The Disabilities Trust

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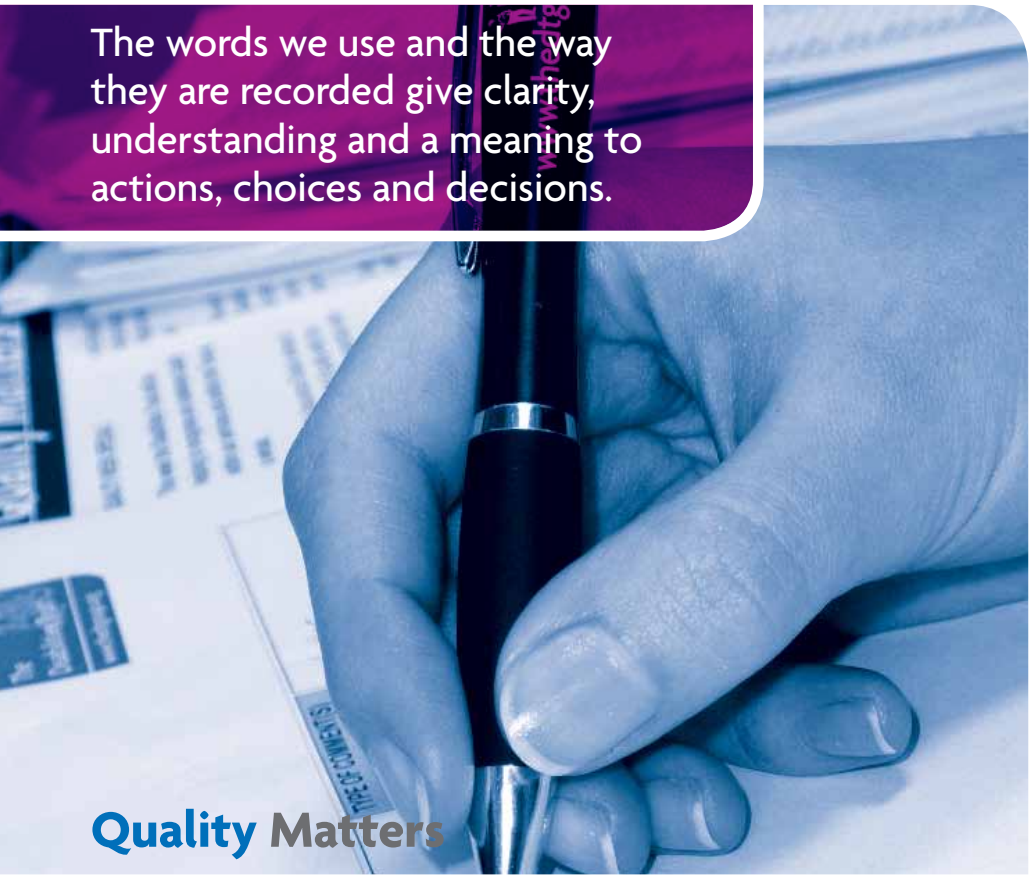
Report Writing and Defensible Documentation:

A Guide for Staff

The words we use and the way they are recorded give clarity, understanding and a meaning to actions, choices and decisions.



Quality Matters

Introduction:

Report Writing and Defensible Documentation: A guide for staff is intended to give some guidance and suggestions in terms of answering questions and offer suggestions for 'best practice' as set by the Quality Assurance Division of The Disabilities Trust.

REMEMBER: The better your report writing is, the less you will need to justify and explain your opinions within the formal meeting.

This Guide on record keeping and report writing is intended for support workers, rehabilitation support workers, one-to-ones and others who work directly with service users. This should help to give you a clearer understanding of the types of reports we write, why we write them and how to write them in the best way.

Please remember the following:

- Service Users **can** and **will** have access to their own records
- **Your** notes could be read out in a court of law
- **Whatever** you write you may be called on to explain the rationale behind writing it

A record is a communication of information, advice or action from one person, or a group of people; to another for a specific purpose. Often the ultimate function of a record is to provide a **basis for decision and action.**

Everything that we record and document as a part of our work should be written with the answers to the following questions in mind:

WHO

- Are we writing for?
- Are we writing about?
- Is likely to read your report?

WHAT

- Do we need to record?
- Is the purpose of the record?
- Do we not need to record?

WHY

- Are we writing this record?
- Do we need this report?
- Is it important?

HOW

- Do we know what to record?
- Do we record fairly and accurately?
- Do we present our report?

