Ethics and Risk Management Challenges in Social Work Documentation: A Primer

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Objectives

The goals of today's training:

- Highlight the critical importance of documentation in social work
- Explore complex documentation decisions
- Review state-of-the-art documentation standards
- Identify the ways in which quality documentation protects clients and enhances risk management (especially related to litigation and licensing board complaints)

I Will Try to Кеер You Awake!



The Role of Documentation



assessment



planning and delivering services



accountability: clients, insurers, agencies, other providers, courts, utilization review



continuity and coordination of services



supervision



evaluation of services

Documentation guidelines from the first national Conference of Boards of Public Charities in 1874:

- Kinds of mental and moral perversion
- Descriptions of morbid and debasing conditions of the mind
- Points at which neglect of social and moral duties began
- Information regarding the totally idiotic or weak-minded in three generations, living and dead
- Total inebriates in three generations, living and dead
- Capacity for self-support without the direction and control of a superior authority or constant advice and supervision

(from Sidell)

A Little History

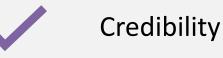
Core Documentation Issues



Content



Language and terminology





Access to records and documents

Ethical Risks

MISTAKES: INADVERTENT DOCUMENTATION ERRORS

> ETHICAL JUDGMENTS: DELIBERATE DECISIONS ABOUT WHAT AND HOW TO DOCUMENT

> > **ETHICAL MISCONDUCT**: FRAUDULENT DOCUMENTATION

Prepared by Frederic G. Reamer, Ph.D.

The Importance of Precision in Documentation



The challenge of *amphiboly*: Ambiguity in speech and documentation, especially from uncertainty of grammatical construction. Amphiboly occurs when the grammar of a statement is such that several distinct meanings can obtain.

- Let's eat, grandma. v. Let's eat grandma.
- Her parents watered the flowers, yet they died.
- If you take the motor out of the car, I will sell it to you cheap.
- Red tape holds up new bridge.
- A woman, without her man, is nothing. v. A woman: Without her, man is nothing.

Amphiboly in Behavioral Health

Sue has not been depressed for more than three weeks.

The client reported that he will not use drugs when he has custody of his child.

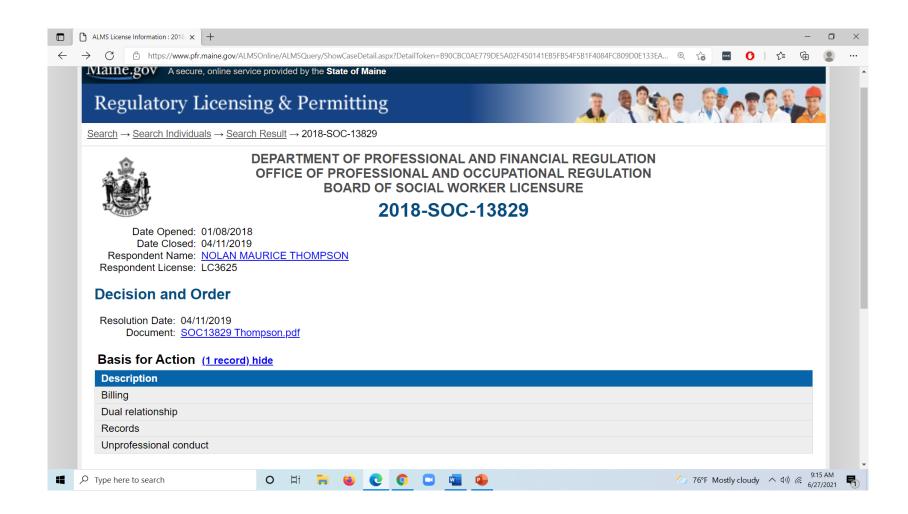
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Both parents tried to take care of the children, but they were hospitalized.

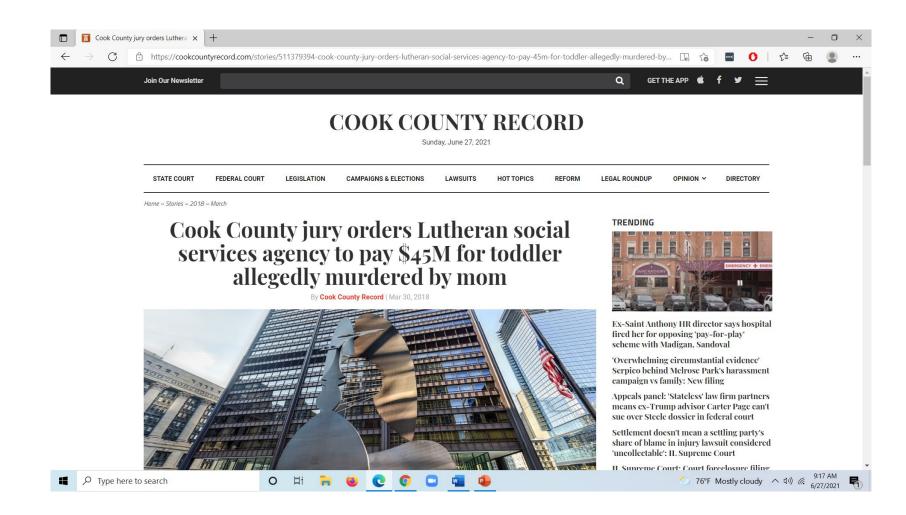
Why Documentation Matters: Case Examples

Prepared by Frederic G. Reamer, Ph.D.

