a case, progress, set-backs or crisis;
 - (b) On-going assessment of needs and whether the needs were met or not met;
 - (c) Verification of services;
 - (d) Case decisions and the rationale for those decisions;
 - (e) Efforts to search for adoptive home;
 - (f) Efforts to locate family members and,
 - (g) Concurrent Planning decisions.
- Do not keep "private" files with information separate from the official case record.

Any action taken not consistent with this standard must be pre-approved by the FACS Division Administrator or designee. The action, rationale and approval must be documented in the file.