MARCHES COUNSELLING SERVICE:

Clinical note writing

Includes guidance on: Note writing & the law

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Document Type: Protocol

Reference: P-014

Document Author: Clinical Management Team

Document Purpose: Protocol for the recording and keeping of clinical notes; how this relates to legislation and rights of clients access

Responsible Group: Board of Trustees, Clinical Management Team

Date Ratified:

Where this is to be held: in the main MCS office, digitally

Information from/sourced/referenced:

- Note Writing & the Law (2014, BAAT policy)
- Standards and Ethics for Counselling in Action – Bond, Tim (Sage 2015) chapter 15
- MCS staff handbook
- MCS policies and procedures folder

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Version History:

Reference Number	Circulation Date/Reviewed	Job title/ name of group circulated to
P-014	July 2019	CMT
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Contents:

This protocol provides general guidance for practitioners on keeping written records of counselling/therapy sessions as well as standards of clinical note taking in relation to the legal process. Privacy & disclosure of information pertaining to clients is not covered here but can be found in the confidentiality policy (C-002).

2. Types of notes and their constraints

2.1 Notes made in MCS of information shared by a client at referral, during assessment, and in ongoing counselling sessions fall into three categories, informal, process and formal.

2.1.1 *Informal* refers to the notes taken when talking to a client or as an aide memoire afterwards, so as to complete the *formal* documents, namely the client index card, the assessment su*m*mary and session notes. The *informal* notes are destroyed as soon as the formal record is created unless being held as process notes for the purpose of training.

2.1.2 *Process* notes refer to the writing practitioners do in order to process the psychological content of sessions. They are not kept as part of a client's clinical record and do not contain information that might identify a client. Such notes are

destroyed when they are no longer useful to the current work, i.e. following supervision.

2.1.3 *Formal* records are completed on the standard MCS forms.
All demographic and identifying information is held separately and securely by admin. This is to ensure confidentiality and compliance with data protection legislation and includes an index card and all signed agreements.
Clinical files containing the assessment summary and session notes are held in a locked cabinet accessible to the counsellors under an identifying number.
These do not contain identifying information such as peoples' names, whether the clients, or people referred to in discussion. In respect of the latter reference can be made to the relationship, such as daughter or partner.

2.2 The BACP ethical framework states: notes that form a clinical record should be "adequate, relevant and limited to the service being provided" (In this respect, MCS being the context, this document, the other policies and protocols referred to below and the Staff Handbook, provide the context for the *service being provided*.

2.3 Legally, clinical notes are the record that the practitioner produces to represent the clinical work that they have been doing with a client to third parties with *vested interests*. People considered as having vested interests in this context is limited but it is important for the practitioner to know who they are. Also a *vested interest* should not be considered to mean 'have routine access or permission to view notes'.

2.3.1 For the purposes of MCS those with vested interests are:

- **Managers** – (clinical managers & supervisors) clinical notes provide evidence of service delivery & information for governance purposes
- **Other counsellors/clinicians** – case transfer, handover, continuity of care
- **Clients** – access to records, freedom of information act & data protection act
- **Professional bodies –** code of ethics, professional conduct guidelines
- **Court of Law** – duty of care, negligence, consent
- **Practitioners –** aide de memoire, continuity of treatment, formulation

3 Clinical note writing guidance: sessions

3.1 Format. All session notes should:

- ✓ be on the printed MCS sheets provided
- ✓ have the therapist name clearly printed at the top
- ✓ record the session number and be signed and dated by the practitioner
- ✓ have a record, if only the word 'attended'
- ✓ be legible
- ✓ be contemporaneous (within a week)
- ✓ document telephone conversations, whether this is via text or a voice call unless this is simply to arrange an appointment
- ✓ record changes in the record by a single line through them, leaving them legible, not using correction fluid.

3.2 Content. Session notes should:

- ✓ be concise
- ✓ not refer to the client by name or abbreviations
- ✓ be limited to factual statements of what occurred in the session, or brief phrases to serve as 'aide de memoire' for the following sessions
- ✓ avoid the practitioners' thoughts, reflections or suppositions
- ✓ include any additional evidence of patient history
- ✓ include information with regard to any change in risk that deviates from the assessor's initial report, including observations of fluctuations in levels of distress.

3.3 Common faults in clinical notes include:

- unexplained discontinuities
- illegible or poor handwriting
- ambiguous abbreviations
- using jargon
- violation of legal concepts
- lack of evidence for statements made
- using diagnostic terms that the practitioner is not qualified to make

3.4 Further support & guidance.

3.4.1 Clinical supervision provides a context for discussing good practice approaches to writing case notes. Trainees can discuss note writing methods with their supervisor.

3.4.2 All practitioners have a yearly review with their group supervisor. They may be asked about their notes and whether they feel confident about what they are recording. In this context notes might be reviewed and guidance provided.

4 Process if legal proceedings emerge during an ongoing counselling/therapy relationship

Refer to the Court Action Protocol (P-006 section 4) and Clients in the Criminal Justice system (C-003)

5 Letters & correspondence with clients

5.1 Letters to clients should follow the same general principles that apply to file notes in terms of referring to what is factual as well as justifiable and refrain from conjecture and supposition

5.2 All letters should be sent on MCS headed paper. The text of the letter may be sent to the office for formatting and sending if the practitioner doesn't have the facility to do this.

5.3 There are pro-forma letter templates for common circumstances such as non-attendance and ending therapy

5.4 If a practitioner is unsure about how to correspond in writing with a client when this is indicated or required, the wording of the letter should be discussed with the supervisor

6 Clients right to access notes

6.1 Under the data protection act clients have the right of access to their notes. The only exception to this is when it is believed that such access would be detrimental to the client's mental state. In this situation it is legally permissible to remove certain information.

6.2 Clients may request to see their notes personally, or that copies be sent to a third party.

6.2.1 Clients wishing to read their notes should be invited in to the office to do so, with their therapist or one of the senior clinicians (ideally the counsellor's supervisor) who can answer any questions they might have.

6.2.2 Clients giving written permission for copies of notes to be sent to a third party, for example a solicitor, should be contacted prior to any copies being released. The duty of care to the client necessitates that they understand how material in their notes may be used by the legal profession or others to support the claims made by others against them. Only once this conversation has taken place will copies of notes be released and the conversation should be documented in the client's file.

7 Relevant MCS documents & other sources of information

- BACP Ethical Framework for the Counselling Professionals (July 2018) – Point 15
- BACP Good Practice in Action 066 - What do we mean by records and record keeping within the counselling professions?
- Clients in the Criminal Justice System (C-003)
- Clinical management - staff responsibilities & duties (P-015)
- HCPC Standards of conduct, performance and ethics (2016)
- MCS staff handbook (2019)
- Standards and Ethics for Counselling in Action – Bond, Tim (Sage 2015) chapter 15