ONTABA
The Ontario Association for Behaviour Analysis, Inc.

Professional Practice in ABA Series

5 WH Questions about Record Keeping

1 WHY is record keeping important to professionalism?

- To record all steps of the consent process and/or withdrawal of consent.
- To carefully preserve information gathered during the course of service provision.
- To document clinical decision-making processes including rationale used to support decisions and recommendations (e.g., data, contextual information, individual/caregiver needs/preferences, etc).
- To maintain a clear, comprehensive record of treatment plans, progress reports, skill development programs, protocols, etc. relevant to service provision.
- To maintain careful documentation of specific details related to any and all contact with service recipient, consent source, caregivers, other clinicians, etc.
- To allow another clinician to take over service provision seamlessly.

2 WHO is responsible for record keeping?

- The person who was present and is delegated to record details of a contact (e.g., session/meeting/conversation) should complete timely and accurate documentation.
- The person who developed the written plan, program, protocol, or report.
- The person who created the document is responsible to ensure it gets safely transferred to the clinical record.
- The supervisor of any person who has created the document is responsible for ensuring the accuracy and completeness of each document and the clinical record as a whole.

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3 WHAT specific details need to be recorded for client related contacts?

- Client name
- Date and time of contact
- Type of contact
- Names and roles of others who were present
- Specific details of the contact
- Action items, next steps, follow up required
- Initials or signature of the person who took the notes
- Initials or signature of the supervisor (as required)
- Date signed by each party

4 WHEN should information be recorded?

- Documentation should ideally occur in the moment or immediately following the session/meeting/ conversation.
- The date that the document was completed and signed should be accurately recorded on the document.

5 WHERE should information be recorded and stored?

- Record information on consent forms, client contact sheets, program data sheets, attendance sheets, communication books, treatment plans, progress reports, etc.
- Documentation can be kept on paper or in a secure electronic system.
- Paper records should be organized in a client file and stored in a locked cabinet.
- Electronic records should be carefully organized and stored on a password protected and encrypted computer or hard drive that is kept in a secure location or a locked cabinet.

More information about Storage & Retention of Records can be found at www.ontaba.org