Newfoundland & Labrador
College of Social Workers

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Documentation Matters: Tip #13

I work in frontline service delivery: What should I include in my social work documentation?

Social workers have a professional and legal obligation to complete documentation. While context of practice, organizational policy and individual writing styles shape social work documentation, it is imperative that client records "contain all information that is clinically relevant and significant to the service delivery" (NLCSW, 2020, Standards of Practice). At a **minimum**, client records should include:

- Client's name and contact information (e.g., address, phone number).
- Professional assessment of client's needs and treatment goals (identifying client's expectations from the social worker-client relationship and what they hope to achieve).
- Client informed consent (dialogue with client on benefits and limitations of proposed intervention, how information is documented and shared, limits to confidentiality, etc.), and updated as necessary (e.g., change in treatment plan, reassessment of client capacity, disclosure of client information).
- Progress notes that reflect professional decision-making and outcomes of service delivery (dates of client contact and clinical notes in chronological order).
- Risk assessments as appropriate (this may also include the assessment of client capacity).
- Communication with other professionals/collateral contacts to support service delivery.
- Emergency planning, particularly when providing e-services (e.g., power or internet interruptions, medical emergencies, safety concerns).
- Statement of when and why the professional relationship ended, including referrals for follow-up services (closing summary note is recommended).
- Fee for service agreements (private practice) and any changes in agreement.

For more information related to social work documentation, visit the NLCSW website www.nlcsw.ca.