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# EAST DUNBARTONSHIRE COUNCIL SOCIAL WORK DEPARTMENT PROCEDURE & GUIDANCE ON CASE RECORDING

**October 2006**

**EDC SOCIAL WORK SERVICES - Children and families policies and procedures**

# CASE RECORDING – POLICY, GUIDANCE & PROCEDURES

**CONTENTS**

# SECTION 1: INTRODUCTION & KEY DEFINITIONS

## 1.1: Purpose of this document

The purpose of this document is to provide guidance and procedures on the purpose and the content of records of all aspects of the social work services contact and involvement with any child and their family.

## 1.2: Definitions

The terms 'record' and 'case file' cover, without exception, all types of information and record, kept by any member of staff, carer, or agency working on behalf of the Council and/or within the Council area, such as voluntary agencies, and residential care. The records may be kept in any medium, i.e. paper, electronically, and in different locations. All constitute the social work case record which in turn is a part of the local authority record.

The term 'child' is anyone up to the age of 18 years, unless assessment of the needs of a young person of 16 years and over has been dealt with only by an adult service. This guidance also covers procedures for work with young adults being supported in terms of Through Care.

# SECTION 2: POLICY AND CONTEXT

## 2.1. Legislation and National Guidance

The legal requirements to maintain records, and the management of this, are covered by a range of legislation and guidance. These are detailed in Appendix 1. In addition, national guidance and standards provide frameworks on content e.g.

- Scotland's Children [1997] –all volumes
- Guidance on Recording –contained in Appendix 2 of Managing the Risk [2006][Scottish Executive]
- Commission for the Regulation of Care in Scotland - Standards
- The draft Integrated Assessment Framework [2005][Scottish Executive]

## 2.2. Links to other EDC policies and procedures.

These include:

- Confidentiality [Children and Families Social Work Policy 2005]
- Inter Agency and Social Work Child Protection Guidance and Procedures
- Children and Families Assessment Report Format and Guidance[2006]
- Care Planning and LAAC materials
- Fostering and Adoption, Residential Care, Befriending, Family Support, Through Care, ISMS Guidance and Procedures

Any team or section notes on case records must be compliant with this overarching policy and be clear that sub section records form part of the whole record. Examples include residential units, family placement workers and carers, voluntary or private agencies. Arrangements must be made for information to be kept in the main file about the existence and location of such records.

### 2.3. Purposes of records

Some of the key purposes of records are:

- So that accurate information and reasons for decisions are available to inform assessment and information sharing at any stage
- So that accurate information can be shared with service users and others, including courts.
- To account for the work of the service
- To assess, plan, monitor and review work
- To facilitate reflection and analysis
- So that managers and auditors can monitor and evaluate work
- So that service users may use records as a source of personal information, and as part of 'life work'.

### 2.4. Principles

The overall value base is that expressed in the SSSC Codes of Conduct for social work and social care staff and employers.

Records must be kept in a way which is honest, using respectful language, and which differentiates fact from opinion, judgement or speculation. It is expected that the service user will see their record, if possible near the time the record is written, unless a decision is made, at the designated level of authority, to restrict information on the basis of one of the legal grounds for this. Any area of restricted access must be clearly recorded as such in the file so that future professionals are aware of this and the reasons.

If records kept are on infants or children too young to read or understand them at the time, it should be borne in mind that that child will be able to see what is written in due course.

Each child must have their own independent record.

### 1.1. Types of information recorded

Information recorded will usually include content on

- Individual and family background history
- Record of the input from and views of the service user
- Information from others, such as health professionals or the police
- Assessments, plans, services, outcomes and reviews
- Record of events, reports and legal orders
- Record of contacts with the service user, family members, professionals and others providing services
- Chronologies of personal history and intervention
- Summaries which assist continuity, especially when intervention is lengthy or complex.
- Notes on supervision and auditing events related to the case.

The range of styles of records is extensive, including typed and handwritten notes; formal reports; electronic notes [e.g. CareFirst]; photographs, drawings, diagrams or worksheets; audio or filmed records of work or interviews.

### 2.6. Pitfalls in Case Recording

Common criticisms of the **content** of records and files are:

- *Not up to date*
- *Narrative has insufficient focus on subject & issues*
- *Disrespectful*
- *No separation of validated fact from opinions or perspectives*
- *Assessment absent*
- *Child as a person not central to the record*
- *File used as 'ventilation' by the recorder*
- *Not used as a tool for analysis*
- *Incorrect assumptions by professionals about who is deemed to be a 'third party' and the reasons that information can be 'restricted'*

  *[See EDC Policy on Confidentiality and national guidance on the Data Protection Act.]*

And

Common criticisms of the **style** are:

- *Difficult to find key information, or follow events and reasons for actions*
- *Files themselves are unwieldy and not well ordered or presented*
- *Not clear where all parts of the record are, e.g. notes kept by residential staff, external agencies and voluntary bodies providing a service.*

