CASE RECORDING GUIDANCE

LONDON BOROUGH OF CAMDEN

Supporting People

Version 6 – February 2018

Version	Author	Date	Comment
3	Reetha Begum	08/08/14	
4	Shari Odunoye	19/05/15	
5	Sadia Iqbal	08/02/18	Amendments made following Staff Engagement Group
6	Shari Kassrai	23/03/18	SMT amendments

CONTENTS

1. Guidance

1.1. Purpose

To provide guidance on high quality case recording for all staff in the Supporting People Directorate in the London Borough of Camden (LBC).

1.2. Scope

This practice guidance applies to all case records relating to adults aged 18 years and those in transition who have contact with the Supporting People Directorate.

It applies to all social care staff, including Social Workers, Team Managers, Service Managers, Head of Service, Occupational Therapists, Access & Support Officers, Outreach Officers and Sensory Needs Workers. It also includes Personal Finance Officers, Direct Payment Officers and Awards and Contributions team workers.

1.3. Legal framework and professional standards

Legal framework

The Care Act 2015 emphasis the need to identify outcomes and how these will be met by the support plan. Workers must take into account all other relevant legislation, notably Mental Capacity Act 2005, Mental Health Act 2005, the Equalities Act 2010 and policies and procedures including London Multi- Agency Adult Safeguarding Policy and Procedures 2016.

Various pieces of legislation form the framework for sharing information.

These include-:

The Data Protection Act 1998
http://www.legislation.gov.uk/ukpga/1998/29/contents

Freedom of Information Act 2000
https://www.legislation.gov.uk/ukpga/2000/36/contents

Professional Standards

A large majority of workers are registered with the Health Care Professional Council (HCPC), the Council states,

'Recording is a professional requirement and practitioners are personally responsible for, and must be able to justify, their decisions and recommendations'.
http://www.hpc-uk.org/

Occupational Therapists have an essential and practical guide for all members of the occupational profession.

Further information can be located here;
The College of Occupational Therapists Professional Standards
https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/professional-standards

The Nursing and Midwifery Council Code (2008) states, "As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions".

Further information can be located here;
http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/

1.4. Responsibilities

- All Team and Service Managers to ensure their staff have access to and understand and follow this guidance.

- The Caldecott Guardian for Supporting People Directorate is Sarah McClinton, Director of Social Services in LBC. Ms McClinton has a particular responsibility for reflecting peoples' interests regarding the use of personally identifiable information. She is responsible for ensuring peoples' (including carers) information is shared in an appropriate and secure manner.

1.5. Why record?

- In order to evidence policy, process and practice have been followed appropriately.

- To provide the rationale behind professional judgement, making it clear how a decision was made and being accountable for why a particular course of action was taken (or indeed not taken).

- To provide a clear picture of the person's story including their wishes, views and preferences. This information can then be used by them or by others to better understand the person's situation and their care and support needs.[1]

- Recording data is important as it informs practice and provides evidence that we are working properly.

1.6. The use of records

Where information is not recorded, there is no evidence the work has been completed. If work was completed but not recorded well, it is considered unfit for purpose. The quality of recording has implications at all different levels. The levels are the person, worker, manager and LBC and the records serve differing purposes as follows-;

a) **Person**
   - Tools to support choices and document the person's decisions
   - Can help a person understand his or her own strengths, capabilities and the resources they can access
   - A record of persons identified needs and how the agreed outcomes will be met
   - Can be used to monitor the person's progress
   - Provides continuity of records when workers change
   - Recorded information, such as previous assessments can be used when the person has lost the capacity to confirm what their wishes and values were prior to losing capacity

[1] Johnson, L, (2017) Research in Practice for Adults (RiPfA)
Good Recording in Practice, Devon, UK

b) Worker

- Evidence of what intervention has taken place
- Enabled to focus and plan their work effectively and provide evidence
- Outcomes can be used as a tool in planning assessments and decision-making
- Evaluate the work they have completed, monitor progress and plan future work with and on behalf of the person
- Evidence partnership working with teams across LBC and external organisation, such as Camden Carers Centre, Camden Safety Net and the NHS
- Chronology of safeguarding concerns and section 42 enquirieswhich workers can use to analysis and make a judgement about risk and need

c) **Manager**

- To update case records with agreed actions following supervision sessions
- Records are a tool for supervisors to monitor the work of their staff and assist them in giving appropriate advice, support and direction.
- Management information taken from records will be used as a basis for evaluating service delivery and planning future services and resources
- To respond to complaints from the person, carer or organisation

d) **LBC**

- Auditing internally and externally to assess the quality of work completed
- Records provide the basis for quality assurance, as they are a source of evidence for inspections, investigations, audits, and legal proceedings such as a Safeguarding Adult Review (SAR)
- All records are legal documents and bind the organisation to the statements made within them. Access to case records can be requested at any time and may be used in any legal challenges and court proceedings.

1.7. Strength based recording

The worker must consider and document the person's strengths and assets when recording.

Strengths-based practice is a collaborative process between the person and those supporting or connecting them. This lets them work together to determine an outcome that draws on the person's strengths and assets.

The term 'strength' refers to different elements that help or enable the individual to deal with challenges in life in general and in meeting their needs and achieving their desired outcomes in particular. These elements include:

- their personal resources, abilities, skills, knowledge, potential, etc.
- their social network and its resources, abilities, skills, etc.
- community resources, also known as 'social capital' and/or 'universal resources'.[2]

1.8. Professional Writing

Writing is a professional activity and all records on Mosaic are pieces of professional writing.

