DARLINGTON
Borough Council

Case Recording Policy and Procedure

1. Introduction

Recording is an essential aspect of providing a social care service. It is a tool for:

- Gathering, organising and analysing key information to inform decision making and planning;
- Reflecting upon and analysing information in order to develop and adjust plans;
- Demonstrating openness with service users and evidencing their views and involvement;
- Evidence children's' views are listened to and considered
- Maintaining accountability within the organisation;
- Transferring information to other agencies.

This document provides guidance in relation to case recording to enable staff to record information in a clear and consistent manner. The standards apply to existing and new records, whether stored in paper format or on electronic systems.

All case workers are responsible for completing social work records in a way which is **timely**, **comprehensive** and of **good quality** and must therefore follow this policy. Managers are responsible for ensuring that their staff adhere to the policy.

2. Scope

This policy applies to all Children's Service social care records.

The main case recording tool is 'Liquid Logic', where all information and contacts about work with individual children, young people and their families and/or carers where the decision has been made for social work intervention. All paper documentation is to be uploaded to the individual's child record within Wisdom e.g. e.g. Birth Certificates and legal documents setting out orders, such as Care Orders and Placement Orders.

3. Record Keeping Values

Each child must have his or her own electronic case record from the point of referral to case closure.

Case recording should be individual to each child / young person and not copied from sibling's record.

There must be a consistent approach to all recording and records should be:

- **Accurate and concise;**
- **Up to date;**
- **Relevant;**
- **Easy to read and in plain English, with any abbreviations explained;**
- **Easily understood by the service user (whether this be the parent, carer or child).**

Good quality recording will assist in the following ways:

- Providing documentary evidence of the authority's involvement with individual service users;
- Providing information to assist with analysis, care planning and reviews and evaluation;
- Documenting services provided to individual service users;
- Allowing continuity when workers change or are absent;
- Providing information when dealing with investigations or complaints;
- Supporting supervision with employee's development;
- Providing service users with a complete record of their involvement with social care

4. **Principles**

The key principles that underpin good record keeping are:

- **Timeliness**. Entries should be written within seventy-two hours of the events actually occurring. Entries will be recorded by the date of the event, not the date of writing up.
- **Legibility**. All recording should be written concisely, in plain English and avoid the use of professional jargon;
- **Any emails** copied and pasted to 'Case Notes' do not contain information relating to any other service user or any irrelevant communication between the sender and the recipient, including any disagreements between them.
- **Where an interpreter** is used this should be recorded, giving their name and whether they were from a contracted service or a named staff member, family member and/or friend;
- **Anti-discriminatory practice**. All records must demonstrate an anti-discriminatory perspective and must not include any derogatory comments by the author on ethnicity, race, culture, gender, age, religion, language, communication, sensory impairment, disability, family make-up and sexual orientation

5. Recording guidance

All entries to be recorded by the date of the event, not the date of writing up

All recording must be finalised within **seventy-two hours** of the event. In the event of a safeguarding issue it must be recorded and reported immediately.

All case recordings are to be finalised within their Liquid Logic record by the 5th of every month to enable performance data to be obtained.

All service users may access their personal records and case workers must ensure records are accurate and nonjudgmental, all recording should be evidence based with clear distinction between fact and opinion.

Case recording must evidence that race, culture, age, disability, gender or sexual orientation are properly recorded and considered.

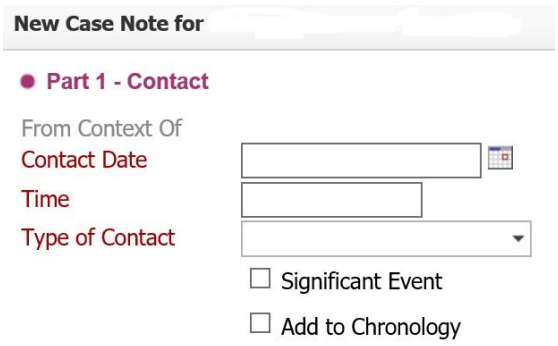
5 (a) Recording style

- Be concise whilst documenting important detail, rrecordings should be clear and chronological. The reader should not be left with an interpretation of a recording that differs from the author's meaning
- Use bullet points to list issues;
- Write in plain English, avoiding long and complicated sentences and words;
- If you need to use a specialist term, ensure that this is explained;
- Where professional judgement is being used to interpret a situation, state this and explain the rationale behind the professional judgement;
- All significant events are to include the wording **What is working well** and add detail of what's working well, **what are we worried about**, detail what you are worried about and **what needs to happen**, detail what needs to happen
- Entries must be accurate and must distinguish between facts, opinions, assessments, judgements and decisions. Records must distinguish between first-hand information and information obtained from third parties

