

MODULE SEVEN

Writing Case Notes

Policy

Every contact, whether face-to-face or non-face-to-face (e.g. telephone), must be recorded in the units of service and case notes section of ARIES. The Client file notes serve as a **running history** of contact with the client and a place to record any client information pertinent to their care that does not fit into any of the standardized forms/ARIES tabs noted in this manual.

Minimum Requirements

Date of the first appointment/Intake with the client.

- Date and type of contact with the client and/or
- Date of any noteworthy action taken by the medical case manager in the provision of client care or service.

A description of the interaction with or action related to the client (e.g. conversation summary and any important decisions made), including any other important facts that are not part of the information recorded on standardized case management forms.

Description of the client's health and/or physical and psychological status, as appropriate. Can use any systematic process that captures detail, e.g. SOAP notes.

Sign and seal notes after proofreading them.

Procedure

(See pages at end of module for ARIES Case Note Instructions)

Create a separate section in the client file for notes to be attached →

- Print the signed and sealed ARIES notes which include date of service activity and details of service activity. These can be in a summary format rather than one note per page.

When first meeting with the client →

- Document the date of the meeting/intake appointment.
- Create a client file (see Module 2 for Intake Procedure)
- Insert the note sheets from ARIES into the file in the notes section.
- See ARIES steps below for completing notes in ARIES.

At every subsequent contact with the client →

Record the following in the case notes:

1. Date and type of contact/action
2. Description of the contact/action including face-to-face and location of visit e.g. phone, clinic, etc.
3. Any important decisions made, any referrals (noted in the referral tabs in ARIES), courses of action, etc.
4. Any other information pertinent to the client's care that cannot be recorded on other case management forms/tabs.
5. Reference to any standard forms that contain information not included in the notes.
6. Sign and seal each entry made in the client case note section.

Do not duplicate information →

- Record any new information that relates to the needs assessment, reassessment, and care plan directly on the corresponding form/tab in ARIES.
- Rather than duplicating information being included on a standard form like the needs assessment or care plan, simply refer to that form in the notes (i.e. “see Care Plan and Reassessment Form for changes to housing status”, etc.).

Do not include full names, or any other identifiers about *other* individuals (i.e. family, partners, other clients) in the notes.

ARIES Format →

Use the ARIES Case Note screen to create notes and include the following required information:

1. The date of contact/activity
2. Category
3. Type of contact
4. Narrative information. Can be written in SOAP or other format which has sufficient detail and includes next steps for action.
5. Staff completing note
6. Sign and seal the note when complete.

See Appendix for sample notes.

Note: Write notes objectively and with respect. Avoid making subjective comments. Also, keep in mind that a client may access the contents of their file including the file notes.

ARIES Case Note Instructions

Within case notes, MCMs provide information about client services that can be shared within your agency and, in some cases, with other agencies to coordinate client care. MCMs also have the option to not share case notes with other agencies by marking the “don’t share” button in each individual case note. By design, legal, substance abuse, and mental health notes in ARIES are not shared between agencies.

In ARIES, to access the Case Notes screen, from a client’s information screen, click the **Case Notes** tab on the right of the top tier of tabs.

John A Porter

Case Notes [New](#)

Date	Category	Type	Staff	Signed 'n Sealed
2/24/2005	Financial	Initial Assessment	Joe Cooper	Edit Print
Cras feugiat posuere eros. Nullam aliquet turpis eu nunc. Maecenas suscipit, diam et vulputate tempus, leo pede molestie enim, et sodales metus risus rutrum magna. Morbi commodo est. Pellentesque sit amet lorem.				
2/24/2005	Legal	Initial Assessment	Joe Cooper	Edit Print
Morbi sit amet purus. Nullam a sapien. Nam nunc. Pellentesque in enim at justo dictum convallis.				
2/24/2005	Health Education	Initial Assessment	Joe Cooper	Edit Print
Cras feugiat posuere eros. Nullam a sapien. Etiam gravida suscipit est. Quisque a ante sit amet lectus laoreet laoreet. Phasellus porta. Etiam gravida suscipit est. Morbi eget nulla. Sed varius quam a sem. Sed nec elit vitae nisl pellentesque rutrum. Lorem ipsum dolor sit amet, consectetur adipiscing elit. Maecenas neque.				

[View For Printing](#)

Before and Category Type Staff

Case notes are presented in a table. Each row displays information for a paragraph of case notes. The table lists the case note date in the left hand column. Next to that displays the case note category: service-related note, administrative, or other type of note. The third column displays the note type. The fourth column lists the staff person who made the case notes. The last column on the right is the “Signed ‘n Sealed” column, which displays the date when the case notes were completed and sealed. When case notes are sealed, they become visible to other agencies with which the client has agreed to share data. Unsealed notes are only visible to staff persons within your agency with the proper permissions.

At the bottom of the screen is the View For Printing button, which allows MCMs to filter case notes in a search by date. Printing notes for files can also be done here.

To change an unsealed case note, click the [Edit](#) button on the right.

