# PARTNERSHIP Concept - Checklist

This handout shows 11 top tips for good social care recording and uses the acronym PARTNERSHIP as a checklist, and to emphasise that the record should be co-produced between you and the person to whom it relates.

**P – Person centred**

Any social care record is written for multiple readers – your manager, your colleagues, other health, and social care professionals – but the most important possible reader is the person who uses services themselves and their families, and you need to bear in mind the importance of the record for the person you are supporting. Try to make your recording as person-centred as any other part of your practice. You may have recorded on hundreds of case files, and on each one, you will have been pushed for time. But each file is likely to be that person’s one and only social care record, and as such it has the potential to shape the services that person receives, and by extension the life they lead.

Example;

Alex asked if his home visits could be scheduled around his work, so that he didn’t need to take time off. This was recorded as ‘Alex needs structured home visits’, which was interpreted by a subsequent worker as ‘Alex needs structure’. Mention was then made of Alex’s need for structure and routine. Before long, someone’s request that a service be based around their work life was being recorded as an indication of possible autism.

It is helpful to take time to check the record you are creating with the person it is about. Sharing case records with a person can help correct misunderstandings and misrepresentations, but also helps focus professionals’ minds on recording respectfully and sensitively.

**A – Accurate**

Whatever it is you are expressing – fact or opinion – state accurately what is happening, or what you believe, and avoid vagueness wherever you can. Saying ‘the front room was in a terrible state’ may be quicker than saying ‘the front room contained 14 bags of rubbish, and I saw 20 empty fast-food packages. I also saw what looked like mice droppings in one corner of the room’. Recording in accurate terms like this avoids any possible value judgements and is more helpful to a colleague who might visit and see a room that is still in a ‘terrible state’, but where there are only six bags of rubbish and 10 takeaway packages, and who therefore can note a significant improvement. Importantly, this would help the person themselves, whose efforts to get on top of things would be recognised, rather than overlooked.

**R – Real**

The fact that lots of people, including the person about whom the record is kept, may read a social care record, is one of the challenges of recording. This can lead to vague wording, particularly when aspects of a person’s behaviour may be causing them or other people difficulties. So, phrases appear such as ‘inappropriate sexual behaviour’, which could cover a huge range of things from serious assaults to ill-advised comments. Such comments may still be distressing but may prompt a different set of responses to criminal assaults.

There is a middle ground between the delicate but uninformative ‘she has issues with personal hygiene’ and the disrespectful ‘she smells revolting’. A more explicit record of ‘due to her advancing dementia, Roweena often forgets to have a bath, resulting in an increasingly unpleasant personal odour that I think is having a negative effect on her relationship with her neighbours’ may take longer to record, but identifies precisely what the issue is, enabling a more honest discussion with the person.

**T – Timely**

Clearly, everything that goes to make up a good social care record – person-centredness, accuracy, detail, reflection, and analysis – is easier to achieve if a record is made promptly, when things are fresh in the memory, and while leaving writing up your notes for another time is always tempting given the pressures on social care staff, leaving a record incomplete can hamper your colleagues if they are working with the same person, and can cause problems for the person themselves. Sometimes it happens, of course – if so, it is good practice to note that the recording was not done at the time. Whatever the temptation to disguise late recording, it is more transparent to acknowledge when it has been necessary.

**N – No jargon**

‘Because my allocated case Kim, despite her ASD, is an activated client, I decided to take an asset-based approach to her affective disorders’ takes just a handful of the ‘A’s in the Think Local Act Personal Jargon Buster to illustrate quite how much jargon there is in social care, and how quickly it can make what we write incomprehensible. It becomes incomprehensible not just to the person we are supporting (who is, after all, the most important audience) but also our colleagues and managers. There is so much jargon that not even fellow professionals will know all of it. ‘I am working with Kim, who has autism and a really good sense of what support she needs. Therefore, I am working with her to identify what her strengths are, as a way of helping her with some of her mental health problems would be a clearer way of making the point.

**E – Evidence based**

We are not suggesting here that every observation you make has to be backed up by an article in a peer-reviewed journal, but you must make sure that you can back up substantiate what you’re saying in a case record. So, if you are stating a fact, be sure that it’s an accurate one. If it is an opinion, make sure you can back it up with evidence from what you’ve seen or heard.

Opinions are OK in social work care records: you are, after all, employed to exercise your professional judgement sometimes. But that’s the key. It has to be a professional judgement, based on something – your professional experience of similar situations, your knowledge of the individual circumstances, some research evidence – and not just a hunch or an assumption. As well as clearly stating that your opinion is solely an opinion, and not a fact, you need to state what you are basing that opinion on. There should be a clear chain of reasoning from what you have observed, through the analysis of what you have observed, to the conclusion you have reached as a result.

