

Rough Guide to Recording and Report Writing



Introduction

The *Rough Guide to Recording and Report Writing* is one of a series of practice guides produced by Hartlepool and Stockton-On-Tees Safeguarding Children Partnership (HSSCP) which have been designed to be read and used by the range of practitioners and professionals working across children's services in the borough.

All of the *Rough Guides* have been developed to support the valuable work that is carried out with children and young people¹ and families by identifying the key elements which underpin good practice and incorporating significant messages from research.

It should be noted that *Rough Guide to Recording and Report Writing* does not replace, provide the detail of or interpret legislation, policy, frameworks and procedures, which are all subject to change, but focuses more on the 'how to', offering advice, suggesting ideas and providing signposts to sources of information and further reading.

Whilst this *Rough Guide* is focused on recording and report writing in relation to child protection, it is likely the information will have wider relevance.

What is recording?

A case record (sometimes referred to as case notes) is an account of an agency's involvement, interactions and work with an individual child and family, and every practitioner working in children's services is likely to be involved in recording. In most agencies, the case record is likely to provide, at a minimum, details of:

- The child and family, such as name, address, dates of birth
- Contacts with the child and family including dates and who was present
- The child's assessed needs
- The plan to meet those needs and achieve the desired outcomes
- The child's outcomes i.e. the difference made as a result of services and interventions

Case recording can be in written, word processed or electronic format.

¹ To avoid repetition in subsequent sections, child or children are the terms used to refer to children and young people.

Why is recording important?

Recording is often viewed by practitioners as an irritating, time consuming chore, rather than being seen as an essential and integral part of the work they do and the services they provide to children and their families.

Recording is important for a number of reasons including the following:

- It structures and clarifies complex information and interpretation
- It supports information gathering, assessment and decision making
- It justifies and explains the rationale for key actions and decisions
- It ensures that important information can be retrieved and understood
- It focuses practitioners and their work
- It supports effective partnerships with children and families
- It provides an archival record of events in the life of a child that can be assessed by the child, family, practitioners and managers and others when needed
- It facilitates reflective practice
- It enables continuity when practitioners are unavailable or change
- It provides an essential tool for managers and auditors to monitor work
- It forms the basis for reports
- It provides evidence for additional resources
- It is an element of professional accountability
- It provides a major source of evidence for inspections, investigations and inquires

“We cannot be certain what passed between the two because of the lack of recorded information

- indeed in the case of the hospital there was none whatsoever
- or whether Ms F simply misunderstood what Dr F was saying.” *Lord Laming, Victoria Climbié Inquiry Report, 2003*



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Tip

Always regard recording as a key element of your practice rather than being an add-on and remember that inferior recording and report writing gives a negative impression of the writer and the agency.

What is effective recording?

There is likely to be a variety of different formats for recording different types of information on children and young people both within and across agencies. However, generally, case recording will be focused on:

- The purpose of each contact or interaction
- The key issues discussed or arising
- Direct observations
- Information obtained from others e.g. family members, practitioners and professionals
- The child and parents' views
- Decisions made and why
- Action taken or required
- Reference to any other relevant information on either the electronic or the paper file.

Effective recording includes the following elements:

➤ It uses plain and clear language

Using plain English is important, not just because records and reports should be shared with family members who need to easily understand what has been written but also because clear and unambiguous language tends to reflect clear thinking. Consider this example. Words and phrases such as 'aggressive behaviour', 'concerns about his educational needs' and 'low resilience' could be used but these are general and jargonistic terms. The following more accurately articulates the concerns. 'Ricky has been excluded from nursery for being very rough with other children and he is reported as not learning as fast as his ability would suggest he could. Coupled with the difficulty he experiences concentrating, Ricky is getting rid of his feelings rather than bottling them up but this ability to 'bounce back' is isolating him and he is becoming very unpopular with most children.' Effective recording also avoids the use of jargon, slang and abbreviations

➤ It makes sense

Your recording should be coherent, any reader should be able to understand it and there should be no room for ambiguity or for misleading readers. For example, always state who the contact was with and always give the relationship of that person to the service user, e.g. 'Mary Smith, maternal aunt ...' or 'Sally Jones, mother ...' rather than only saying 'aunt' or 'mum'. Be precise and specific in your recording. For example, describing someone as being 'supportive' or 'capable' or having 'a good relationship' with someone else is likely to mean different things to different people

➤ It is up to date

If decisions need to be made in your absence, your recording needs to be up to date. Unless information is recorded verbatim and in real time (eg on a tape recorder), a record will only be as accurate as the memory of the person making it. Unfortunately, there is plenty of evidence that our recall of even factual information is unlikely to be completely accurate and so it is important that recording takes place as soon as possible after the contact or event. Your agency may have specified timescales for completing case records and these should, of course, be adhered to. Generally, recording should be completed as soon as possible (the more complex the information, the sooner it should be recorded) after the contact or event

➤ It differentiates between fact, assumption, opinion and professional judgement

A fact is an objective piece of information that can be verified, something that is known to have happened. Assumption is supposition, taking for granted without evidence. An opinion is a personal view or belief about something which may or may not be based on specialised knowledge. Professional judgement is a conclusion or decision based on professional or specialised knowledge.