Unprofessional Documentation



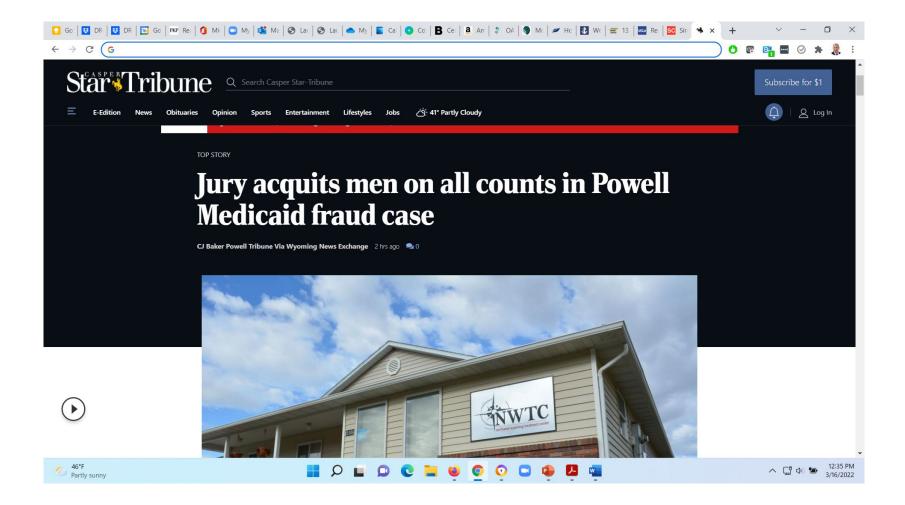
Documentation Errors



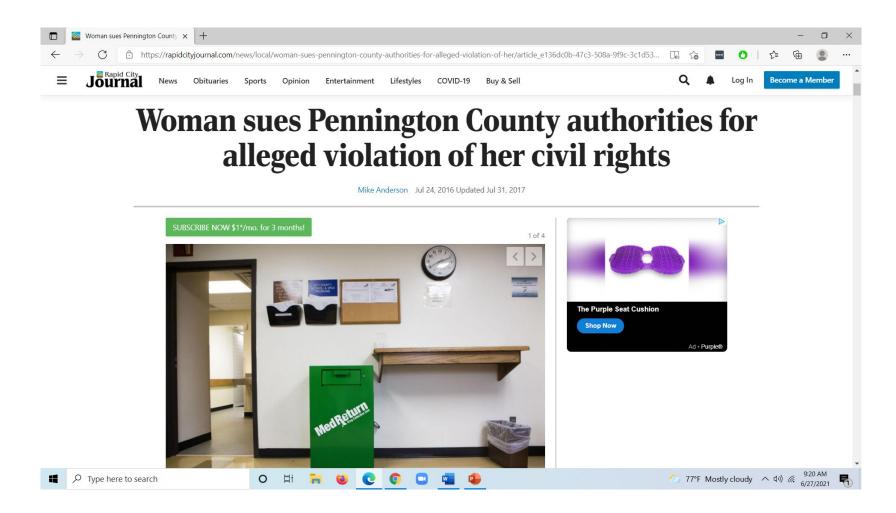
Documentation Judgments: When Clients Share Your Notes

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The Importance of Careful Documentation



Disclosures to Law Enforcement: 42 CFR Part 2



The Importance of a Paper/Digital Trail

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Parents' Access to Records of Minor Clients

In The Matter Of Kathleen Quigle × +						-	o ×		
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THE SUPREME COURT OF NEW HAMPSHIRE									
Hillsborough – northern judicial district									
No. 2005-002									
IN THE MATTER OF									
KATHLEEN QUIGLEY BERG AND EUGENE E. BERG									
Argued: July 13, 2005									
Opinion Issued: October 18, 2005									
Harvey & Mahoney, P.A., of Manchester (J. Campbell Harvey on the brief and orally), for the petitioner.									
Wiggin & Nourie, P.A., of Manchester (L. Jonathan Ross and Elizabeth M. Leonard on the brief, and Ms. Leonard orally), for the respond	ent.								
Judith A. Roman, of Concord, by brief, as guardian ad litem for the minor children.									
Duggan, J. This is an interlocutory appeal from an order of the Superior Court (<u>Mangones</u> , J.), approving the recommendation of the Mari guardian ad litem's (GAL) motion to seal the therapy records of the parties' children. We reverse and remand.	al Mas	ter (<u>Le</u>	eonard S	. Green	, Esq.)	, deny	ing the		
We accept the facts as presented in this interlocutory transfer and additional facts that are undisputed by the parties. The petitioner-mother, Kathleen Quigley Berg, and the respondent- father, Eugene E. Berg, are divorced. Pursuant to the final divorce decree, they have joint legal custody of their four children, whose ages range from eleven to seventeen. The mother has primary physical custody, while the father has specific custodial time with the children.									
After entry of the final divorce decree, the children at times did not visit the father as scheduled, because either they refused to do so or the mother. The children reported to the mother instances of alleged inappropriate conduct by the father and their reasons for not wanting to v individual counseling to address each child's resistance to visitation and his relationship with the father. Three children remain in regular is	sit. As	a resul	lt, the m	other ar	ranged	l for	2		
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Clients' Remote Access to Clinical Notes