Example;

‘I believe that Sam is at risk from her relationship with the two men who come to visit her in the scheme. Sam has told me that she is happy to see them, but I have learnt from her that while a month ago she saw them once or twice a week, she is now seeing them daily, for hours at a time. I believe the risk comes from the effect this seems to be having on the rest of her life – I know she has missed college three times in the last week – and the behaviours of the men seem to fit into a pattern of grooming. I say this because they appear to be discouraging her other activities and contact with other people, and Sam has told me they have been buying her gifts, drinks, and takeaways. I have therefore discussed a possible safeguarding referral with Sam, but she has not given consent. I am therefore holding off but monitoring the situation.’

The case note acknowledges the professional’s concerns but recognises that they are unproven opinion at this stage and records the different perspective of the person who uses the service. The professional has set out their reasons for their thinking so that colleagues and others can take their professional judgement into account.

A note here about differences of opinion: as we see in the example, the professional and the person they are supporting have differing views about the situation. This will almost inevitably occur in any ongoing relationship between a social care organisation and its client. It need not be problematic in terms of recording – your responsibility is to set out your view clearly, and to do the same, explicitly and without bias, for the view of the person. Such differences may also occur of course between you and the carer, fellow professionals, or anyone involved in supporting a person.

**R – Reading the previous record/s**

It is vital that you know what is in the social care records of the person you are supporting. This can be difficult, because of time pressures and/or filing systems, but it is important to understand the histories, care plan, routines, and issues of the people you work with. Updated case summaries, where key facts, events and people are collated in one place that is easily accessible can be really important. However, it’s helpful not to be hidebound by what has been written before: it may contain inaccuracies; things may have changed; and you need to form your own judgements. But nonetheless you must read what is on the record. Not doing so may mean that you miss potentially crucial information, about a person’s history, and about how best to support them.

Example;

A person with learning disabilities was placed by social workers in a woman's refuge, where she was exploited by one of the other tenants. It was soon learnt that there was a note on the file of the exploitative woman that she should never again live in that refuge, because of a history of exploiting the other vulnerable women there. Because that note was not read, a pattern of abuse was allowed to continue. As an organisation, the local authority ought to have devised a system to flag up vital pieces of information, but the social worker has a professional responsibility to read the file properly.

**S – Succinct**

Much of what we’re saying here focuses on the need to be detailed and accurate in your recording, and to back up what you’re writing with evidence. This might suggest that we are advocating ever-longer recording when many of you will be struggling to make the time to record your work as it is. But, if you concentrate on writing detailed, factual reports, with opinions being clearly expressed where appropriate, this need not take any longer, and in fact may be quicker and easier than vaguely worded, unclear text. Make sure you avoid repeating yourself: a point made well once will have more impact than one that is repeated throughout a report or case record. Compare these two examples.

Example 1:

‘I visited Mrs Ali at 12:30pm today and stayed for 20 minutes. She was a bit disorientated, and her personal appearance wasn’t good. She was sitting on her sofa. I massaged her legs and re-placed her protective socks. I heated up her lunch and asked about her mobility to ensure she was able to move around the house and use the bathroom. She said she was able to do this without too much effort although she said her back was still giving her some pain. I gave Mrs Ali her medication and checked she had enough meds to cover the next seven days. We talked about how her reablement was going and she mentioned that her daughter-in-law wanted her to go into a home. Her son did not want this and thought she could manage at home with care workers coming in regularly. I signed her care record and left to move on to the next person on my visiting list.’

Example 2:

‘I visited Mrs Ali at 12:30pm today. I massaged her legs and re-placed her protective socks. She said she was fairly mobile although she said her back was still giving her some pain. I gave Mrs Ali her medication and checked she had enough meds to cover the next seven days. Her family is discussing whether she should go into a home.’

**H – Holistic**

Increasingly, social care staff are based in multi-disciplinary teams. Their record, therefore, will often be just one part of the paperwork that exists about a person. It is to everyone’s benefit – the professionals in multi-disciplinary teams, but more importantly the people they support – if it is possible to have one record that presents a coherent, holistic picture of an individual. So, make sure information can be shared with colleagues where appropriate. Professionals need to know what their colleagues are doing with a person at any given time, so work can be planned in a way that makes sense – for example, a social worker may need to know where an occupational therapist has got to in helping a person develop their independent living skills before helping the person to apply for a one-bedroom flat. And should the person choose to see their case file, clearly, it’s better to have just the one record to share with them.

**I – IT compliant**

Like it or not, most social care recording will be done recorded on IT systems. There will also be occasions when the social care record is produced for a specific purpose e.g., a court report, a safeguarding investigation, a housing application, and it may be necessary to complete a report using a template provided for the purpose. While IT systems may not always be very user-friendly, the onus is on you as the professional to ensure that you do all you can to make use of whatever system is provided to record appropriately on behalf of the person you are working with.

**P – Professional**

You are a professional, and your recording work must reflect that. Much of what that entail is covered in the top tips we’ve already looked at: timeliness, evidence, clarity and so forth. In order to enhance credibility, casual recording styles – for example using colloquial terms or ‘cutting and pasting’ from emails instead of tailoring the record for the specific purpose – should be avoided. Your record is an important document which represents you, the organisation you work for, and most importantly the person you are working with.