"Every conversation starts with the child"

"Recording"

Every time I am on the phone, no matter who to, I find myself with pen in hand making 'notes' of our discussion, even if that was with a friend about children or events which have happened recently. I think it's a habit which has developed over a number of years in SW and in the realisation that if I don't write it down I am 'quite' likely to forget!!

Feelings regarding case recording has huge variations in SW and sometimes SW's can feel a sense of ambivalence towards recording. It can sometimes feel as though recordings are made primarily for the benefit of others rather than as **essential** to good practice (O'Rouke, 2009) and sometimes you might also feel that given the volume of work you need to complete, spending time in front of a computer, updating records, it is simply another activity that prevents you from spending time with children. According to Eileen Munro;

> *"Recording is a key social work task... Getting effective recording systems in place to support practice is critical." (Munro, 2011).*

Munro has written a great deal and had a massive influence of SW practice and although this statement is intended within CP SW, the point made regarding the importance of effective recording systems in supporting good practice applies across SW.

Who are we recording for?

When you are recording it's important to remember your audience. How easy would it be for another worker to pick up your case file and understand what the risks and strengths are for the child/family? How would they know what work you have already done and that which you intend to do? Would EDT be able to quickly manage risk in an emergency and understand what you and the family wanted to happen in these circumstances? **Would the child** understand why decisions were made about their lives? A brief synopsis of this needs to be encapsulated within the case summary which should appear on the front page of the child's record – as I am sure you know there is a case summary section on MOSAIC which must be completed (if not let me know and I will help you find this).

Chronologies.

Lots of things happen in a child's life, of course, not all of them have to be recorded in full. But the most significant events – for example, a placement move, separation of parents, death of a relative, birth of a sibling…. should always be captured, so that the record properly reflects a child's experiences and progress. The record should clearly explain what has happened to, and for the child, both to inform the support provided to the child today, and, to help them understand what decisions were made during their childhood and why. Chronologies should include a record of the event and importantly the impact of this on the child and on planning. The chronology does not need to be an in depth account of the event, this can be recorded in the case notes and analysed in the assessment, but it does need to provide a visual account of significant events which is easily accessible and provides an opportunity to consider patterns and themes. A chronology is not an end in itself but a working tool which promotes engagement with children and families and with other professionals.

> *"Chronologies provide a key link in the chain of understanding needs/risks, including the need for protection from harm. Setting out key events in sequential date order, they give a summary timeline of child and family circumstances, patterns of behaviour and trends in lifestyle that may greatly assist any assessment and analysis. They are a logical, methodical and systematic means of organising, merging and helping make sense of information. They also help to highlight gaps and omitted details that require further exploration, investigation and assessment".*
> http://www.gov.scot/resource/0040/00408604.pdf

Think about how you might record differently… Is there any reason you cannot record the outcome of a home visit and your analysis of this work in a draft single assessment or SW report? Assessment is an ongoing process and although it will always be a 'snapshot in time' it is important that the information and analysis within it is current. This is much easier to do if you see completion of this as an ongoing process, this way the analysis of this is an analysis you have made at the time and not one you subsequently have to remember. There are lots of parts of the single assessment or indeed a review CP CYPiC report which can be included iteratively

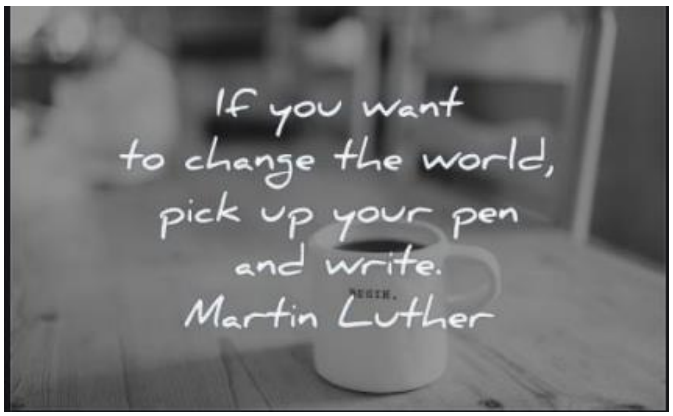
and which will support you to complete the document within the appropriate timeframes and also will mean less work as a large proportion of the work will already be done?

It's easy to misunderstand the nature and purpose of a chronology and producing a chronology can be seen as an 'administrative chore'. Chronologies are an *essential* part of a good assessment, a vital foundation for analysis, and a useful tool to help you to develop relationships with children and families. I've never understood when a social worker says "I've done my assessment, now I have to do a chronology" – how can you write the one without the other? For me, the chronology is the start, and heart, of a good assessment.