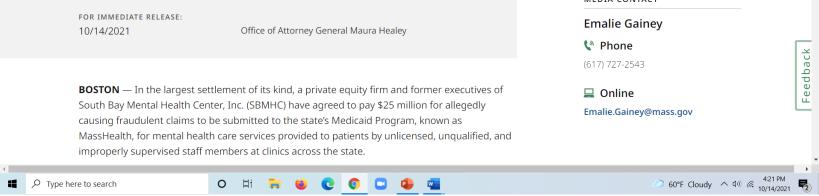
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Federal Ru	ules Mandating Open Notes	5
Cures Act specif information tha	federal rules implemented the bipartisan 2 ⁻ Fing that 8 types of clinical notes are among at <i>must not be blocked and must be made c</i> <i>cients</i> . To meet the interests of some patient exceptions.	g electronic available free
OpenNotes continues to monitor details affecting the	Federal Rules on Interoperability and Information Blocking, and open notes	
implementation of the Information Blocking Rule and may update this web page on occasion.	Beginning April 5, 2021, the program rule on Interoperability, Information Blocking, and ONC Health IT Certification, which implements the 21st Century Cures Act, requires that healthcare providers give patients access without charge to all the health information in their electronic medical records "without	Except where otherwise noted, the content by OpenNotes is licensed under a Creative Commons Attribution 4.0 International License.
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Documenting Online Searches

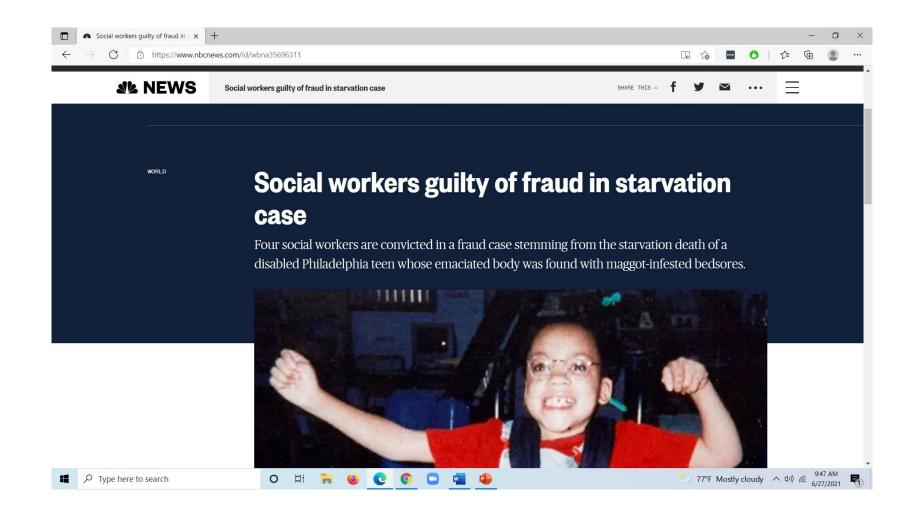


"False Claims" and Billing Fraud





Falsified Records



Paying the Price for Falsified Records



Sexual Exploitation + Fraudulent Documentation

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Medicaid fraud, sexual assault results in prison time for former Cheyenne counselor

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LOCAL NEWS

Federal fugitive apprehended in Cody

Drought conditions 'extreme' or 'severe' in Park County

Two area artists to be honored

Education advisory group begins seeking public input

PHS art students take on their most complicated assignment

Robinson to three to five years of incarceration for a felony count of seconddegree sexual assault by a health care provider. Under Wyoming law, a person commits the crime when they have sexual contact while acting in their "capacity as a health care provider in the course of providing care, treatment, services or procedures to maintain, diagnose or otherwise treat a patient's physical or mental condition."

Robinson said he and a patient had sexual contact during a regularly scheduled therapy session in July 2018, and that he billed Medicaid and received

reimbursement for both the June and July visits.

Posted Tuesday, October 19, 2021 8:00 am

William Dale Robinson

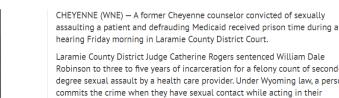
A 12- to 16-month sentence for a felony count of obtaining property by false pretenses in an amount greater than \$1,000 - associated with incorrectly billing Medicaid - will run concurrently with this sentence. Robinson had one day of credit for time served.

Robinson, who is 38, brought a cashier's check for \$6,397.36 to the courtroom. It's the amount he'd falsely claimed from Medicaid and he agreed to repay the sum to the Wyoming Department of Health's Division of Healthcare https://www.powelltribune.com/stories/drought-conditions-extreme-or-severe-in-park-county.37416

