ADULT SOCIAL CARE
PRACTITIONER GUIDELINES

Note: this document is for immediate reference only. Do not file it, as it will go out-of-date over time and be replaced by newer versions on-line. Always refer to the latest on-line version.

101 RECORD KEEPING

Record keeping is an integral aspect of the service and our duty of care, and is a written reflection of the type and quality of intervention. We should ensure that our recording shows a clear, accurate and up-to-date record of our contacts concerning service users.

Departmental standards for record keeping are necessary in order to provide a consistent standard of documentation across all teams and workers. The standards for record keeping are applicable to all members of the service, including support staff, social workers, social care coordinators and management.

101.1 Why we keep records:

- to ensure a comprehensive and accurate record of the service user's needs, the objectives and outcomes of intervention, and the reasoning used to achieve the objectives
- for audit and evidence-based practice
- to ensure accountability to service users, managers and the employer
- to provide a systematic record of on-going intervention
- to enable staff to provide continuity of service where the case is transferred or where the worker is unavailable
- to act as a legal record of our actions and the service user's interaction with the service. Records provide evidence for complaint investigations and enquiries e.g. when service users challenge a lack of or refusal of service, seek damages or in cases of professional misconduct. Failure to maintain adequate records is often regarded as misadministration by the Ombudsman.

101.2 What to record:

- All important telephone calls, especially to the service user – successful and failed attempts
- correspondence, including emails, received or sent
- all visits
- discussions in supervision regarding particular cases and key decisions made
- professional advice
- key documents produced
- meetings held including panels and multi-disciplinary reviews
- all reports that relate to the service user
- mandatory fields within the electronic record, including the offer of a carer's assessment, and direct payments: you must complete mandatory fields.

101.3 What to include in records:

- date and time all assessments or contacts were carried out
- the type of contact i.e. telephone call, visit
- the consent of the service user to be assessed by a worker and how this was given i.e. verbal, written, or by a next of kin, including when consent is refused or withdrawn
- a detailed note of what was said when conveying information to other agencies – do not generalise
- contact details for all involved with the service user e.g. carer, next of kin, doctor, professionals (to be recorded on the ASCC Network Sheet), and any contacts made with them
- views and wishes of service users and carer: the wishes and views of the service user should be recorded and the recording should make clear any disagreements or differences in perception the service user may have
- unmet needs
- who was present at visits
- as much information as possible should be collected at referral including name, telephone number, date of birth, GP and other contact details.

101.4 Basic information

It is important to keep personal information up-to-date and accurate, since this is information required by any person involved in the case. Particular things to pay attention to include:

- checking the address of the person
- making sure the person's consent has been requested and what the answer was, and that this up-to-date
- recording warnings of risk to the person or to professionals or members of the public
- recording ethnicity in the Equalities section of the Basic Information Sheet (BIS), as this is a key performance measure of compliance with the Race Relations (Amendment) Act 2000. We need the information to monitor fairness of access and service provision.

101.5 Warnings

Warnings are strictly about the safety of staff and members of the public. They should be added to cases where there is a risk to staff members or members of the public. Warnings should not be used for any other reason.

Warnings are added via the Person Index. Once added they appear across social care systems so they will appear in ASCC and ICS – the Integrated Children's System. The warning is also linked to the Council's corporate warning system – In Check – so that colleagues across the Council can be alerted to concerns about a person.

In ASCC, every time a document is opened on the case the warning will appear as a window.

Warnings should reflect real and verifiable concerns and should always be backed up by evidence. A threat may be real or perceived as long as in every case they are supported by evidence.

If you wish to add a warning for a person, please speak to your manager to agree the warning. The information should be passed to a member of business support staff who will add it to PI – practitioners are not able to add warnings themselves. You will need to supply the reason for the warning – this should be evidence based e.g. “Mr X has made inappropriate remarks to members of care staff on a number of occasions; see diary sheets of 12/09/2010 and 01/03/2011. Staff should not visit alone.”

Ideally service users should be informed about warnings, but in many cases this may not be practicable. Warnings should also be reviewed at regular intervals, at least annually. If a warning changes or is no longer appropriate, please tell a member of business support staff. Warnings can be de-activated – leaving a record of it as part of the case history, if this is appropriate – or deleted completely. Please advise business support accordingly.

