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Families

Agency Service Coordination Manual

2.1a Community Service Delivery Case Recording Standards

Definitions

For the purposes of these standards the following definitions will be used:

Participant(s): a service recipient as identified in a Program case file.

Case Notes: an individual entry of an event either on paper or electronically.

Case Files: also known as case or client records, this is the entire collection of data regarding a Program participant and would include information held in an actual paper file as well as electronically.

Case Management: a collaborative process of assessment, planning and facilitation for the exploration and provision of options and services to meet a participant's social service needs.

File Management: the process by which case files are maintained, augmented and retained. This includes time frames for and location of information considered critical in the determination of program eligibility as well as the information required for assessment, service planning, service provision, progress, summaries, reviews, closures, transfers, etc. File management standards will also detail the Program specific content required to be documented for each of these areas.

Program Staff: for purposes of these standards, Program staff refers to all Manitoba Family Services and Housing staff required to generate case notes.

External Service Provider Staff: are staff of non-governmental organizations with responsibility for the provision of case management services on behalf of Manitoba Family Services and Housing in the program areas noted in 1.6 above.

Scope and Purpose

These standards apply to all Community Service Delivery staff and staff of non-governmental agencies who provide case management services on behalf of the Department. The principles laid out in these standards apply to all records that are held about Program participants and includes information held in paper files or electronically.

These standards set out a framework for recording case notes, identify key principles and reflect core values that Program and External Service Provider Staff will need to consider. While these standards provide a minimum standard, it is expected that each Program area will describe their respective program protocols and expectations in detail.

This document should be read in conjunction with the following as appropriate:

- Personal Health Information Act (PHIA)

(http://web2.gov.mb.ca/laws/statutes/ccsm/p033-5e.php)

- Freedom of Information and Protection of Privacy Act (FIPPA) (http://www.gov.mb.ca/chc/fippa/index.html)
- Child and Family Services Act (http://web2.gov.mb.ca/laws/statutes/ccsm/c080e.php)
- The Child and Family Services Standards Manual (http://www.gov.mb.ca/fs/cfsmanual/index.html)
- The Adoption Act (http://web2.gov.mb.ca/laws/statutes/ccsm/a002e.php)
- Employment and Income Assistance Administrative Manual (http://www.gov.mb.ca/fs/eiamanual/index.html)
- The Vocational Rehabilitation Program Operating Manual (http://www.gov.mb.ca/fs/vrmanual/toc.html)
- Supported Living Policy and Procedures Manual (unavailable online)
- Children's Special Services Policy Manual (unavailable online)

Policy and Principles

Case recording is an integral part of the services we provide. It is an essential component of information gathering, analysis and decision making and a means by which staff can justify, explain and be accountable for their actions.

It is recognized that good recording supports good practice in a number of ways.

Good case recording:

- helps to focus the work of Program and External Service Provider Staff;
- supports effective partnerships with participants;
- facilitates reflection, analysis and planning;
- ensures there is a written record of involvement with participants and service providers;
- provides a venue to document that the Department and its agents are meeting expected standards of service;
- facilitates continuity when Program and/or External Service Provider Staff are unavailable or change;
- provides an essential tool for supervisory review;
- supports the formulation of risk assessments and risk management plans;
- provides a critical source of evidence for investigations and enquires;

- provides evidence for planning and allocating staff and financial resources at an individual and strategic level.

As government moves toward greater transparency in the services we provide, offering more choice and control to Program participants, our records need to demonstrate that we are fulfilling our obligations.

General Principles of Recording

Record keeping is central to the processes of assessment, decision making, service planning and delivery, monitoring and evaluation. The following general principles will provide further guidance toward these ends. Case files that are held on Program participants will follow these principles:

- An electronic case management system with a case note function is recognized as the system of official record for case recordings completed by Departmental staff. In these instances, paper files are viewed as auxiliary information and for storing all non electronic items such as letters, court documents and psychological assessments and reports.
- Records clearly show the nature of involvement with participants, what decisions have been taken, by whom and on what basis.
- Participants understand the purpose and content of their case files.
- Participants are informed of their right to access their case files and the procedures for doing so, their right to request corrections and their right to file a statement of disagreement if necessary. Participants who request access to their personal records are provided any necessary support in reading and understanding their records. Upon request, trustees of personal health information must provide an explanation of any terms, codes or abbreviations the individual does not understand (See s. 6(2), 7(2) of PHIA).
- Participants are informed of service decision outcomes and receive appropriate documentation.
- Case files identify barriers to service and how these have been taken into account.
- Case files are maintained in accordance with Program standards and will comply with all relevant legislation and regulations including FIPPA and PHIA.
- The use of abbreviations, symbols or language not readily understood by participants and/or service providers are avoided wherever possible.
- Case files must be completed in English.

Case File Format

Participant information is kept in both manual (paper) records and electronically. Part of the manual record may provide data for the electronic system and the relationship between these two methods of storage is crucial if information on participants is to be kept accurate, up to date and secure.