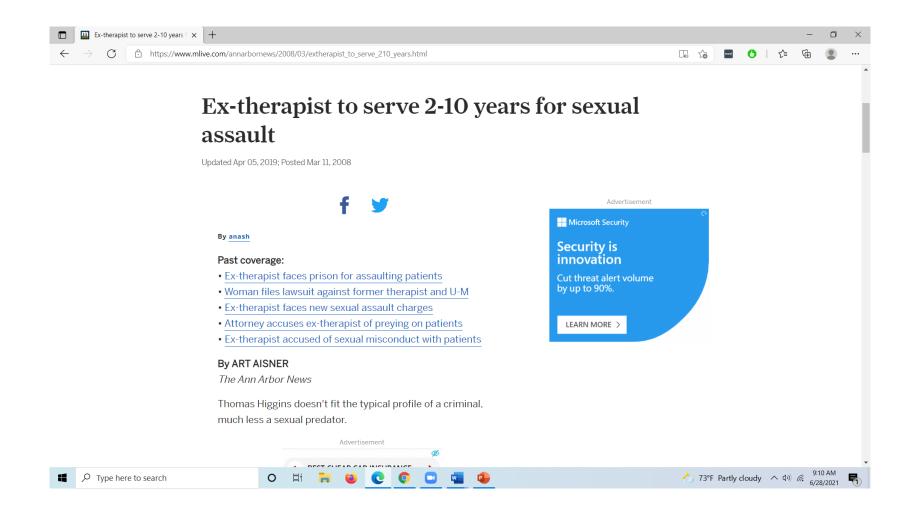
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The Consequences of a Digital Footprint



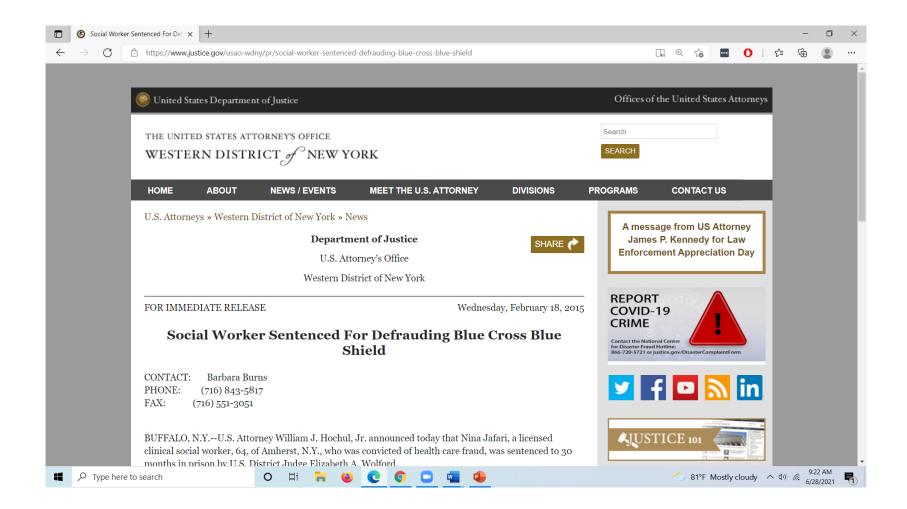
Fraudulent Documentation

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Practitioner Fraud



The Consequences of Fraud

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Standard of Care

What a *reasonable* and *prudent* practitioner, with the same or similar training, should have done under the same or similar circumstances.

Professional Negligence: Key Elements

- Clinician has a duty
- Evidence of breach or dereliction of duty concerning documentation
- Harm or injury
- Evidence of *proximate cause* (or "cause in fact" an uninterrupted causal connection between the breach of duty and harm)

Forms of Negligence

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- Acts of commission
 - Misfeasance (wrongful exercise of lawful authority; performing a proper act in an injurious manner)
 - Malfeasance (wrongdoing; performance of a wrongful or unlawful act)
- Acts of omission (or nonfeasance)

The Relevance of Documentation During Legal Proceedings

A typical attorney's request in a "Notice to Produce":

Papers, publications, drafts, telex messages, memoranda (whether formal or informal to the file or otherwise), notes, notations, interviews, data, work papers, diaries, agendas, bulletins, notices, announcements, minutes, folios, interoffice communications, interdepartmental communications (whether formal or information or otherwise), correspondence, books, transcripts, affidavits, statements, summaries, opinions, court pleadings, steno-graphic notes, indices, analyses, questionnaires, answers to questionnaires, telephone logs, lists; minutes of meetings and other reports, records or recordings of telephone conversations, conferences, meetings or other conversations, forms, studies, plans, specifications, evaluations, contracts, agreements, licenses, invoices, checks, drafts, vouchers, ledgers journals, books or records of accounts, bills, receipts, desk calendars, appointment books, calculations, charts, graphs, maps, surveys, drawings, shop drawings, renderings sketches, diagrams, schematics, data sheets, microfilms, price lists, tabulations, bids, bid materials, quotations, supplements, amendments, addenda, blue prints, statements of account, orders, purchase orders, brochures, pamphlets, manuals, warranties, literature, inspection re-ports, operation reports, maintenance reports, notebooks, communiques, requests for change orders, change orders, requests for information, requests for drawing approval, drawing approvals, punch lists, schedules, job calendars, cash flow studies, computer tapes, punch cards, computer printouts, data processing input and output, magnetic tapes, computer programs, computer program coding sheets, any retrievable data whether in computer storage or carded or taped or coded or stored electrostatically, electromagnetically or otherwise, and all transcripts thereof, programming instructions and other material necessary to understand the above-mentioned computer related items, all other records kept by electronic means, all other writing, and all things similar to any of the foregoing, regardless of their author of origin, however, denominated.

Assessing Your Documentation Protocol

To evaluate the quality of your documentation, conduct a thorough assessment of the policies and procedures you use to document. [The following protocol is excerpted from: Frederic G. Reamer, <u>The Social Work</u> <u>Ethics Audit: A Risk Management Tool</u> (Washington, DC: NASW Press, 2001). It includes an outline of key issues to address when you examine the adequacy of your documentation. The first section focuses on your *policies* and the second section focuses on your *procedures*.]

