

# Effective Documentation

- **Case documentation should be as accurate as possible:**
  - Case record should be as accurate as possible. If worker learns that information is incorrect, add updated accurate information to the case record. **NEVER** erase original information.
- **Record facts not judgments:**
  - Case records should concisely record what the worker sees, hears, and experiences while working with a family. They should document facts and clear behavioral descriptions. Example: "The house was dirty" vs. "There was food and clutter all over the floor, un-rinsed, dirty dishes piled in the sink and sitting on the table, and the trash was overflowing from the garbage can and creating a noxious odor."
- **Use behavioral-anchored language:**
  - Avoid using jargon: Ex: "Derek was acting out" vs. "Derek skipped school and was caught shoplifting."
- **Record only relevant information, and be concise:**
  - Avoid extensive, unnecessary, run-on information.
  - Use quotations to paint a vivid, concise picture of the family. Ex: "Mrs. Jacobs seems very depressed," vs. "Mrs. Jacobs said, "Of course I'm depressed. Wouldn't you be if you were in my situation?"
- **Summarize activities in lists, not narratives:**
  - Record the date of contact, who was seen, the purpose, and the outcomes in a list or chart. It is easier to understand the sequence of contacts and the important outcomes of the visit than if they are buried in a paragraph of description.
- **Use summary dictation whenever possible, not process recording:**
  - Avoid a "running record" (verbatim blow-by-blow descriptions of what happened) because it is wordy, redundant and confusing, and doesn't get to important information quickly. Summary recording is a concise summarized description of important facts and events in the case that enables the reader to quickly discern family's needs, services provided, and outcomes.