101.6 Record keeping standards

Records should be written with a view to the service user and, if necessary, the courts having access to the record.

- Records should be **chronological**. The notes should record a sequence of chronological events relating to the service user.
- All recording must be **professional**

  Writing should be:

  - legible where paper documents are kept on file
  - professional and typed
  - factual – containing relevant information
  - clear – clearly recorded needs, actions and outcomes
  - concise and complete: consider using headings and bullet points to ensure content is concise
  - relevant and unambiguous
  - cross-referenced where appropriate to other documents or paper files.

- All language used must be **appropriate**

- Language must be professional. Please proof read all recording to ensure a good standard of English.
- Language should be objective. Identify subjective statements as such..
- Avoid or keep abbreviations and jargon to a minimum as they can be ambiguous. If abbreviations are used make sure that they are clear in context or do not use if they may not be understood.
- Be careful of terminology. Different meanings are associated with the same phrase e.g. ‘confused’ it could be anything from a misunderstanding to a severe cognitive impairment.
- Avoid slang except where directly quoting others appropriately.
- Record direct quotations carefully with an awareness of the impact of recording some information.

- All recording must be **clear**

- Identify source of information using names and then descriptions – e.g. service user, carer, daughter, Emergency Duty Team etc.
- Record whether the information is based on observation, what is reported by the service user or what is

your professional judgement. Distinguish between fact and professional opinion. There is a difference between what was observed and what the assessor's professional opinion is about what they have observed.

- Make sure opinions refer to the evidence upon which they are based.
- Record only relevant and significant information, not a detailed narrative of each contact. Don't be too wordy.
- Fully date every contact concerning service users (day, month, year) and make clear who has made each entry (e.g. signature and designation). Common sense must play a part in deciding how multiple daily contacts are recorded; e.g. "three attempts were made to contact the service user."
- Clearly record decisions and the decision making process on the case.
- In complex cases, if further action is required, use 'action/planning' statements at the end of each diary entry, so that ongoing action is clearly recorded. This enables other staff to respond to enquiries and provide intervention in the absence of the allocated member of staff. Make sure that action statements are clear and specific regarding the tasks outstanding, and identify accountability for implementing the individual tasks.

- All recording must show respect for diversity:

- many of the issues relating to equal opportunities follow from quality of language. Staff should be aware of their own views and how these are expressed. It is important to be aware that some service users and their networks may not share these views
- recording needs to be sensitive to differences in culture, class, language, race, gender, disability, sexuality and religion
- check with the service users how they spell their name and how they wish to be addressed. Don't assume we all have the same naming system
- avoid stereotypical language

- All recording must be timely:

- remember that ASCC is a "real time" electronic record; therefore timely recording is imperative
- record write-ups from any assessments, follow-up visit or any joint visits, on the day they are completed or at the latest by the next working day, within 24 hours of the visit, unless exceptional circumstances prevent this from happening, in which case make it clear that this is a late entry
- write up interactions, phone calls and other contact with service users, carers and colleagues immediately and not later than within 24 hours of the contact in all circumstances unless exceptional circumstances prevent this from happening, in which case make it clear that this is a late entry
- note any issues arising from emails from the Emergency Duty Team on the diary sheet of the appropriate service user and add the email as an attachment on the day that they are received

101.7 Additional documents

The core documents on ASCC are displayed on the toolbars in the main **User A-Z view** and the **By Team/Worker View**. There are a range of other documents available on ASCC. These are documents which are used either only occasionally, or by specialist workers, or because it is not feasible to put them elsewhere.

Additional documents may only be created (with the exception of the OT Equipment MedeQuip document) on **open** cases.

To view the list of additional documents, highlight the Basic Information Sheet on a case and click the **Additional documents** button at the top of the screen.

These documents appear in the main views with the rest of the documents on the case building up a complete service user record.

 For details of the steps on ASCC, **see ASCC Guidance Sheet 20** [PDF] (file size: 104Kb).

The **current** documents (as at **March 2011**) are:

ASW form – a blank document but allows a Word template form for Mental Health Assessment reports to be attached. It is only completed by **Approved Social Workers**.

Appropriate Adult – a Word template attached to what is in effect a contact sheet.

Medical Assessment – a Lotus Notes document detailing diagnosis, medical history and medication etc, which can be completed if appropriate.

Carer's Assessment – a copy of the Carer's Assessment which is often auto-generated when other documents are filled in. If one has not been created, or you need a further one it can be created here.