Assessing Documentation Policies

- Documentation: The agency has appropriate policies in place to ensure proper documentation.
- **1 point no risk**: clear, comprehensive policies exist concerning practitioners' documentation in client records, consistent with relevant laws, regulations, and ethical standards
- **2 points minimal risk**: policies concerning practitioners' documentation in clients' records exist, but require minor revision
- **3 points moderate risk**: policies concerning practitioners' documentation in client records exist, but require significant revision; policies concerning aspects of practitioners' documentation in client records need to be created
- 4 points high risk: existing policies are inadequate or are seriously flawed; policies need to be created to address a significant number of issues related to practitioners' documentation in clients' records

Key Content: Policy

- Social histories, assessments, and treatment plans
- Informed consent procedures
- _____ Contacts with clients (type, date, time)
- Contacts with third parties
- Consultation with other professionals
- Decisions made and interventions/services provided
- Critical incidents
- Instructions, recommendations, advice, referrals to specialists
- Failed and canceled appointments
- Previous or current psychological, psychiatric, and medical evaluations
- _____ Information concerning fees, charges, payments
- Termination of services
- _____ Final assessment
- Inclusion of relevant documents (for example, consent forms, correspondence, court documents, fee agreements

Assessing Documentation *Procedures*

- Documentation: The agency has appropriate procedures in place to ensure proper documentation.
- **1 point no risk:** practitioners routinely follow proper procedures when they document in clients' records
- **2 points minimal risk:** practitioners usually follow proper procedures when they document in clients' records, but there are exceptions
- **3 points moderate risk:** practitioners are very inconsistent in their use of proper procedures when they document in clients' records
- **4 points high risk:** practitioners rarely or never follow proper procedures concerning documentation in clients' records

Key Content: Procedures

- _____ Social histories, assessments, and treatment plans
- Informed consent procedures
- _____ Contacts with clients (type, date, time)
- Contacts with third parties
- Consultation with other professionals
- Decisions made and interventions/services provided
- Critical incidents
- Instructions, recommendations, advice, referrals to specialists
- Failed and canceled appointments
- Previous or current psychological, psychiatric, and medical evaluations
- _____ Information concerning fees, charges, payments
- Termination of services
- Final assessment
- Inclusion of relevant documents (for example, consent forms, correspondence, court documents, fee agreements)

Prepared by Frederic G. Reamer, Ph.D.

Online and Distance **Services:** Informed Consent

- Importance of revising standard consentto-treat form to address remote service delivery
- Sample documentation in chart: "In light • of the declaration of federal and state emergencies related to the COVID-19 virus, and the [state] Medicaid Program Instructions During the COVID-19 State of Emergency, pursuant to which [the state health insurance commissioner] instructed all health insurers to update their telemedicine policies to include remote services for behavioral health providers, I have suspended all in-person services and will exclusively use services via telephone and video. I will read and explain, as necessary, the attached informed consent form to all clients, answer all questions and document the verbal consent obtained from the clients."

Issues to Address During Informed Consent Process

- What telehealth means
- Continually assess appropriateness of telehealth
- Client can opt out of telehealth visit at any time, but during pandemic this may change social worker's ability to provide services
- Risks/benefits of telehealth
- Risks of interception/hacking, breach of confidentiality
- Electronic communications can be forwarded, intercepted, or changed without client's knowledge, despite social worker taking reasonable measures
- Client's location

Issues to Address During Informed Consent Process (continued)

- Electronic systems accessed by employers, friends or others are not secure and should be avoided
- Need to use secure network, not public WiFi
- Risk of sessions disrupted by technology failures; need to plan for that possibility
- Assume risk of using video platform that may not provide secure HIPAA-compliant protection
- Need back-up plan and safety plan

Issues to Address During Informed Consent Process (continued)

- Responsibility to take reasonable steps to protect client from unauthorized use of electronic communications by third parties; find private place for session where will not be interrupted, other people not present and cannot hear
- Importance of verifying client identity
- Failure to comply with procedures may terminate visit
- Responsibility of client to verify identity, credentials of provider
- In general, telehealth sessions may not be used for emergencies, time sensitive matters; social worker has limited ability to respond to emergencies; need for emergency contacts

Issues to Address During Informed Consent Process (continued)

- Limits related to non-visual communications, e.g., inability to see/interpret body language
- Confidentiality still applies, subject to usual exceptions
- No recording of any online sessions by either party
- If having suicidal or homicidal thoughts, actively experiencing psychotic symptoms/mental health crisis that cannot be resolved remotely, may need higher level of care
- Sample consent form—NASW Assurance: <u>https://naswassurance.org/pdf/telehealth-informed-consent.pdf</u>

Electronic Records: Ethics and Risk Management Advice

- Utilize appropriate clinical decision support tools, including alerts, guidelines, tracking, and reminder functions.
- If you choose to override or ignore an alert or reminder, document briefly the clinical justification.
- Avoid cutting and pasting.
- Ensure appropriate, applicable templates; understand the automatic populating features and default language.
- Ensure appropriate data input and retrieval.
- Periodically print out a client record and evaluate for adequacy. Would another clinician (such as a subsequent provider or an expert witness) be able to understand what happened in treatment and why?
- Understand metadata—and the fact that the user's every key stroke will be tracked and recorded.
- Ensure appropriate security protections on hardware (including portable devices) and software; an example is an automatic lock-out after a specified period of inactivity.
- Ensure compliance with federal and state confidentiality law, including confidentiality agreements with those third parties accessing your electronic health record.
- Prevent inappropriate access and disclosure; appropriate employee training is key.