[2] SCIE, March 2015, What is a strengths-based approach to care? https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/what-is-a-strengths-based-approach.asp

Records must be completed to a professional standard, this means records must be-;

- clear and logical
- unambiguous
- accurate, differentiating fact from opinion
- accessible, using Plain English wherever possible
- accurate in terms of grammar, punctuation and spelling
- free from unexplained technical terms, acronyms, abbreviations and jargon
- proportionate, concise and avoiding unnecessary repetition
- respectful and not fall into stereotypes or assumptions
- reflective of equality and valuing diversity policies and promote anti-discriminatory practice

An excellent practitioner is also an excellent recorder of information

2. Procedure

2.1. Personal details

Personal details about the person i.e. name, must be spelt correctly, abbreviations must not be used, and age, ethnicity, disability and next of kin must be checked with at each relevant opportunity to ensure information is up-to-date on Mosaic. Details of gender, ethnicity, religion and first language must always be recorded where appropriate.

2.2. Case notes

Case notes must provide brief details of all contacts and needs to include:

- the name of the person with whom contact has taken place
- type of contact e.g. home visit, telephone call- select Mosaic heading
- purpose of the contact
- brief record of any discussion
- the information must be pertinent and succinct with the case
- evaluation of information received
- outcome or action planned as a result of the contact
- reference to any documents uploaded with consistent titles used.
- contact Mosaic will 'stamp' the entry with workers details including name, date and time of entry
- full names, role and contact details of any others in the personal or professional network
- any steps taken to facilitate participation of customers who have communication difficulties, for example use of interpreters or relevant accessible format

Entries must be made immediately or within two working days following contact, communication or meeting. If recording after this time period, change the Mosaic date prior to recording the case note.

2.3. Safeguarding and complex cases

. In safeguarding, recording is a critical component for individuals, workers and managers where there are concerns or complexities such as self-neglect, high need/risk and fluctuating capacity.

When completing assessments or safeguarding concerns, workers are to ensure they address the following-;

Evidence- what information was gathered and why, consider multiple sources including multi-disciplinary team, needs/risk assessments, specialist's assessments?

Analysis- what do you think this information means and why, what are the key issues? Record where professionals/carers have conflicting views and discuss this with the Safeguarding Adults Manager (SAM)

Rationale-What is your professional judgment based on your thoughts? Demonstrate your working out, consider positive risk taking and defensible decision making

Action taken/not taken- what should or should not happen? Who can or cannot do it?[3]

Information, events and actions in high-risk situations and Safeguarding Concerns must be recorded on the same day. This ensure the emergency duty team have up to date information available to them if the need arises.

2.4. Emails

Email has become an integral aspect of communication and correspondence with information flowing both within and outside of Supporting People Directorate. Workers are required to use discretion when determining which information contained within an email needs to form part of a person's records. The following points must be taken into account-;

- Do not automatically copy emails onto case records. Think about the information contained and if it is relevant to the individual
- Do not copy emails with other people's details in them
- Emails threads must not be routinely copied case notes. A full email thread can be uploaded if it contains important information AND it's relevant for worker to have access to the discussion e.g. safeguarding or high risk
- Part email threads must not be copied as they do not provide any context
- Workers must use all of the secure email servers such as, Egress

2.5. Worker away

Where the allocated worker is away for more than two weeks, a case note must be added with a brief summary of work carried out and future action required. This provides easily accessible information to various teams, such as, Multi Agency Safeguarding Hub (MASH) and the duty locality team.

2.6. What not to record

Certain topics must not be recorded in case notes as the person and carer can request access to these case notes. Funding issues can be recorded by Team Managers, Service Managers, Heads of Service and members of the Quality Assurance Panel. Any funding disputes must not be recorded, for example, when the team manager does not agree/authorise a funding request. This will be recorded on supervision notes and not on case notes.

[3] Johnson, L, (2017) Research in Practice for Adults (RiPfA)
Good Recording in Practice, Devon, UK

Any disputes between services and workers must not be recorded on case notes, for example, dispute between two services regarding the most appropriate service for the person.
This will be recorded in supervision notes as part of the case work discussion.

2.7. Restricted access/warnings

Where workers identify that a case record needs to be recorded as a restricted access or have a warning added, this must be agreed with a Team Manager and Service Manager. This provides management consistency on the decision taken to add such restrictions and warnings. Warnings should be proportionate and contain appropriate, factual information. As with case notes warnings should be written with the premise that it could be made available at some point and must therefore remain professional at all times.

3. Additional information and review

This guidance will be reviewed annually or earlier in accordance with relevant changes in legislation, regulations or guidance. Any major changes to this guidance will be subject to consultation.

An ASC Practice Guide has been developed to support Camden adult social care practitioners understand and deliver their duties in line with the legal requirements outlined in the Care Act 2014.

The ASC Practice Guide can be found here.

References

(2017) Johnson, L, Research in Practice for Adults (RiPfA), Good Recording in Practice, Devon, UK

(March 2015) SCIE, What is a strengths-based approach to care? https://www.scie.org.uk/care-act-2014/assessment-and-eligibility/strengths-based-approach/what-is-a-strengths-based-approach.asp

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