WHO:

- **Are we writing for?**
- **Are we writing about?**
- **Is likely to read your report?**

Who is the report for? Who is likely to read it?

You need to consider who you are writing this report for. Staff, external professionals, service users, families, lawyers and inspectors may all have access. When you write an entry into a service user's file you need to make sure you know 'who' you are writing for.

People who use our services:

- Recording a person's wishes/choices and needs
- A daily diary of a person's life
- Goals/rehabilitation targets for a person

Clinical Teams:

- Providing evidence for medication/treatment decisions
- Monitoring recognised behaviour/mood/anxiety
- ABC/BARS/OBS-LDASC

Commissioners:

- Are allocated hours of support being used?
- Are targets/outcomes being met?
- Is rehabilitation successful?
- Is the individual being treated with support and dignity?

Organisation:

- Professional indemnity
- Identifying trends in support
- Outcome focused support plans
- Learning from experiences
- Preparing reports for key decision makers

Family/friends:

- A true record of the individual's journey within our services
- Comfort in knowing what goes on and that their family member is being supported to a high standard and in the right way

Other people may be able to access this paperwork but only after the service user has given permission for this to take place.

If a person asks to read any paperwork containing personal information you should first check with a member of the management team to make sure that person has the right to access that information. If permission is given, a record of this should be kept within the Service User file.

REMEMBER: Goal, Audience, Structure

Goal:

- What is the aim of the report?
- What is the context of the report?
- What are we trying to achieve?

Audience:

- Who will read the report?
- Who has asked for the report and why?
- What does the 'audience' already know about the person or the situation?

Structure:

- Is there a set format that needs to be completed?
- What are the main events/points that need to be covered?
- Should the report be written in a formal language? First or third person?

TOP TIP

Always discuss the content of your report with the individual service user, where possible and their family if the individual wants them to.

A professional report should give the reader EASY access to a logical evidence-based account of the issue in question.

Start with the facts, which can then be analysed to form any recommendations. This order helps to make things within the report flow naturally.

WHAT:

- **Do we need to record?**
- **Is the purpose of the record?**
- **Do we not need to record?**

What types of record do we need to consider?

- Daily recording – activity/appointments/anxieties
- Food input and output, if there is an identified need to record this
- Ask the person you are supporting – what would THEY like recorded
- Appointments/outcomes – why did the person go? Was it routine? What did the professional suggest? What has changed? When is the person meeting again?

SUBJECTIVE	OBJECTIVE
Brian wasn't very hungry today. He only ate a few chips, I don't think he wanted his steak.	Brian ate half a portion of chips at dinner. I asked him if he wanted an alternative to the steak, but he said that he was fine.

Think about the person and the situation – Does Brian have a new problem with eating/chewing/swallowing? Would he prefer something else? Could he be a vegetarian or have a specific diet?

- Were behavioural guidelines needed and implemented, what was the outcome?
- Medication – what medication is prescribed; medication offered/accepted/refused
- General health and mood
- Progress reports
- Review reports/risk assessments
- Accident and Incident reports

When you write an Accident or Incident form you need to make sure that you not only give clear information about what led up to the event occurring, but also how you have managed the situation to ensure that it will not happen again. Best practice in documenting this type of event would include ensuring that copies of reviewed documents are clearly referenced, detailing any changes in circumstance that are now relevant.

Deciding what to record:

- What will the record be used for?
- Understand what NEEDS to be recorded
- Personal challenges in writing records can be resolved through e-learning – talk to your Line Manager
- The Trust supports transparency and a 'no blame' culture

Summarising:

In summarising we capture all the important parts of what we have recorded and express them in a short space. When summarising try to make sure that you:

- State the main points and leave out any information that is not essential
- Analyse the information and distinguish important from unimportant
- Link any key points, using sentences or paragraphs as appropriate
- Only give opinions, unless you are professionally qualified to do so, and this is clearly identified within the record

WHY:

- **Are we writing this record?**
- **Do we need this report?**
- **Is it important?**

Record keeping and documents are recorded to ensure that legal requirements are met and necessary standards are reached. A good record can clarify decisions, provide understanding and rationale to support plans, as well as helping to evidence what level of intervention/interaction is working and what may not be working.

We need reports so that we can accurately review, evidence and support choices, decisions and standards of care, education and the provision of care and support.

When writing a report, record or communication, it is important that you always bear in mind WHY you are recording this specific information.

REMEMBER: Stick to the point! – There should be a purpose to what you put in your report; it should not be a list of everything you know but should demonstrate the factual information and evidence that are needed to make the point in question.