Client Portals and Remote Access: Ethics and Risk Management Advice

- Define appropriate use.
- Determine how clients will communicate through the portal and what they should expect for a response turnaround time.
- Determine if clients will be permitted to upload information to be included in their record, how the information will be uploaded, and what types of information will be accepted.
- Develop and implement a portal user agreement that includes what the client may expect from the office practice. Describe unacceptable uses, such as emergency or urgent situations, and specify the consequences. Use the agreement as a teaching tool and as documentation of informed consent. Provide the client with a signed copy of the agreement and maintain a copy at the practice.
- Include language on the appropriate portal pages—such as the entry page and the messaging window—that clearly states the portal is not continuously monitored, must not be used for urgent communications, and that portal users are to call 911 in the event of a medical emergency.
- Consult with legal counsel to determine if your state has specific requirements.
- Determine whether and how the portal may be used by clients who are minors. This raises the question of
 whether and when parental access to the minor client's portal should be limited or completely restricted.
 Answers to these questions will be driven by your state's laws pertaining to services minors may obtain based
 on their own consent, and whether health information related to these services may be blocked from display
 on the portal to prevent parental access to the information.

Consider Conducting a Privacy Audit

Privacy audits are designed to ensure compliance with recognized standards. Practitioners can conduct privacy audits for the purposes of:

- detecting unauthorized access to client information;
- establishing a culture of responsibility and accountability;
- reducing the risk associated with inappropriate access;
- providing forensic evidence during investigations of suspected and known security incidents and breaches to client privacy, especially if sanctions against a workforce member, business associate, or other contracted agent will be applied;
- tracking disclosures of PHI;

(continued)

Privacy Audits (cont'd.)

- responding to client privacy concerns regarding unauthorized access by family members, friends, or others;
- evaluating the overall effectiveness of the organization's policy and user education regarding appropriate access and use of client information (this includes comparing actual workforce activity to expected activity and discovering where additional training or education may be necessary to reduce errors);
- detecting new threats and intrusion attempts;
- identifying potential problems; and
- addressing compliance with regulatory and accreditation requirements.

Steps in a Privacy Audit

- 1. Determine the activities that will be tracked or audited. Obtain and review documentation to determine whether audit controls have been implemented over information systems that contain or use PHI.
- 2. Select the tools that will be deployed for auditing and system activity reviews. Inquire of management as to whether systems and applications have been evaluated to determine whether upgrades are necessary. Obtain and review documentation of tools or applications that management has identified to capture the appropriate audit information.
- 3. Develop and deploy the information review/audit policy. Obtain and review formal or informal policies and procedures and evaluate the content to understand whether a formal audit policy is in place to communicate the details of the entity's audits and reviews to the workforce. Obtain and review an email, or some form of communication, showing that the audit policy is communicated to the workforce.
- 4. Develop appropriate standard operating procedures. Obtain and review management's procedures in place to determine the systems and applications to be audited and how they will be audited.



Strike a reasonable balance between including too much information and not enough information. Include information that is essential in order to be accountable to (a) the client, (b) colleagues/agency, (c) third-party payers, (d) utilization review organizations, and (e) courts of law. Avoid including gratuitous information, e.g., sensitive information that is not essential or warranted.

Less Documentation



- Gratuitous information It's not essential
- Potentially embarrassing information
- Information that could be misinterpreted by individuals who have access to the record (e.g., clients and their relatives/significant others, colleagues, attorneys)

More Documentation

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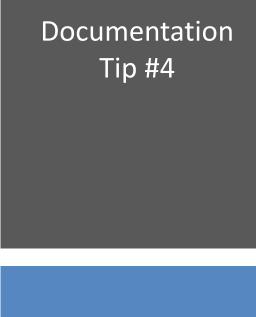
- Crises and critical incidents
- New information that is clinically relevant (including electronically generated, e.g., email, text, telephone)
- High-risk situations where there is a risk to client or other parties
- Legal action is likely (e.g., litigation, licensing board complaint)
- Interruptions in service delivery (e.g., failed appointments)
- Unusual circumstances during assessment (e.g., incomplete assessment forms)



Carefully review the language you use to document. Be careful to avoid *defamation of character*. Defamation of character occurs when (a) you say or write something that is untrue; (b) you knew that what you said or wrote was untrue or you should have known that it was untrue; and (c) the party you wrote or talked about was harmed. Defamation of character can occur in two forms: slander (oral communication) or libel (written communication).

 Handle documentation errors with great care. Avoid "white out." Acknowledge errors clearly and forthrightly.

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• Avoid ambiguous abbreviations.



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 Avoid broad characterizations: "poor outcome," "good result," "moderate compliance," "drunk," "aggressive," "combative" – always include specific evidence to support conclusions (e.g., ". .. as evidenced by ...")

• Do not "over document" in a crisis



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- Document as soon as possible.
 Common standards:
 - Critical incidents: within 24 hours
 - Significant changes in client needs: within 3 days
 - Indicators of progress toward goals: every 3rd service contact
- Edit carefully.
- Beware blanks.
- Write legibly.

