CENTRE OF RESEARCH EXCELLENCE
Safer Families

Documentation Tips

Documenting your observations, your response to disclosure and the safety plan that has been negotiated is required. There are several reasons why you need to document the process, including:

- ensuring that the individual does not need to repeat all of the story,
- providing consistency in care,
- providing evidence of abuse in the case of a court appearance. (This is not common but can be vital in establishing that the abuse has occurred).

Be sure to ask the individual's permission prior to documenting abuse, and never put unnecessary details on referrals or records that could be seen by a partner. In cases of assault it is important for the health professional to document clearly and accurately what the individual has said and a description of any injuries, as clinical notes may become evidence in criminal court proceedings.

Here are some tips for documentation

Objectively document any injuries. With the individual's permission, take photographs of all injuries known or suspected to have resulted from domestic or family violence. If that's not possible, clearly document the location, number, type, and characteristics of injuries, using an injury location chart or body map.

Use quotation marks to denote the individual's own words or use phrases such as patient states or patient reports to indicate information that came directly from the patient. When you use quotation marks, the statement must be an exact repetition of what the individual said, not paraphrased.

Identify the person who hurt the individual as stated by the individual, using quotation marks and recording the identifying information, e.g. "my husband," "my stepfather," or "my mother-in law-slapped me."

Don't write your personal conclusions about the situation, document the facts clearly and objectively and let others draw conclusions.

Don't put the term domestic violence or abbreviations such as "DV" in the diagnosis fields of an individual's records. These may inadvertently get seen in referral letters or by the perpetrator. Some clinics and services use a special code or the hidden areas of their client software.

Record your observations of the patient's general appearance or demeanor, for example, patient crying and seems agitated.

Record the time of day the individual consults with you. If possible, indicate how much time has passed between the incident and the client's visit.

Women's Legal Services NSW (2013) When she talks to you about the violence. Available Online at **http://itstimetotalk.net.au/gp-toolkit**