HOW:

- **Do we know what to record?**
- **Do we record fairly and accurately?**
- **Do we present our report?**

Writing in Plain English:

Trust standards of writing reports:

FONT: **Arial 12pt**
ACRONYMS: **Written in full on the first use**
ALIGNMENT: **Left**

- Quality of records and communication with all external parties/stakeholders is a direct measure of the service we provide
- Failure to record accurate information can have serious consequences. We need to ensure that service users are treated effectively and appropriately
- It can provide an objective record of service user care that can be used in court or in the event of a complaint
- Provide a record for the person of their time in the service
- Contribute to the development, implementation and review of the plan for the person
- Identify and respond to the person's needs
- Help recognise and establish patterns in the person's life and/or behaviour
- To support the provision of consistent, high quality care
- To demonstrate that the service meets regulatory requirements

Use of Language:

Although for professional reports it may be necessary to use technical language, the extent to which we do this will depend on the audience. Slang and colloquial terms should always be avoided, unless it is a direct quote from an individual which is clearly indicated. Acronyms should always be spelt out in full the first time they are used in a report.

REMEMBER: Who is the report written for? Service users and other agencies may not understand some of the terminology you use in everyday conversations.

EXAMPLE NARRATIVE

Date & Time	Observation / Progress Report	Print & Designation	Sign
14:30	John went for a walk today and got angry with Eric. Feedback given.	J Smith	J Smith

THE CORRECT NARRATIVE

Date & Time	Observation / Progress Report	Print & Designation	Sign
14/05/2010 14:30	Whilst out on his morning walk John started to shout at another service user (EL001). He stopped shouting when he was reassured the service user (EL001) was not following him. John completed his walk and returned to the unit.	J Smith RSW	J Smith

- Capturing all the important parts and recording in a short space
- Stating main points

Keeping it Safe:

The Data Protection Act:

Principles:

- Information MUST be obtained and processed legally
- Data should ONLY be held for specific purposes
- Personal data held for a purpose should not be disclosed in a manner incompatible with that purpose

Personal data held:

- Must be accurate, up to date and not kept longer than necessary
- An individual should have access to their records but they have to formally request this. Normally this would be access in the presence of someone qualified to help to understand them. Access can be refused if it would be psychologically disturbing for them to see the records
- Appropriate security measures should protect the data

The Act means everyone has a right to know:

- How and why information is recorded about them
- Who has access to the information now and who may have access in the future

REMEMBER:

S Situation – describe the situation, who you are talking about and what is happening at the moment (the reason you are writing now).

O Options – outline the options, show that you are aware of more than one way to respond to the situation.

S Suggestions – explain your suggestions, back up the option you prefer with more detail and reasons why. Make clear this is your opinion rather than facts.

Words and phrases we use regularly:

You need to choose your words carefully so that they make sense within the context of the report.

EXAMPLE: Instead of writing: 'Harry was kicking off so we took him to the floor until he stopped screaming – then we removed him to his bedroom.'

Consider writing: 'Harry hit the cupboard door eight times with his open right hand. After the second hit against the door, Harry began vocalising screams. These activities did not appear to be directed at any specific person. Behaviour guidelines were followed and staff supported Harry to leave the area using a 'turn and guide' procedure. Intervention form completed. Harry was supported to spend time in his own room'.

Key Points:

DOs

- Identify the service user on each page
- Write legibly
- Use permanent black ink
- Avoid errors in grammar, spelling and punctuation
- Correct any errors with a single line through so the error is still legible, then sign and indicate designation
- Document facts not assumptions or opinions
- Date/Time/Name/Designation/Sign
- Indicate other service users within the report using the Data Protection 'codes' for individuals

DON'T

- Document anything before it has happened
- Erase or use corrective fluid
- Enter any identifying information about another person, it may breach the Data Protection Act
- Leave blank lines or pages
- Amend someone else's notes
- Make suggestions
- Use slang terms or jargon
- Diagnose unless clinically qualified to do so

Good Practice:

- Ask the person about their day, what do they feel should be recorded?
- What activities has the person undertaken today, did they choose not to do some of the activities, what reasons did they give?
- What has that person had to eat or drink; do we have a medical or behavioural need to record input/output
- Medical or Therapy Appointments: Where did the person go? Who did they see? Has anything changed? How do we follow this up?
- Has there been a need to implement behaviour support guidelines? What were the triggers? How was this managed?