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- Document your explanation of client's right to confidentiality and any boundary issues.
 - Confidentiality exceptions: Threat to self, threat to others, mandatory reporting, supervision/consultation, court orders.
 - $\,\circ\,$ Relevant laws and regulations.
 - Policies related to record storage, access by third parties (e.g., managed care organizations, insurers, employee assistance programs).
 - $\,\circ\,$ Social media policies.

• Do not document interventions before they occur.



Use correct grammar (credibility issue).



• Do not tamper with or alter records.



Prepared by Frederic G. Reamer, Ph.D.

 Do not document staffing problems in clients' records.



 Do not document professional disagreements ("jousting") in clients' records

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Beware spell-check

Candidate for a Pullet Surprise I have a spelling checker, It came with my PC. It plane lee marks four my revue Miss steaks aye can knot sea. Eye ran this poem threw it, Your shore real glad two no. Its very polished inn it's weigh. My checker tolled me sew.

(Zar, 1994:

http://www.bios.niu.edu/zar/poem.pdf)

• Document what you know, not what you think.



 Know how to respond to subpoenas of your records.



• Handle personal notes carefully; be aware of the risks.



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- Document carefully when providing services to couples or families.
 - Summary note for the group
 - Separate notes for group members' individual records when there is an unusual event that affects an individual client

 Become acquainted with key national and provincial regulations related to confidentiality and privacy.



69

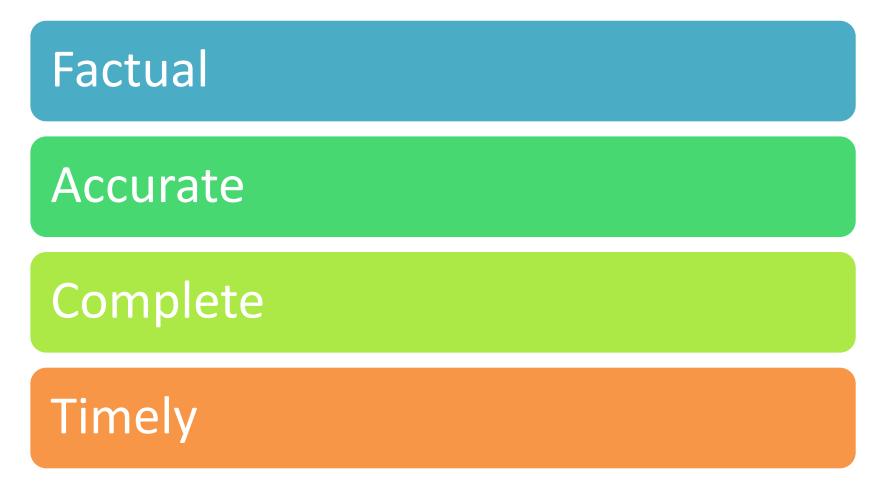
- Be familiar with provisions in pertinent state statutes, contracts, codes of ethics, and agency policies related to:
 - Client access to records (including online portals)
 - Record retention
 - Record storage
 - Protection of clients' and collaterals' confidentiality and privacy
 - Access to electronic records (especially in integrated settings)

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Beware electronic records risks:

- Copy-and-paste
- Auto population (e.g., dates of entry)
- Clients' remote access (portal)
- The importance of logging off
- Firewalls and break-the-glass protocols in integrated health settings

The "FACT" Approach to Documentation



Typical Progress Note

- New information about the client's needs
- Clinician's assessment of the status of the client's needs
- Steps taken toward completion of or movement away from the service plan
- Interventions and service activities
- Assessments of the purpose, goals, plan, process, and progress of treatment or service
- Changes in the purpose, goals, or service plan

(Kagle and Kopels, 2008)

Popular Documentation Format: SOAP

- Subjective information (client report)
- **O**bjective information (facts from practitioner's perspective)
- Assessment (practitioner's conclusions)
- Plan

Popular Documentation Format: SOAIG

- Supplementary data base information
- **O**bservations
- Activities
- Impressions
- Goals

Popular Documentation Format: DAP



- Data
- Assessment
- Plan

Supervision Notes

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- Guidelines given to supervisees (e.g., purpose of supervision, expectations)
- Issues addressed
- Supervisee's strengths
- Feedback from supervisor to supervisee
- Job performance reviews and expectations
- Recommendations regarding future job performance

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Version A: *Ms. A's health is* poor. She is not taking care of herself and isn't getting the services she needs.

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Version B: *Ms. A reports health problems related to her heart and diabetes conditions. She said that she feels depressed and is not getting the help she feels she needs.*

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Version A: Mr. T clearly is ready to be discharged.

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Version B: Mr. T meets the criteria for discharge, as evidenced by his: (1) satisfactory completion of treatment goals, (2) consistent compliance with staff recommendations, and (3) active participation in development of discharge plan.

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Version A: It was felt that Ms. D was high risk for substance abuse relapse. Assessed for SA.

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Version B: The treatment team reviewed and discussed Ms. D's clinical progress. The team concluded that Ms. D is at risk for substance abuse relapse, based on her inconsistent attendance at treatment groups and infrequent participation during group discussions. This writer met with Ms. D immediately after the meeting (2:30 p.m.) and assessed for substance abuse risk.

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Version A: Ms. L was hostile and resistant during her enrollment in our program.