### *2.7.* Good Practice Guidance

Recommended sources on good practice which follows the above principles and expectations can be found in

- The EDC IAF Social Work Report Format Guidance
- The detailed website on recording practice, www.writeenough.org.uk

## SECTION 3: PROCEDURES FOR THE CONTENT OF CHILDREN AND FAMILY FILES

### 3.1. Purpose:

a. A written account of assessment, intervention and contact with child(ren), families, and other agencies, and content of discussion.

b. A written record of events and changing circumstances

c. A mechanism whereby both practitioners and managers are held accountable for practice and decision making

a. A valuable tool to assist planning and evaluate progress

### 3.2. File Content:

Files relating to Children and Families work in EDC Social Work Services will contain [as per identified sections and in chronological order with most recent material first]

- A ***Case Front sheet*** giving Core Details
- ***Formal Assessment documents [***e.g. IAF, SBR,YSL]
- ***Care Plans***

- ***Contact sheets*** noting dates/times of interventions
- ***Progress sheets*** noting narrative account of interventions
- ***Work summaries*** detailing summary analysis of interventions & progress
- ***Review documents***
- ***A Chronology of Significant Events***
- Copies of ***legal orders and other documents of significance*** [e.g. child's birth certificate, medical assessments, specialist reports, copies of completed assessment and intervention tools used, handwritten letters and contemporaneous handwritten notes].
- ***LAAC materials*** if relevant

**[See following Section 4 on CP recording for guidance on completing specific sections, and separate formats and guidance as relevant e.g Assessment report format, work summary format, chronology format and guidance]**

### 3.3. Maintaining both Electronic & Hard Copy Records

Records input onto the Carefirst electronic system should be printed and kept in a hard copy case file.

### 3.4. Contemporaneous notes

It is **very important** that workers in any setting write down as soon as possible the exact words, details and context of any ***disclosure of abuse or other significant information*** from a child or from an adult about a child. This also applies to the witnessing of any concern, such as a child being hit. Even if typed up exactly without delay, the original note must be kept, timed, dated and signed. The reason is that the original record kept at the time of the conversation or of witnessing a concern will be considered the most reliable evidence.

### 3.5. Settings other than fieldwork/practice teams

While the detail of sections 3 and 4 will apply most closely to the work of fieldwork/practice team social work staff, the same value and principles and general processes will apply in any setting where social care staff and/or carers are delivering a service, e.g. family placement, residential child care, specific projects.

## SECTION 4: PROCEDURES FOR CHILD PROTECTION CASE RECORDING

### 1.1. Purposes:

- A written account of contact with child(ren), families, and other agencies, and content of discussion
- A mechanism whereby both practitioners and managers are held accountable for practice and decision making
- A valuable tool to assist planning and evaluate progress

### 1.2. Front sheet

- This is very important and should include relevant details of family members and other agencies working with the family.
- Details should cover: names, addresses, phone numbers and fax numbers. Efforts should be made to ensure that all names are cross-referenced at the front of the file. The front sheet should also include category of registration and date of registration. It is imperative that it is updated every three months (i.e. at review stages).

### 1.3. Contact sheets

- Should be in chronological order [most recent first/front to back]
- Should be completed within 3 working days. Record should be made as quickly as possible after the event
- Should include dates of contact with the child(ren) and family members, and other agencies. Highlight occasions on which a child is seen. Contact events cover home visits, office interviews, letters and phone calls. It should also detail dates of attendance at Court, Children's Panels, Reviews, Case conferences, case discussions and any other relevant meetings.
- Record unsuccessful attempts to contact or see someone.
- Contact details should be brief and cross refer to any additional papers in file or held by other staff
- Reference must be made to any risk assessment (e.g. Violence at Work Policy)
- The key worker is responsible for ensuring all social work contacts are recorded.
- Where there is joint working in a team or more than one worker involved with a service user a single file should be maintained

## 1.4. Progress Notes

The progress notes essentially provide a facility to record detail where this is appropriate and to record progress towards the objectives. While effective contact sheets can usefully reflect *activity*, the progress note allows this to be considered in relation to the stated objectives including changes of direction.

A recorded assessment should be the starting point of the progress notes.