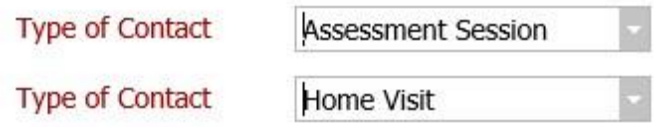
5 (b) Case note recording

Part 1 – Contact

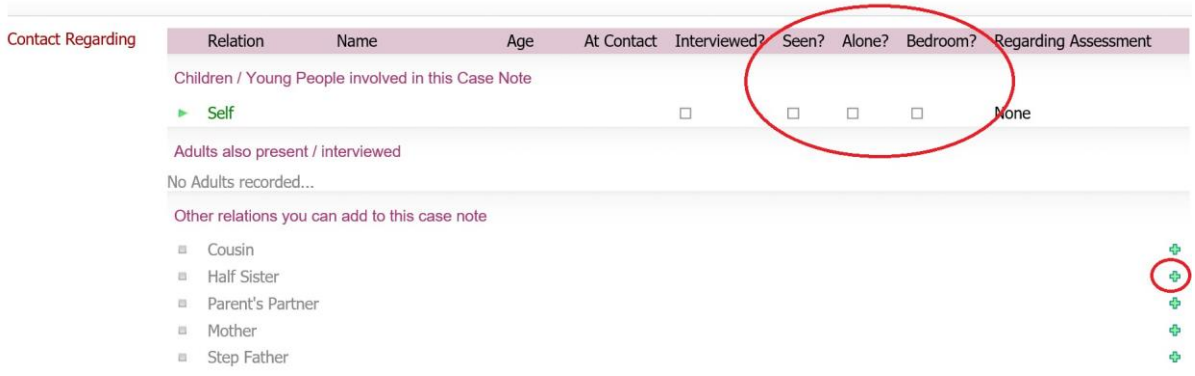
The date, time and type of contact should be recorded in the appropriate boxes. If this is a statutory visit you must ensure you select the relevant visit type i.e. Statutory Visit, Child In Need, Child Protection, Statutory Looked After Child visit.



If you are completing a Child and Families assessment on a new case and the case does not yet have a status, i.e. Child In Need, Child Protection then visits should be recorded as either 'Assessment session' or 'Home visit', they should not be recorded at Stat visits.



If you have any visit, either statutory or an assessment session on a new case you must tick the box to say whether the child was seen or not, whether they were seen alone and whether their bedroom was observed. You must also ensure you include any siblings or seen within the visit by clicking the green + next to their name



Reason for contact

- This is a short text field summarising the contact / purpose of the visit and forms the chronology entry
- Any case note where you have seen a child i.e. statutory visit/direct work session/attendance at a meeting the wording Child seen – is to be added in green
- Any case note where you have a planned visit/contact with a child, and they are not present note in red text that the Child not seen
- Any case note that reflects a meeting has been held, consent obtained from a family member or written information/records shared with a family note in blue text this event e.g. Correspondence with family and sharing of information, Completed Child & Families Assessment Shared with both parents.

Within **Detailed Notes** you should detail

- Who you have seen, children and adults, and whether you have seen the child/ren alone?
- What you saw, e.g. rooms, home conditions, observations of interactions between household members, visitors;
- What practice tools you used and how the family responded;
- What issues were discussed; advice given;
- The child's story as they have told it to you. This includes the child's views, wishes and feelings about what they would like to happen both now and in the future;
- What challenges were made to the family and how did they respond;
- Any safeguarding/risks or issues.

- If you include any direct quotes of the child's wishes, feelings or comments within these contacts in the write up of this case note then highlight their actual words in green. E.g. Statutory Visit to home address, mother and Dawn seen. Dawn and I discussed recent events. Dawn told me sometimes I get scared when we were talking about the recent Police referral received

Within **Analysis of information**

All significant events (home visit, direct work, significant information received) must include an analysis, case notes should be analytical and not a transcript of the visit. Within this section, you should describe:

- Weigh up the issues, challenges and other information you have obtained against the purpose of your visit/contact;
- Consider the strengths of the situation set against any concerns or risks and what impact these issues will have on the family;
- How is the family progressing towards the plan and the outcomes we are trying to achieve?
- Case worker analysis of the visit should consider how the information impacts on the safety and welfare of the child and how this affects the plan in place/any changes required or specific progress made.

Within the **Actions section you should discuss the actions from the visit**

- Using your analysis, determine what actions are needed next;
- Also consider any other actions to take forward.

Appendix 1: Recording Successfully - Avoiding the Pitfalls

Pitfall	How to Avoid it
Case Notes are out of Date	Recording is an important task, not just for the Children and Family's Services but for the child and their family or carer, even when what you are writing does not directly involve them. It is better to record as you go along because keeping information in your head to be recorded later may result in crucial information being lost. Allocate time for recording to minimise interruptions, remembering that all recording should be completed within three working days.
The child is 'missing' from the records	The child is a person not an object of concern and it is crucial that their wishes and feelings, their views and understanding of their situation are recorded. If this does not happen it suggests that no work has been undertaken with the child or that the child has not been an active partner in any work. Ensure that you see the child

	alone and record what the child says in their own words. It is important to observe a child's body language as children communicate through their actions as well as words. Explain any tools you use and drawings etc. can be uploaded onto the file.
You can't tell the difference between fact and professional judgements	Records should contain both facts and professional judgements, but they should be clearly separated and not mixed up throughout the case notes so that it is difficult to tell which is which. If professional judgements (or opinions) are accepted as facts, then they can unduly influence the management of the case. Use the sections of the case notes to help you by recording the facts in the detailed notes section, put your professional judgements and analysis (see below) of the situation in the analysis section and then note any actions in the actions section.
The record is not used as a tool for analysis	Case recording is a valuable tool, not a casework diary. Do not record simply what has happened but use analysis to move beyond this to hypothesise and explain why particular situations and events are occurring. Using recording for analysis requires you to assess the weight of the information gathered and to do this you need to draw on your knowledge from research and practice together with an understanding of the child's needs. Record this in the analysis section of the case notes.
There is too much to read	It is important to maintain a clear focus in your recording. Record significant information, using research and supervision to assist you in identifying what is and what isn't significant. Consider using the structure of the plan for working with the child to structure your recording. Cross reference rather than duplicate. The larger the record the more difficult it is to locate key information and identify patterns within the child's life.