To create a new case note, click the [New](#) button at the top of the screen.

Either action takes you to the [Case Notes Edit](#) screen.

On the next page is a sample screen in Case Note Edit Mode followed by explanations of the fields in this screen.

Case Notes Edit

John A Porter Case Notes

Staff: Jones, Mellisa (dropdown) Created: 2/17/2005

Type: Client Update (dropdown) Activity Date: 1/27/2005 (calendar icon)

[Presenting Problem]
Client was recently evicted from apartment. Works part-time and needs a second job.

[Housing]

Category: Employment (dropdown) Don't share

New Paragraph
Client finished training and started work a week ago. Spoke with supervisor who felt that John understood the job well and could transition to full-time within three months.

Password to sign and seal note: [password field]

Buttons: Save, Sign 'n Seal, Cancel, Deactivate

“Staff”: select the staff person who recorded the case note. ARIES lists whoever is logged in as the default.

“Created date”: lists the date the case note was created.

“Type”: select which kind of case note to be entered. A note may be entered as an initial assessment, service assessment, progress report, client update, crisis note, or case conference.

“Activity Date”: Enter the date the note was recorded or updated. Use the format MM/DD/YYYY.

“Category”: select which category of a case note to be entered. MCMs can select from service-related categories like “Housing” or “Medical.” MCMs can also enter notes about a presenting problem, general impressions, or an incident report.

“New Paragraph text box”: Enter the body of the case note for that category. MCMs can type the note in MS Word using the spell check function, then cut and paste it into the text box of the case note in ARIES.

“Don’t share check box”: to prevent other agencies from viewing a client’s notes. If a client has elected not to share their information with other agencies, this will be selected by default. Mental health, substance abuse, and legal case notes cannot be shared with other agencies.

“Save button”: This will save all changes and return to the Case Notes screen.

“Sign ‘n Seal” button”: To finalize case notes and make them available to other agencies (if the client has agreed to share their data), enter your login password in the

text field in the bottom and click the button. Once case notes have been sealed, they cannot be edited or deactivated. All case notes should be signed and sealed when complete.

“Deactivate button”: removes the case note from view and future access. It means the record will be hidden so it is no longer available in ARIES. This would be used when a note has been signed and sealed, but is not accurate or problematic for some reason. It should be rare instances when this function would be used, and not everyone has the ability to access this function.

MODULE 7 APPENDIX

Example for Writing Notes in Client Files

There are many methods for writing case notes. Below is one example used in the medical field.

Example of SOAP Notes

S = Subjective

O = Objective

A = Assessment

P = Plan

Subjective Data: What the client (or significant other) tells us about their condition,

Example 1: Client describes feeling very tired in the morning and not able to get out of bed until 11 a.m. after starting new medication and it is impacting ability to work. Worried about not having income.

Example 2: Client reports great concern about losing housing - owner is losing the property. Client reports not sleeping well, no appetite, and doesn't know what he's going to do.

Objective: What you observe or find during the medical case management visit.

Example 1: Client yawning during noon appointment appears more unkept than usual, and speech is more slow and clipped.

Example 2: Client is visibly upset (crying, frantic speech, pacing, shifting in the seat often.

Assessment: The Medical Case Manager's opinion or interpretation of the client's situation as reported and you observe. The conclusions made in the assessment are more than a restatement of the problem as it determines whether or not the situation can be resolved.

Example 1: Appears that client having difficulty with new medication. Client committed to finding a different way to manage the difficulty.

Example 2: Client upset about possible loss of housing and its effects on client's health.

Plan: What do the client and case manager want to do to resolve the issue or situation? How will it be accomplished? Who will do what part of the service? This can often be incorporated into the care plan.

Example 1: Listen to concerns of client regarding change in energy level. Rule out other causes of exhaustion (e.g. substance use, grief, other mental health concern, etc.). Discuss with patient and doctor other methods for taking medication to not impact sleep and work function. Discuss referral to mental

health or substance abuse support. Explore work options to avoid discipline for tardiness, etc.

Example 2: Provide emotional support regarding fear of losing housing. Rule out other causes of eviction and agitation. MCM will prepare referral to housing advocate to minimize disruption and provide hope for new housing option. Client will gather proof of income, etc. to prepare for housing meeting. MCM will update care plan with new housing goal.

This is one method of recording notes that are comprehensive. Your notes do not have to be done in this format, but should include a systematic process to capture, what the concern is, what is observed by the provider, what the assessment is and what's the plan to address the issue.

A full note example could be:

Client presented with complaint that that they are not going to be able to stay in their house because the owner is going into foreclosure. Client says he is not sleeping and eating because he is so worried. Client is visibly agitated and worried. Discussed with the client a referral to the Housing Advocate and he is willing to meet with him. Client will gather proof of income documents and other items for the housing search and MCM will contact housing advocate to schedule appointment. Will check in on Wednesday.

The goal is to be concise, specific and accurate so anyone following up on client care would be able to clearly understand what is going on with the client and what the intended next steps are for each to respond.