- The purpose and specific method of assessments should be recorded (eg initial CP assessment, comprehensive/risk assessment, etc and include the record of who was involved and consulted)
- Timescales for assessment completion and review assessment should be recorded.
- The outline plan to protect the child, as agreed at the case conference, should be recorded and specific detail on how this is to be expanded on and implemented made clear. The team leader and social worker will then, with the Core Group, including family members, progress these tasks and record the detailed plan of aims, planned outcomes and action.
- The progress notes should contain a detailed record of interventions, including relevance to the aims of the Care Plan and progress towards objectives.
- Relevant detail regarding the nature and content of contact with the child and family should be recorded. Progress notes should record significant discussions with the family members, covering the nature of problems experienced by the family, advice given and response from the family and any adjustment to the plan and reasons why.
- Detail of practical tasks done on behalf of the family should be described e.g. benefits work, escorts, access.
- Recording of direct work with children should record methods, nature of intervention and then child(ren)'s response.
- Relevant detail on the nature and content of contact with other agencies should be recorded e.g. their observations of the child(ren) and family, evidence and opinion on progress, concerns about risk or lack of access.
- In keeping with the principles of the Children (Scotland) Act 1995, and effective practice, case records should reflect the child's view.
    - Significant events giving rise to concern should be highlighted.
- An evaluation of the risk of future harm to the child(ren) should be recorded and an assessment of needs and supports required.
- Cross reference should be made to decisions made at case conferences, case discussions, quarterly assessment meetings, Children's Panels and Courts.
- Identified gaps in resources and communication of this to management should be recorded.
- Summaries must be included at times of transfer and closures.

- The closure summary should include file retention instructions and destruction date.

***Suggested Headings for Progress Notes***

- Family dynamics
- Significant discussions with family
- Practical tasks
- Significant events
- View of the child
- View of the parents / family
- Areas of positive change
- Areas of concern
- Decisions of significant meetings
- Involvement of other agencies
- Evaluation of risk
- Needs assessments and future plans

### 4.5. Frequency

Child protection case notes should be typed and presented to the Team Leader fortnightly for counter signature and quarterly (12 weekly) to the Service Manager. A monthly summary should be included.

## SECTION 5: RETENTION AND ARCHIVING OF RECORDS (CHILDREN/YOUNG PEOPLE)

### 1.1 Introduction

**1.1.1** Records are not purely a Social Work tool but contain information given in trust and for some service users would be their only means of finding out their history, antecedents etc.

It is recognised that some children/young people change categories over the years and the following retention periods are ***minimum standards***. Where records fall into more than one category, the longest applicable period for retention should be used. If there is a prospect of legal action consideration should be given to retaining records for an extended period.

**1.1.2** The documents/files covered by this procedure are the child/young person's main file held within a fieldwork team, files and records held by any residential

unit/carer with whom a child/young person has been placed, all relevant day books/log books and incident records held by residential units, children's centre records, any personal information held by the Senior Management Team, etc. and records pertaining to foster carers.

| Retention Periods<br><br>C(S)A 1995 = Children (Scotland) Act 1995) | |
|---|---|
| **Category** | **Retention period** |
| Child Protection (Enquiries Made whether Registered or Not) | Till youngest child in family reaches 16 |
| Adoption | 75 years after adoption order granted, a legislative requirement |
| Children's Hearing Supervision Requirement | Until service user reaches 75, if child dies before 18th birthday then 25 yrs after date of death. |
| Children Looked After, including PRO, Sect 25, Sect 70, Sect 86 of C(S)A 1995 | Until person reaches 75, if child dies before 18th birthday then 25 yrs after date of death. |
| Family/Child (General) | Till youngest child reaches 16 |
| Child/Young Person in a Residential Unit | Files must be retained in line with established practice. All files must be culled before being passed to main fieldwork team for future reference/archiving. |
| Foster carers and other substitute carers | 25 years after ceasing to foster or from time of application to foster/care/adopt if not approved |

## 1.2 Procedure

### 1.1.1 Children and Families Teams

The files/records of all children/young people must be retained for the appropriate period of time after the case has been closed. All records must be clearly indexed and be readily accessible either within the general filing system or preferably in a separate archive/storage arrangement. Files/records may be microfilmed and archived centrally. The location of all closed files must be recorded on the Care

First System. The Team with responsibility for the child/young person is responsible for ensuring that all relevant information is brought together when a case is closed, including the integration of records from any residential units in which the child/young person resided. An acknowledgement must be sent to units from which records have been received.

### 5.2.2 Residential Units, Carers and other agencies.

#### (a) *Child/young person's records/files*

The Carer/Manager (Officer in Charge) of a residential unit or other agency must ensure that the child/young person's record/notes etc are passed to the appropriate Local Authority/Practice Team within a period of 3 months after the child/young person has been discharged from the unit. In the case of Foster Carers this should be done via the link worker. Any missing information should be identified and the appropriate Team Manager notified.

#### (b) *Unit log books/incident registers etc.*

All log books etc which identify the children/young people resident within the unit must be retained at the unit for 1 year (for ready reference as required) and thereafter passed to the Administration Manager, Social Work Department for archiving and storage. Any missing documentation must be reported to the Service Manager, Resources.

#### (c) *Closure of a Residential Unit*

Before any residential unit is closed down, all child/young person specific files must be passed to the appropriate Practice Team and all log books, incident registers etc must be passed to the Administration Manager, Social Work Department.

Details of all files/records passed for storage should be recorded and verified by the Service Manager, Resources.

## Version Control

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|---|---|
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