Initial Action Agreement – a document which can be completed, printed, and given to the service user at the point of referral and assessment detailing what we have done and what are planning to do for them.

OT Equipment MedeQuip - opening this form displays the OT equipment a service user has. Medequip is the private company that delivers OT equipment to Kensington and Chelsea residents. When you open this form, ASCC goes across the internet and pulls in the equipment information directly from Medequip's database, so it is always up-to-date and accurate.

Minor Adaptations – for OT use only.

Network Sheet – One of the many ways you can create the network sheet is by using this option. If there is one already in existence on the case it will open that document – you can't have more than one network sheet on a case.

Housing Needs – a Word template attached to a Lotus Notes document recording an **Occupational Therapy Housing Needs** report.

Record of Enquiry form. Please see **ASCC Guidance Sheet 11** [PDF] (file size: 82Kb) for full information on how this form should be used.

Sensitive Information. Please see **ASCC Guidance Sheet 12** [PDF] (file size: 111Kb) for full information on how this form should be used.

Sensory Disability Action Plan – for use by the Sensory Disability team only. The team should see the **ASCC Guidance Sheet SDAAP** [PDF] (file size: 70Kb) for full information on how to use this form.

Brompton & Marsden OOB work – for use by the Brompton and Marsden hospital social work teams only. No longer used.

Residential Care Plan – Please see **ASCC Guidance Sheet RC1** [PDF] (file size: 167Kb) for full information on how this form should be used.

Residential Placement Search – Please see **ASCC Guidance Sheet RC2** [PDF] (file size: 104Kb) for full information on how this form should be used.

Residential Placement Record – Please see **ASCC Guidance Sheet RC3** [PDF] (file size: 139Kb) for full information on how this form should be used.

Safeguarding Adults Alert – Use this form to record concerns about a service user who you feel may be at risk or vulnerable. **See ASCC Guidance Sheet 21** [PDF] (file size: 173Kb) for full guidance on the practice and on filling in this form.

Alcohol & Drug &JHT Monitoring – for use by the Substance Use teams only.

SU Risk Assessment 1 – for use by the Substance Use teams only.

SU Risk Assessment 2 – for use by the Substance Use teams only.

Risk Assessment – Use this form to attach a Word Risk Assessment document. For use by Older People's teams as well as Disability teams.

LD Health Action Plan – for use by the Learning Disability team only.

LD Hearing Screen - specialist document for use by the Learning Disability team only.

LD Occupational Therapy Report - specialist document for use by the Learning Disability team only.

LD Psychology Report - specialist document for use by the Learning Disability team only.

LD Community Nursing Report - specialist document for use by the Learning Disability team only.

LD Speech and Language Screening Assessment - specialist document for use by the Learning Disability team only.

Telecare Application Form – Please use this form if you are referring someone to the Community Alarm Service (CAS) for Telecare equipment to be funded by Social Services. Once completed it should be sent, using the Send button, to the mailbox called **HHASC Telecare Service**.

Full practice guidance about Telecare is available on the intranet at **HHASC/Doing My Job/Adult Social Care//Telecare** (Note: this isn't a link, you'll need to go into the intranet and follow that menu route)

Social Care Personal Budget form – See the separate guidance on this form **ASCC Guidance Sheet 23** [PDF] (file size: 677Kb).

Mental Capacity Information – See the separate guidance on this form **ASCC Guidance Sheet 22** [PDF] (file size: 65Kb).

KCRS – a form for use only by the Kensington Community Rehab Service (it's essentially just a blank form which they post attachments on).

101.8 Solicitors' letters

Solicitors' letters must be treated with priority. They need to be read carefully to ascertain whether there is a time limit for a response or threats of legal action. A copy of the letter should be given to your team manager. A copy should also be faxed to a named person in the legal department. That named person needs to be advised of the substance of the response. The only exception is routine solicitors' letters regarding appointments etc. Solicitors' letters must not be ignored.

101.9 Court orders

Court orders must be complied with. There are very serious implications for this Local Authority in respect of both costs and reputation if court orders are not complied with. Timetables set by court must be strictly adhered to. The legal department should be consulted on all court orders received. You must advise the legal department if you cannot comply with a court timetable as soon as you become aware – do not leave advising the legal department until the deadline date has expired.