**Recording standards – overview**

Essentials

Aim for clarity and brevity, while maintaining the “Court fit” standard

Avoid copying and pasting information that is a) irrelevant or b) relating to another service user.

Avoid use of “suffers”, “bed bound”, “chair bound”. Use “is diagnosed with” or “has”, and “is cared for in bed”.

Stay in the 3rd person. Avoid moving from the 3rd person to the 1st person.

Style

To give structure to your recording summaries, use:

* Headings
* Bullet points

Content

Recording should be:

* Factual
* Evidence-based
* Proportionate
* Analytical, not purely descriptive
* Linked to Care Act domains
* Outcome-focused, but with time and task summaries included
* Coherent, with a clear narrative flow
* Court fit
* Compatible with the case audit process

Consent

If the resident is capacitous, always record that they have given informed consent for you to proceed with an assessment

Mental capacity

If the resident has a level of cognitive impairment, your recording should include:

* An assessment of their mental capacity to give consent to participate in the assessment process.
* An assessment of their mental capacity to make an informed decision about their care and support needs