InterACTT
— INTERNATIONAL ALLIANCE —
FOR CARE AND THREAT TEAMS

TODD: How Should We Document What We Do?

Good documentation provides risk mitigation in the legal realm, allows for accurate oversight of cases over time, and increases continuity of care across service providers, position and during personnel vacancies. When providing care to those who come to the attention of the CARE team, the behaviors the student engages in bring an element of risk and potential liability for both the student and the professionals working with them. Consistent and quality record keeping (from the initial intake document and informed consent through ongoing contact/case notes) provides documentation and a clear paper trail of what, where, when, why and how services are offered.

Additionally, depending on where the CARE team operates, some records management may be considered privileged mental health or medical notes, whereas others may be considered education records and subject to FERPA or FIPPA (in the US and Canada). Nevertheless, once the information is shared with the CARE team or otherwise outside of counseling or health providers, the information is governed by FERPA or FIPPA.

CARE teams must document their deliberations, actions considered, and decisions made. Many teams use "homegrown" packages from their own institutions or develop their own system. Some have purchased software packages, that keep notes in databases for easy access and retrieval. At a minimum, you should be documenting the date of discussion, identifying information (using coded identifiers to avoid potential confusion), reason for concern, offices or departments involved, what interventions were considered and decided upon, and follow-up action items.

Please avoid the trap of not documenting teams' deliberations and actions out of fear that a bad outcome will result in your records being subpoenaed in a court proceeding. Though there is some inherent risk in documenting any activity, it is always preferable to document carefully your deliberations and courses of action rather than having members called to testify without an accurate record of what was discussed and agreed upon. Remember, if you didn't write it down, it didn't happen.

Another reason to invest in a solid information record management system is to offer some legal defensibility in the event a team needs to demonstrate their work. Having access to this data provides documentation of the steps team members took to address the potential risk.

For some teams, this seems like a scary proposition.

- Isn't it risky to be writing down all the things we are doing?
- What if we missed something?
- What if we don't handle each case the same?
- Won't we be giving ammunition to the other side?

These all become fair points if you aren't addressing risk well, if you let students slip through the cracks, miss appointments, demonstrate poor follow-up and have no methods in place for quality control or review. If this is how your team operates, then it is likely your documentation will not be helpful to mitigate legal risk. But if this is the case, you have bigger problems with the team than note keeping.

In the end, documentation is protective and demonstrates the thought process which drives the treatment plan. When done well, this provides a level of protection and risk reduction for the clinician. When done poorly, this provides CSI-like evidence of the "scene of the crime." If you are part of a team that functions well, there is no risk and only benefit to documenting what you and making your best effort to prevent violence. If your team is functioning poorly and carelessly, well... I suppose that might make for a good argument to bypass careful documentation. Or, perhaps, this should serve as a call to action to improve your process and invest in adopting a continuous improvement plan.