It is recognized that electronic record keeping across the Department is not uniform as dissimilar data systems exist among and sometimes within Program areas.

Notwithstanding the above, **recording standards apply equally to both manual and electronic records**. Clarity, coherence and evidence base are important factors whether you are recording on paper or on an electronic system. It is the quality of recording that allows case files to provide a clear account of individual cases.

Ideally, each Program area will have a case recording protocol detailing how manual records are held. These program specific standards will take into account how they link with records held electronically.

Recording Standards

Demographic Information:

- Basic demographic information (i.e. name, date of birth, address, contact numbers, relevant collateral contact information, etc.) will be clearly and accurately recorded at point of first contact; this will be updated as required and regularly reviewed.

Essential Components:

- contact concerning participants will be recorded;
- decisions will be recorded and clearly identified;
- the evidence on which decisions are based will be clearly shown;
- there will be clear evidence on the record showing when copies of key documents (e.g. assessments, plans, reviews, minutes of meetings, etc.) are supplied to participants;
- the wishes, feelings and views of the participant (when provided) will be recorded on file and clearly identified;
- the name and position of the staff person making the record will be clearly identifiable.

Format of Records (General Considerations):

a. Wherever possible case notes will include:
    i. what the case note is about;
    ii. who the case note concerns;

   iii. when the event did or will occur;
   iv. why the case note is being recorded, i.e. how it is relevant;
   v. where the event/contact prompting the case note occurred.

b. Records will include information under headings or in the format directed by each Program and will reflect relevant requirements accordingly.
c. Contact with or regarding participants will be recorded. All entries will identify purpose of the visit, meeting or telephone contact and any action resulting from the visit, meeting or telephone contact will be clearly recorded.
d. In meeting the expectations set out in 5.3.c., there must always be an indentified purpose for documenting information and staff must always distinguish between fact, judgement and unverifiable information.
e. The amount of information collected and recorded will be the minimum necessary for the particular purpose but should include all essential information relevant to related decision or activity.
f. Where service eligibility is being determined, the assessment of the person's eligibility will be clearly identified. The content of the assessment and review of service needs will follow Program specific requirements and processes.
g. Case Summaries/chronologies will be kept up to date to provide an accessible overview of each case.
h. Records will indicate appropriate authorization from management wherever relevant.
i. Although specific content requirements will be determined by each Program area, key points concerning the content of all case notes are that they will be:
   i. accurate and to the point;
   ii. up to date;
   iii. relevant;
   iv. easy to read and in plain language;
   v. easily understood by the participant;
   vi. entered within 2 business days.
j. General safety concerns are noted and updated, when appropriate.

Format of Records (Detailed Considerations):

In addition to the general content standards in 5.3.i., the following detailed considerations will also be taken into account:

a. Information recorded will be accurate and relevant and the content of case notes will include:

    i. factual information;
    ii. descriptions of direct observation by the worker;
    iii. wishes, feelings and views of participants where expressed.

b. In each case, any non-factual information will be clearly identified and recorded in a separate sentence or paragraph from the factual information.
c. Unsubstantiated and unattributable information will be recorded on the file only if it is determined to be of current or possible future significance and will be identified accordingly. Attempts must be made to confirm accuracy in a timely manner and results recorded.
d. All decisions will be recorded indicating who was involved in the decision making, what information was taken into account and the reason for the decision. This includes conclusions, assessments or evaluations that have been arrived at:
    i. by a collective view of the participant's circumstances by more than one worker, professional or volunteer (e.g. a case conference);
    ii. by a considered review by the worker;
    iii. by agreement with the participant.
e. On occasion, when a participant reviews their case file, and there is a disagreement concerning recorded facts; the disputed facts and the participant's views will be noted.
f. The decision to no longer provide a service will be recorded and the case manager will ensure that the record is in good order.
g. The closure or transfer of any case will be clearly recorded and authorized by the appropriate manager.
h. The case manager is responsible for ensuring the case files are maintained in accordance with Program standards and will comply with all relevant legislation and regulations including FIPPA and PHIA.

Confidentiality and Sharing Information

Program and External Service Provider Staff have an obligation to safeguard the confidentiality of personal information and must conform to the standards set out in PHIA and FIPPA. Verbal consent must be recorded including consent given by whom, when and for what purpose.

Staff will pay particular attention to ensuring consent to share information is clearly recorded on file. Where it has been necessary to share information without consent then the justification will be recorded and authorized as appropriate.

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Monitoring and Compliance of the Required Standards

Managers need to ensure that staff have appropriate orientation, development and training opportunities to develop professional recording practices that will result in compliance to the Case Recording Standards.

These processes should include:

1. Discussions concerning the quality of case recording and the content of a file with the relevant manager/supervisor as part of routine staff supervision.
2. Routine monitoring and auditing of case files by managers. The frequency and methods of audits will be determined by Program areas.