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Version B: On three occasions, Ms. L did not respond to telephone messages to contact this program to schedule an appointment (date01, date02, date03). This writer mailed Ms. L a letter on (date04) asking her to call this office to schedule an appointment. On (date05), Ms. L called me and screamed, "You are never to call me again. Never." This writer encouraged Ms. L to make an appointment to discuss her concerns. Ms. L responded by saying, "I never want to see you again." This writer sent Ms. La follow-up letter on (date06) explaining her status in the program, inviting Ms. L to schedule an appointment, and providing Ms. L with a list of resources in the event she needs assistance.

(Humorous) Documentation Tips

The first set of rules (1-23) was written by Frank L. Visco and originally published in the June 1986 issue of *Writers' Digest*. The second set of rules (24-53) is derived from William Safire's *Rules for Writers*.

- 1. Avoid Alliteration. Always.
- 2. Prepositions are not words to end sentences with.
- 3. Avoid cliches like the plague. (They're old hat.)
- 4. Employ the vernacular.
- 5. Eschew ampersands & abbreviations, etc.
- 6. Parenthetical remarks (however relevant) are unnecessary.
- 7. It is wrong to ever split an infinitive.
- 8. Contractions aren't necessary.
- 9. Foreign words and phrases are not apropos.
- 10. One should never generalize.
- 11. Eliminate quotations. As Ralph Waldo Emerson once said, "I hate quotations. Tell me what you know."
- 12. Comparisons are as bad as cliches.
- 13. Don't be redundant; don't use more words than necessary; it's highly superfluous.
- 14. Profanity sucks.
- 15. Be more or less specific.
- 16. Understatement is always best.
- 17. Exaggeration is a billion times worse than understatement.
- 18. One word sentences? Eliminate.
- 19. Analogies in writing are like feathers on a snake.
- 20. The passive voice is to be avoided.
- 21. Go around the barn at high noon to avoid colloquialisms.
- 22. Even if a mixed metaphor sings, it should be derailed.
- 23. Who needs rhetorical questions?

(Humorous) Documentation Tips (continued)

- 1. Parenthetical words however must be enclosed in commas.
- 2. It behooves you to avoid archaic expressions.
- 3. Avoid archaeic spellings too.
- 4. Don't repeat yourself, or say again what you have said before.
- 5. Don't use commas, that, are not, necessary.
- 6. Do not use hyperbole; not one in a million can do it effectively.
- 7. Never use a big word when a diminutive alternative would suffice.
- 8. Subject and verb always has to agree.
- 9. Placing a comma between subject and predicate, is not correct.
- 10. Use youre spell chekker to avoid mispeling and to catch typograhpical errers.
- 11. Don't repeat yourself, or say again what you have said before.
- 12. Use the apostrophe in it's proper place and omit it when its not needed.
- 13. Don't never use no double negatives.
- 14. Poofread carefully to see if you any words out.
- 15. Hopefully, you will use words correctly, irregardless of how others use them.
- 16. Eschew obfuscation.
- 17. No sentence fragments.
- 18. Don't indulge in sesquipedalian lexicological constructions.
- 19. A writer must not shift your point of view.
- 20. Don't overuse exclamation marks!!
- 21. Place pronouns as close as possible, especially in long sentences, as of 10 or more words, to their antecedents.
- 22. Writing carefully, dangling participles must be avoided.
- 23. If any word is improper at the end of a sentence, a linking verb is.
- 24. Avoid trendy locutions that sound flaky.
- 25. Everyone should be careful to use a singular pronoun with singular nouns in their writing.
- 26. Always pick on the correct idiom.
- 27. The adverb always follows the verb.
- 28. Take the bull by the hand and avoid mixing metaphors.
- 29. If you reread your work, you can find on rereading a great deal of repetition can be by rereading and editing.
- 30. And always be sure to finish what

The Importance of Careful Wording and Documentation

A panda walks into a café. He orders a sandwich, eats it, then draws a gun and fires two shots in the air.

"Why?" asks the confused waiter, as the panda makes towards the exit. The panda produces a badly punctuated wildlife manual and tosses it over his shoulder.

"I'm a panda," he says, at the door. "Look it up."

The waiter turns to the relevant entry and, sure enough, finds an explanation.

Panda. Large black-and white bear-like mammal, native to China. Eats, shoots and leaves."

From Lynne Truss, <u>Eats, Shoots & Leaves</u> (New York: Gotham Books, 2003).

The Importance of Careful Wording and **Punctuation: Examples** from Lynne Truss, Eats, Shoots & Leaves

- A woman, without her man, is nothing.
- A woman: without her, man is nothing.
- The people in the queue who managed to get tickets were very satisfied.
- The people in the queue, who managed to get tickets, were very satisfied.
- A cross-section of the public.
- A cross section of the public.

Resources:

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- Luepker, Ellen. *Record Keeping in Psychotherapy and Counseling* (2nd ed.). New York: Routledge, 2012.
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- Reamer, Frederic G., *Risk Management in Social Work: Preventing Professional Malpractice, Liability, and Disciplinary Action.* New York: Columbia University Press, 2015.
- Reamer, Frederic G., *The Social Work Ethics Audit: A Risk-management Tool.* Washington, DC: NASW Press, 2001.
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- Sidell, Nancy, *Social Work Documentation* (2nd ed.). Washington, DC: NASW Press, 2015.
- Wiger, Donald, *The Clinical Documentation Sourcebook* (4thed.). Hoboken, NJ: John Wiley, 2009.