MAKE A MELODY
*Arts Therapy and Counselling*

# Writing Clinical Notes

*"Our memory is not the most reliable recording keeping tool. Therapists have long relied on notes to track client progress and maintain continuity from session to session. Remembering previous sessions is a basic demonstration of respect for our clients"*

– Rao, 2023

Clinical notes summarise the content of each session with a client. They are variously described as session notes, case notes, or consultation notes and they form a significant part of the Client's Record.

Clinical Notes are an integral task of our professional practice and an ethical requirement for all counsellors and therapists. Make A Melody commits members to standards of practice that will support safe, high-quality services for clients and enable those who work to the code to reflect on the ethical dimension of their practice and to make responsible ethical decisions in complex situations.

These guidelines provide good practice guidance to enable members to align with Make A Melody's ethical framework in writing their clinical notes.

## Why do we write Clinical Notes?

Bond (2015) writes that the purpose of clinical notes is to support our work with clients. The writing process itself provides us with the opportunity to review, self-monitor, reflect on, and be clinical accountable for our work.

We need also to bear in mind that clinical notes have legal implications, including court subpoenas and the client's right of access to read what has been written about them.

As such, the purpose of clinical notes is to:

- Allow for accurate recall of relevant client information and assist us in understanding the client's needs and concerns
- Ensure good decision-making with a view to providing the best possible client care and outcomes
- Allow for uninterrupted continuity of care if the client is seen by another practitioner
- Allow us to represent the client's concerns and needs whenever required by another person, for example, if a referral becomes necessary or in the case of a court subpoena.

We are also mindful that:

- In the event of ethical or legal proceedings, accurate and factual clinical notes provide clear and concise documentation of the client's continuum of care
- Clinical notes provide protection from professional liability. Accurate, clear and factual clinical notes help to protect us from complaints made against us or in cases where a client's recall significantly differs from ours.

## What information should we include?

Clinical notes should include impartial, respectful and accurate chronological summaries of interactions, observations and interventions used during client sessions.

When deciding on what information to include in a clinical note, the guiding principle is whether it is relevant to the specific service or intervention being provided.

Since the primary purpose of clinical notes is to support our work with the client, clinical notes typically contain:

- Date and time of attendance and session number
- A summary of what the client shared and what was objectively observed by the practitioner
- A record of interventions used by the practitioner
- A record of any strategies pursued, and any actions taken, with an explanatory note for such actions
- Any correspondence and contact since the previous session
- Any homework set
- Details if a referral has been made
- Plan for future sessions.

In writing our clinical notes the question to ask is; "if I were to be called upon by a court to divulge my notes, would they be adequate and defensible?" If in doubt, supervision provides a safe space for discussion.

## Is there a particular style to use?

While Make A Melody does not prescribe what type of clinical notes you adopt, a variety of clinical-note approaches are available. These range from those offering general guidance, such as a summary style, while others are specific to a service or context. For example:

- SOAP notes (Subjective Data, Objective Data, Assessment and Plan)
- BIRP notes (focus is on Behaviour, Intervention, Response and Plan)
- DAP notes (focus is on Data, Assessment and Plan).

Notes for group work may differ from those described above and may include:

- A group summary or outline, identifying information for each member of the group
- Objective information on each member's mood and body language
- Notes on each member's participation, behaviour and response to other group members
- A description of issues and events between the members of the group

- Objectives and goals for each group member and how each member might achieve them
- Interventions used to address each client's goals
- Responses of individual members, for example, feedback and suggestions about the process
- Plans for future sessions including homework for each member.

This list is not exhaustive; for further details on each, please see here.

Each of us will develop our own method of note-taking, and, in most cases, the style will be relevant to our particular context and workplace.

## What not to include in clinical notes

This list provides some good guidance on what not to include:

- Do not use language that could be deemed derogatory by the client. Write as if the client will be reading our notes.
- Do not use subjective opinions that are not substantiated. For example, subjective opinions must always be qualified by relevant background information, theory or research.
- Do not include any extraneous information that is not relevant to the client's care.
- Do not use emotive language.
- Do not use abbreviations that are not recognised in our field of practice.

## Timeliness of clinical notes and making amendments

- Writing notes close to the time of the service provision will ensure they are as accurate and up-to-date as possible. The Policy is that all clinical notes should be made the same day as the session took place. Anything after this is unacceptable.
- The goal should be to minimise the amount of information included in our clinical notes with the aim of meeting a client's desired outcomes. Guidance on how to write notes that are brief, relevant and limited to what is necessary in the context of the service provided can be found in Bond (2015).
- Should it be necessary to make amendments to our clinical notes, best practice is the inclusion of the date of the amendment and if stored electronically, both the original and amended note should be stored.
- Re-writing notes or changing or removing information with the intention of preventing disclosure is an offence.

## References

Bond, T. (2015). *Standards and ethics for counselling in action (4th ed.)*. Sage.

Rao, K. (2023). *Case notes and record keeping in therapy.* eiseEducation. Retrieved from eiseeducation.com/live-webinar