

STANDARD: DOCUMENTATION

PURPOSE

The purpose of these standards is to provide direction and guidance to the Children and Family Services (CFS) programs regarding case record documentation. These standards are 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 standards 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 our funding sources.

Definitions:

Contact: For purposes of documentation, 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 a letter. For example, when a social worker goes to the home to see the family or child, it is considered a contact, not a visit.

Visit: For purposes of documentation, a visit is defined as face-to-face contact between a child in out-of-home care with his or her family. It is the primary mechanism through which family relationships are maintained while a child is in out-of-home care. Visits may be with parents, grandparents, relatives, siblings, and other individuals with whom the child has previously established a significant relationship.

STANDARDS

Basic documentation of a case record will be entered in FOCUS. Information that can not be entered in FOCUS such as court documents, medical evaluations, school records, signed consent forms, correspondence, and critical incident reports must be kept in a file in an area that can be locked for purposes of confidentiality.

Documentation will occur at intake, assessment, and service planning according to procedures set forth in the respective standards. Information that is obtained during or considered part of the immediate safety or comprehensive assessment will be documented on the assessment screens in FOCUS. This will 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. An example of case management functions includes meeting with the resource family with placement information or to give 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 below:

Contact with Families and Other Parties

Contact between CFS staff and the child, family members, resource families, and/or other professionals, will include the following:

- Date of the contact;
- Method and location of the contact (face-to-face, telephone call, home, office, work).
- Names of individuals with whom contact is made;
- Name of individual making the contact;
- Notation of failed or cancelled appointments;
- A brief summary of contacts occurring during the month, including the purpose of the contact and relevant information derived from the contact. All contact descriptions should be written in complete sentences and will include a brief description of the social worker's/clinician's reasoning for all decisions made during or as a result of those contacts.

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 who is monitoring the visit;
- Children and adults who were 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.
- Immediate Safety Assessment -- The immediate safety assessment shall be completed 5 working days after seeing the child.
- Comprehensive Assessment --A comprehensive assessment shall be completed thirty days after seeing the child.
- 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 and signed 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 within 30 days of the child residing in foster care for 90 consecutive days.
- An independent living plan shall be completed within 30 days of the completion of the Ansell Casey Assessment.
- Social History and Information regarding Birthmother, Birthfather, and Child Forms – Obtaining this information should be one of the early steps of a Concurrent Plan; 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 following the pre-placement home study 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.

- In all documentation, record facts, with clear behavioral descriptions. Avoid judgments or statements that could be misinterpreted or show disrespect;
- Record only information that is relevant to the case and be concise. 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. Summary notes are structured to require social workers/clinicians to 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.
- Avoid documenting your emotions or opinions;
- 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,
 - (g) Concurrent Planning decisions.
- Do not keep "private" files with information separate from the official case record.

Any variance to these standards will be documented and approved by Division administration, unless otherwise noted.

STATE OF IDAHO
DEPARTMENT OF HEALTH AND WELFARE
FAMILY AND COMMUNITY SERVICES
CONTACT VISITATION SUMMARY REPORT
FAMILY : DAWSON, ANGELA - CHILD PROTECTION
10/01/2004 - 10/26/2004

| Date | Contact/Visit Id | Type | Participants | Location Length | Method Results Role | Staff | Name Staff Id |
|--------------|------------------|---------------|--------------------------------|-----------------------------------|---|---------------|-----------------------------|
| ===== | | | | | | | |
| OCTOBER 2004 | | | | | | | |
| 10/01/2004 | Contact 92 | Alternate Car | ALLEN, DARLA DAWSON, TROY | Foster Home 45 Minutes | Face to Face Successfully Completed Foster Mother Child of Concern | Performed by | ATLEY, MOIRA SUPER 00015 |
| 10/03/2004 | Visit 91 | Parent/Child | DAWSON, TROY DAWSON, ANGELA | Office 1 Hour | Face to Face Successfully Completed Child of Concern Mother | Supervised by | ATLEY, ROSLIN 00004 |
| 10/05/2004 | Visit 93 | Parent/Child | DAWSON, TROY DAWSON, ANGELA | Foster Home 1 Hour, 30 Minutes | Face to Face Successfully Completed | Supervised by | Mrs. Allen, Foster P |
| 10/06/2004 | Contact 94 | Other | Gomez , Jaunita | Other 20 Minutes | Telephone Successfully Completed Substance Abuse Provider | Performed by | ATLEY, ROSLIN 00004 |
| 10/06/2004 | Contact 95 | Other | Smythe , Gloria | Other 15 Minutes | Telephone Successfully Completed Health Care Professional | Performed by | ATLEY, ROSLIN 00004 |
| 10/08/2004 | Visit 96 | Parent/Child | DAWSON, TROY DAWSON, ANGELA | Foster Home 1 Hour, 30 Minutes | Face to Face Successfully Completed Child of Concern Mother | Supervised by | Mrs. Allen, Foster P |
| 10/11/2004 | Contact 97 | Family | DAWSON, ANGELA | Office 20 Minutes | Face to Face Successfully Completed Mother | Performed by | ATLEY, ROSLIN 00004 |
| 10/15/2004 | Visit 98 | Parent/Child | DAWSON, TROY DAWSON, ANGELA | Foster Home 1 Hour, 30 Minutes | Face to Face Successfully Completed Child of Concern Mother | Supervised by | Mrs. Allen, Foster P |

* * * * * END OF REPORT * * * * *

For Family: FAMILY 0000000361 - DAWSON, ANGELA

All Service Areas
All Dates
Ascending within Family

| Create Date | Create Time | Service Area | Created By Name |
|-------------|-------------|------------------|------------------------|
| 10/15/2004 | 16:23:01.1 | Child Protection | 00007 - COVELLI, VICKI |

Object Type
Narrative Text

10/15/2004 16:23:01.1 Child Protection 00007 - COVELLI, VICKI
Month Served

Angela kept four out of four scheduled visits with Troy. During the visitation, she interacted with Troy by reading him storybooks, reciting "Three Little Monkeys Jumping on the Bed" and holding Troy in her lap. During the visit on 10/05/04, Troy laid on the floor and screamed because he wanted ice cream. Angela placed him on a chair for a time out for 3 minutes and continued to talk softly to him.

In reviewing Angela's Service Plan with her, she said she did not begin her outpatient group with Road to Recovery because they have a waiting list. On 10/06/04, I called Road to Recovery and spoke with Jaunita Gomez, Substance Abuse Provider. Ms. Gomez confirmed that Angela is number two on the list and will be eligible to attend a new group that will begin 11/25/04

Troy had an EPSDT Assessment on 10/04/04. Ms. Smyth, EPSDT Evaluator, recommended that Troy receive Early Language Development services. An appointment was made for 10/20/2004. According to the Service Plan, Angela will attend future appointments with Troy. On 10/04 /04, she was given a card with the date of the appointment as a reminder. Angela agreed to arrange transportation with a friend.

Mrs. Allen, Troy's foster parent, reports that Troy is adjusting well to care. He sleeps through the night and is eating meals. Troy hans on Mrs. Allen's leg when company comes. Mrs. Allen says she gives him reassurance by patting him on the back and after awhile he will leave her side and play nearby. Mrs. Allen will meet Angela at the EPSDT Assessment. Mrs. Allen states she sees no unmet needs for Troy.

***** End of Report *****