Write clearly and without jargon

Think about the language you are using, who is the audience? It is too easy to unwittingly use complicated language or jargon in a way that confuses what you mean. When under pressure, many of us use abbreviations to save time – SWET, ICPC, CP, CYPIC etc. and this can mean that parents and children are excluded from clearly understanding what is meant.

One of the difficulties with jargon is that sometimes we can use it without even realising because it becomes part of our everyday vocabulary. Phrases that you may not consider as jargon can still be confusing for children and families. And even without it, SW records can still be too complicated and lacking in clarity. Using more common words does not mean being patronising or missing out important information, a key test of how well you understand something is being able to explain it to someone else.

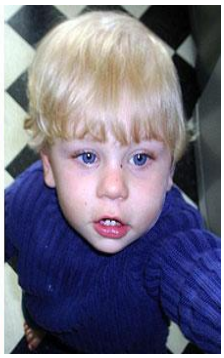


Language is also important. Anything that implies victims are to 'blame' for any abuse they suffered during childhood can compound the impact of that abuse, as can casual statements about 'lifestyle choices' by vulnerable teenagers. My view is that this is less prevalent now but we still sometimes see inappropriate language in case records. Remember when you are recording email correspondence that you avoid mentioning other children or anonymise this information before it becomes part of the child's record. Please also remember to respect the young persons preferred pronoun, I have seen recordings, in York where a young person identifies as male but the recording refers to this young person as 'she' because this is the gender recorded on the young person's birth certificate.

Distinguish between facts and opinions

SW's need to be comfortable making – and recording – professional judgments. Being personally non-judgmental is important but being able to judge levels of risk and need is a key social work skill. The inclusion of opinions in social work records is not necessarily a problem, good records will contain both facts and opinions but there should be a clear distinction between the two.

As SW's we need to be comfortable with the fact that our role involves making professional judgements about other people. Being "non-judgemental" in our practice does not mean that we should not reach conclusions about, for example, whether the care a child is receiving is safe or unsafe, indeed, these are the kind of judgements/assessments we make every day. As a result our recording will include opinions and this is not in itself a problem. The difficulty arises when fact and opinion are not clear, when opinions are mistaken for facts and when opinions are unsupported by evidence or information which explains how/why you have reached this conclusion. It may be tempting to conclude that, given these difficulties, we should aim to compile records without including opinion. The problem with this would be that a purely "fact-based" record would be lacking analysis and so from the perspective of a child/family or other professional, no way of knowing or understanding the rationale behind decisions



Record wishes, feelings

Remember to clearly record what a child/young person has said. In many serious case reviews, children's views and needs were lost among discussion of the parents' views and needs. This is not a new problem. In his landmark 2003 report regarding the death of Victoria Climbié, Lord Laming noted that Victoria's wishes and feelings were almost entirely absent from her own file. Before you can record the wishes, feelings and views of service users, you first need to know what they are. This can only be achieved through spending time with children and forming a trusting and meaningful professional relationship. Don't forget to distinguish between wishes and feelings (of the child) and your analysis of the child's 'lived experience' which should be an analysis of what the world looks like from the child's perspective, what might it be like to be 5 when you hear your parents arguing every night and your dad is often drunk and sometimes mean to you? Evette Stanley, Ofsted said; 'Really high-quality recording lets the quality of the relationship between social worker and child, and the social worker's aspirations for that child, shine through. How important that must be to any care-experienced person looking at their childhood records in later adulthood'.

What does good like?

The case record is not just a place to record information, but should assist you in planning and making the best decisions for children. Description without analysis makes it so hard to understand how and why some important conclusions have been reached and decisions have been made. We need to think about the purpose of each piece of recording. For example, when recording a home visit to the child, the record is about the reason for the visit itself as well as its contribution to the whole assessment; the importance of not just what happened or was said, but what that means for the child. This does not need to be verbatim. The recording should include;

- What is the purpose of the visit?
- What were the main areas of discussion
- Any significant information/event
- What were any actions arising from the visit for either the child/family or for you?
- Reflection/analysis of the visit

What can we improve?

Ofsted Inspectors have identified some common weaknesses in recording, including records that:

- are not up to date, have gaps or lack analysis;
- only focus on the very negative things that happen to children, rather than their lives as a whole;
- are not bespoke to each child or use too much professional jargon;
- show a lack of care and attention, or are just poorly written;
- lack parents' views or the level of their engagement;
- do not show clear decision-making;
- are not age appropriate;
- mix up recording about brothers or sisters;
- show little purpose for visits to children and families and do not influence the plan or the next steps;
- fail to capture disabled children's views.

Finally, Sophie Wales, Assistant Director, Children's Services has asked that the enc. poster be shared with you regarding the PAMIC tool

Brian poster.pdf

Please remember to share your thoughts on this blog and any other with me, your feedback is vital, is this blog useful? What are your thoughts/tips on recording?

What is going well	What is not going well	What would you like to change
Comments		

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