Partner Policy: Clinical Documentation

Introduction

Accurate documentation of service provisions is an essential aspect of WPO quality management and good documentation practices are critical to the success of the organisation. Effective documentation is essential in any potential litigation. Without it, WPO, partners and individual clinicians, could be open to serious challenge from complaints. Inaccurate, incomplete or misrepresentative documentation could be extremely damaging for a participant if produced in a Court of Law. Everyone delivering the WPO service is utilizing the same set of participant documentation so it is essential that this documentation should be clear, concise, correct, complete and comprehensible.

Policy

It will be agreed with WPO during a partner implementation whether the documentation produced by the partner will be provided in English or in the partner's local language.

As dictated by professional guidelines, quality guidelines and the law, all contact with those using the WPO service via a partner, along with any other action that is taken on a case, will be documented (whether in hard copy or electronic form) as appropriate to the service(s) provided. This record will remain in the possession of WPO, and WPO will retain ownership and primary responsibility for its maintenance.

According to data protection guidelines, participants who use the EAP service will have access to a copy of their records, both in a report format and, in some instances, in the form of a complete record of interactions with the service, upon their appropriately authenticated request. Therefore, case details will be composed in such a manner as to reflect participant interactions and overall service provision objectively and with accuracy.

Accurate and timely documentation is essential to EAP operations. All documentation should be completed as soon after the interaction with the participant as possible and must be completed on the WPO Case Management System by the end of the working day. Any action taken by a clinician on a case, for example a case review with and agreed outcome with clinical management, should also be immediately documented.

WPO is a 24/7 365-days-a-year operation so all clinical notes must be presented clearly and concisely such that any WPO or partner employee can efficiently and accurately absorb the information held within them and progress the case appropriately in the absence of the clinician who originally produced them. All EAP clinicians will utilise the same set of documentation rules or guidelines. The documentation will always be clear and the message concise.

Care will be taken to ensure that all clinical documentation is reflective of the gender with which the participant identifies. This includes being gender-neutral where appropriate.

The outcome of any conversation with a participant, highlighting the way forward that was agreed and what expectations were set, will be clearly documented.

Partners will ensure that no abbreviations are used during the production of their clinical documentation; all documentation must be spelt out in full.

Clinical Practice

- Clinical notes will be recorded objectively. They will not exaggerate the discussion nor will they be partly based on the clinician's interpretation of the interaction. For example, a clinician would not record: "The participant had a right to go at me" or "The participant rattled on and on." Rather, a more objective approach would be: "The participant stated that they were angry, frustrated and unhappy with the services provided" or "The participant talked at length on this issue and, sometimes, without clear focus."

- For clinical judgments, clinicians must be careful not to be too conclusive. EAP clinicians do not diagnose. Global statements like "the participant is depressed" should not be used, but rather the emphasis placed on the symptoms the participant is reporting: "the participant reports symptoms of depression." This in turn would be qualified with objective examples from the participant's own description of these symptoms.

- Case notes document what a participant has reported, and clinicians must be careful not to document this as fact; but rather present it as the participant's experience. For example, where a participant states, 'My boss bullies me' this should be documented as 'The participant reported that they feel bullied by their boss' and then provide examples of why the participant is feeling bullied.

- All notes will be reviewed and edited before being saved onto the case management system. Accuracy in all respects will be checked, including wording, spelling, content, and grammar. All means available, including a computer spell check, will be utilised to ensure that the final version is the most accurate.

- Case notes will be written to be read by a third party. Case records may be used in hearings and other legal proceedings, where third parties will review the actual details of the participant interactions with the EAP. Once case notes are saved onto the case management system, they cannot be struck out or changed. In certain circumstances, a case record could be amended (with additional information or corrections), however, no information can be removed once it has become part of the case record.

- Particular care needs to be taken when documenting cases involving potential risk. Risk of any kind; risk of harm to self/others, child or vulnerable adult, abusive relationships or any risk arising out of substance use, will always be documented. It is critical to ensure that any risk factors are noted on the record, but also that there is sufficient detail to identify the level of risk, the actions taken (including discussion with a supervisor), and any follow-up activities that are required. Clinicians will be objective, clear, and thorough in their description, as these notes could be used as a primary source of information for further crisis management, and to verify that all appropriate actions were taken. In the rare instances when a risk assessment is not completed as appropriate, this needs to be accurately documented to determine if follow up action is required. A summary of participant risk will be provided with the presenting issue, with specific detail documented in the risk section of the Assessment. Any documentation requirements for specific types of risk are detailed in the appropriate Policy.

- Case notes are used to summarize, capture, and document any interaction with a participant, or any action associated with their case. All case notes will record the purpose of the interaction with the participant, the clinician's intervention (i.e. what the clinician did for the participant), how the participant responded to this intervention and a plan detailing the next steps agreed with the participant.

- Internal e-mails will not be copied into a case note; instead internal conversations (whether via email, instant messaging or an in-person, telephone or video discussion) will be summarized into a case note with a clear indication of what follow up action Is required as appropriate. E-mails from outside sources can be copied directly into a case note.

- All documentation should reflect the depth of the conversation with the participant. The notes recorded on the Case Management System should not be a verbatim, word for word account of what the participant said throughout the whole course of the conversation but rather should summarise all of the main presenting issues as disclosed by the participant; providing the reader with a real sense of what occurred during the conversation**.**

- Special care must be taken with the use of pronouns. These must be accurate as using the wrong pronoun risks completely changing the meaning of a sentence.

- The rule of thumb is not to withhold any information that could be useful in the ongoing management of a case. For example, if a participant's circumstances are discussed with Clinical Management, and a way forward agreed, the details and outcome of the conversation must be accurately noted on the case: 'Discussed the Case with a Team Lead' is simply not enough.

- Where clinicians adopt standard canned conclusions, they must ensure that these are edited, where necessary, to accurately reflect the interaction with the participant.

- The case documentation will record who provided the Call Recording (where appropriate) and Confidentiality Statements to the participant and whether the participant objected to having the call recorded or requested that the call recording be deleted at any time during the conversation. Any supplementary questions raised by the participant with regard to the confidentiality statement will also be recorded in the notes.

- The clinician will also document whether the participant refused, or was unable, to complete the Outcome Rating Scale (ORS). Where the clinician chooses not to ask the ORS questions, the reason for this should be documented.

- Directly quoting a participant can be very powerful in highlighting something that is of significance to them and is often helpful in describing not just what, but how, a participant presents on the call. It is at the clinician's discretion whether they document a participant's use of slang/swear words but where they are included, they must be in direct quotes.

- Clinicians must think carefully about the language they use to describe their interactions with participants to ensure the words selected best reflect not just what was actually said but the way in which it was communicated. For example, 'The participant stated….' implies the participant was very confident and firm in their communication while 'shared' or 'expressed' may be more reflective of less surety.

- All case notes will be signed and credentialed by the clinician completing the documentation.

- Clinicians will ensure that they are very clear in their documentation when they suggest to a participant that the latter engage with a particular resource. Abbreviations will not be used to describe the resource to ensure that any clinician accessing the case who is unfamiliar with that resource will understand what it offers. For example, the NSPCC would be documented as the National Society for the Prevention of Cruelty to Children making it clear to those unfamiliar with that organisation what it provides.

CHANGE HISTORY:

Document Original Author: Alison Brown; Vice President Global Clinical Quality

Stakeholders: Global Infrastructure, Clinical Operations, Quality, Learning & Development, Sales & Account Management.

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