- Medication changes: Has the medication changed? What needs to be recorded?
- What have you observed about their general health and mood, is the person reacting in a different way 'from normal'

SUBJECTIVE	OBJECTIVE
Brian spoke with Miranda and she has agreed to go shopping again with Brian next Thursday. It'll be fine as they've done it before.	Brian spoke with Service User MS001 asking if they would like to go shopping with him next Thursday. Risk assessments in place following the last visit have been reviewed and are still relevant.

Think about the person and the situation – What actually happened?

Make sure that your writing is free from assumption or judgement. Keep to the facts.

REMEMBER:

- **Service users can and will have access to their own records**
- **Be aware your notes could be read out in a court of law**
- **Whatever you write you may be called on to explain the rationale behind writing it**

Mistakes:

- Subjective comments
- Rushed narratives
- Lack of communication
- Slang/unauthorised abbreviations
- Clear and transparent corrections
- Poor or illegible handwriting

SUBJECTIVE	OBJECTIVE
Brian was angry, shouting and hitting things.	Brian slammed the door and told staff to 'get out of my way' in a raised voice.

Think about the person and the situation – What triggered this behaviour? Is it a new situation? Are there guidelines in place? Were they being followed? Does this excerpt tell the whole story for others to read, knowing if it could be handled/managed better?

Review reports – What do people look for?

When people read reports they look for key words and phrases that may affect decisions and opinions around quality of care, support, medication and hygiene. Use the colour coding to see what different people may interpret from this one standard report:

PERSONAL CARE (Mum)

Johnny cannot use a normal shower because of his physical problems and epilepsy. This also affects his performance in the kitchen and he always burns his dinner. In the assisted shower he can wash himself, but doesn't really try. This means that he is often unwashed if staff are not available to do things for him. Because of this he smelled badly last Tuesday and couldn't go to work. It is very important for Johnny to go to work as there is nothing on his programme as an alternative on those days. Also, his leg gets infected if he doesn't keep it clean and dry.

PERSONAL CARE (Social Worker)

Johnny cannot use a normal shower because of his physical problems and epilepsy. This also affects his performance in the kitchen and he always burns his dinner. In the assisted shower he can wash himself, but doesn't really try. This means that he is often unwashed if staff are not available to do things for him. Because of this he smelled badly last Tuesday and couldn't go to work. It is very important for Johnny to go to work as there is nothing on his programme

as an alternative on those days. Also, his leg gets infected if he doesn't keep it clean and dry.

PERSONAL CARE (PCT)

Johnny cannot use a normal shower because of his physical problems and epilepsy. This also affects his performance in the kitchen and he always burns his dinner. In the assisted shower he can wash himself, but doesn't really try. This means that he is often unwashed if staff are not available to do things for him. Because of this he smelled badly last Tuesday and couldn't go to work. It is very important for Johnny to go to work as there is nothing on his programme as an alternative on those days. Also, his leg gets infected if he doesn't keep it clean and dry.

PERSONAL CARE (Defence Solicitor)

Johnny cannot use a normal shower because of his physical problems and epilepsy. This also affects his performance in the kitchen and he always burns his dinner. In the assisted shower he can wash himself, but doesn't really try. This means that he is often unwashed if staff are not available to do things for him. Because of this he smelled badly last Tuesday and couldn't go to work. It is very important for Johnny to go to work as there is nothing on his programme as an alternative on those days. Also, his leg gets infected if he doesn't keep it clean and dry.

PERSONAL CARE (Plaintiff Solicitor)

Johnny cannot use a normal shower because of his physical problems and epilepsy. This also affects his performance in the kitchen and he always burns his dinner. In the assisted shower he can wash himself, but doesn't really try. This means that he is often unwashed if staff are not available to do things for him. Because of this he smelled badly last Tuesday and couldn't go to work. It is very important for Johnny to go to work as there is nothing on his programme as an alternative on those days. Also, his leg gets infected if he doesn't keep it clean and dry.

Legal Framework:

- Data Protection Act 1998
- Freedom of Information Act 2000
- Confidentiality Policy
- Caldcott Principles
- Access to Health records Act 1990
- Storage and security of information
- CQC Essential Standards of Quality and Safety
- HASAW 1974 (COSHH/RIDDOR/First Aid)
- The Public Interest Disclosure Act 1998
- Health and Social Care Act 2008
- Civil Evidence Act 1995
- The Caldcott Committee Report on the review of patient identifiable information, Dept of Health (1997)
- Access to Medical Records Act 1998
- Data Protection Act 1998
- Human Rights Act 1988
- Data Protection Order 2000
- Freedom of Information Act 2000
- Freedom of Information (Scotland) Act 2002
- Communications Act 2003