Guidelines On Case Notes

A case note is used to identify, describe, and assess the client's situation. It allows for a clear communication and description of the client's progress and what has occurred. It is also a tool that can be used to review what kind of service a client has received. **<u>All notes must be dated and signed with the volunteer's full name.</u>**

<u>CASE NOTE ACRONYM: S (subjective), O (Objective), A (Assessment), and P (Plan)</u>

<u>Section</u>	**<u>Definitions</u>**	**<u>Examples</u>**
Subjective(**S**)	• What the client tells you. • What caregivers and significant others tell you. • How the client experiences the world.	• The client's feelings, concerns, goals, thoughts. • Relevant (applicable to the client) comments by family, caregivers. • The client's orientation to time, place, person.
Objective (**O**)	• Factual information you observe (i.e. See, hear, smell, touch, etc.). • No personal opinions.	• Client's appearance, affect, behaviour.
Assessment(**A**)	• Describe any factors that may require consideration. • Are there suggestions that could be given to the caregivers that would enhance client safety and care? • ***Does the Care Plan need to be revised?***	• ***Is the care plan still appropriate given what you have observed?***
Plan (**P**)	• ***What is the action plan?*** .	• Next step needed.

Do's and Don'ts in Writing your Case Notes (I.e. SOAP)

DO

- Be brief and concise
- Keep quotes to a minimum
- Use an active voice (ie the client slept a lot)
- Use precise and descriptive terms
- Record immediately after each visit
- Start each new entry with date and time of visit
- Write legibly and neatly
- Use proper spelling no abbreviations or symbols

Don't

- Avoid using names of family members or others named by client
- Avoid terms like seems or appears
- Avoid value-laden language (labeling) and opinions
- Avoid using terminology (technical terms)
- Avoid writing between lines or in margins

General Considerations:

- Ensure that the client is aware that you are taking notes within the "circle of care". That the notes are kept confidential.
- After consultations with the client and caregiver, notes may be written in French or English but the writer must be available to translate their case notes if necessary.

Storage of the Binder:

In the Home: in safe place where caregivers and volunteers have access (i.e. top of fridge with the CCAC binder if possible)

Long-Term Care Facility: in designated place authorized to NNPCN volunteers

Hospital: in designated place authorized to NNPCN volunteers

Critical Incident report forms:

Safety 3 Volunteer Safety (Form 027) – conditions unsafe

Safety 4 Medical Emergency (Form 027, and 089)

Safety 5 Non- Medical Emergency and Unusual Incident (Form 027)

Safety 7 Suspected Harassment / Abuse (Form 027)

Safety 8 Suspected Child Abuse (Form 027)

EXAMPLES/SCENARIOS

Scenario 1- Understanding the situation and client: Mrs. X is 67 years old and has stage 3 cancer of the liver. Barb the volunteer comes in every Tuesday and Friday from 3pm to 8pm. Recently Mrs. X has been less active and mostly in bed. Barb notices… What will Barb document in her case notes at the end of her visit?

Example of good case note: client is less active than in previous visits and spends more time in bed. Care plan may need to be revised.

Example of a bad case note: client is lethargic and doesn't seem to have long to live.

Scenario 2 – describing the facts: Mrs. X is a 76 year old woman with a brain tumor causing blindness, confusion and hallucinations. She had been a very active person in the past and cannot understand that she can no longer do the things she did previously. She is still mobile but needs to be guided everywhere. A volunteer comes 3 times a week from 1 to 4 pm to provide respite to her husband and extensive guidance for the client. The volunteer notices the client getting out of her chair despite urging her to wait for assistance. In the process the client injures her leg on chair mechanism.

Example of good case note: client verbalized she needed to start supper and quickly attempted to get out of her chair despite my urging her to wait for my help. She caught her leg on the metal footrest mechanism, breaking the skin. Client refused assistance and became verbally abusive. I called the caregiver to return.

Example of bad case note: client was restless and agitated. She would not listen to me. She hurt her leg and lost her temper, she called me names. I called her husband.

Scenario 3 – conscise language: using last scenario, Mrs. X often has hallucinations.

Example of good case note: client starts talking to an imaginary child , offering to get her ice cream. No one is present except for client and myself.

Example of bad case note: client is irrational and delusional.