Some examples:

'I saw Peter playing with his toys when I last visited' is factual.

'The child's grandfather was drunk' is an assumption when based on nothing more than hearing slurred speech. (An alternative explanation may be that the person in question had suffered a stroke.)

'There are inadequate play opportunities available' is a judgement which needs substantiating.

Recording statements like *'The parents have a history of drug use'* may be fact or it might be based on a considerable amount of third hand unsubstantiated information. *'I have concerns that there is drug-taking going on in the house; however, the only evidence I have for this was how Mrs Green and Mr Green were behaving. They may or may not have been under the influence of drugs when I spoke to them'* is much more specific and avoids inappropriate labelling.

Recording when pushed for time can result in only opinions being recorded, like a professional short hand. However, the absence of supporting information means that readers cannot follow or test the conclusions arrived at. One or more practitioners, or indeed family members, presenting a strong opinion about an individual or situation can result in their opinion being recorded as a fact. But it is also important that records are not simply confined to factual information. So, aim to separate facts and opinions in your recording. Record the facts first and then record your analysis of them. Remember to include any research evidence you have used to inform your views and opinions and to reach your conclusions. Where another professional or family member gives an opinion, ensure that this is recorded as such

➤ It is relevant

Some practitioners record too much and some too little but deciding what is relevant to record isn't always easy. Over recording may be due to practitioners failing to understand what is significant, what needs to be recorded, so they record everything. Consequently, specific incidents or events are over emphasised in recording and, whilst unimportant, take on excessive significance. As case records have increasingly become important measures of accountability and the effectiveness of the practitioner and organisation, practitioners may fall into the trap of using case records to try and protect themselves from some future, unspecified challenge (so called defensive recording). But, as practitioners cannot know the nature of any future challenge, it is difficult to know what may be safely left out. Taken to its logical conclusion this means practitioners must record everything. This is clearly not practical and undesirable.

"The standard of record keeping was generally below an acceptable standard. ...I found examples of important discussions not being recorded on case files. ...All agencies need to ensure more detailed recording of critical issues"
Serious Case Review, 2009

The practice of under recording, i.e. failing to record significant information, is clearly also to be avoided. As we know from inquiries and serious case reviews, minimal recording means crucial information can be omitted from the case record, placing children at risk of significant harm. Identifying the significance of the information recorded for the particular child will help to avoid the pitfall of over or under recording. Ensuring that there is a clear plan for the child will help to focus the practitioner on what is relevant

➤ It includes analysis

A common criticism of case records is that there is an absence of analysis. A lack of analysis can result in records that just focus on descriptive narrative. The focus is on what is happening, but does not move beyond this to consider why it is happening. Any analysis takes place outside of the record in the mind of the practitioner. Consequently, the rationale underpinning decision-making is not evident or clear in the case record. Good case recording doesn't just describe (the what) but goes on to analyse 'why' and 'what might be done'. Often recording focuses almost exclusively on the 'surface' of what practitioners are seeing, rather than on 'what lies beneath'

➤ It contains a sense of direction

Without too much searching, it should be possible to easily ascertain what the agency's involvement has been and where it is going. It is not always easy to gain such an impression, however, because often practitioners are too focused on the 'here and now' aspects of the child and family's life and not with the outcomes and results being aimed for and how these are being achieved. Relating the information being recorded to the overall plan will ensure that records remain child and outcomes focused

Remember.....



The case record should be more than a complex diary of the practitioner's actions and the response of the service user. To use it in that a way is like buying a mobile phone and then only using it as a clock to tell the time. Practitioners should use case recording to support analysis and reflection.

Sharing case records with children and their parents, in particular key documents such as case plans, assessments and reports, really does help to ensure that records are both accurate and that recording takes place in in a transparent way.

Chronologies

In case recording, the aim of a chronology is to provide a clear and succinct account of all significant events in a child's life to date, drawing on the knowledge and information held by agencies involved with the child and family. The key purpose of a chronology of significant events is early indication of an emerging pattern of risk and concern. For example, this may be evident by gradual and persistent withdrawal from protective factors such as non-attendance at health appointments and non-attendance at nursery or school alongside frequent attendances at the A&E department or GP out of hours service.

A significant event is anything that has a significantly **positive or negative** impact on the child. It does not have to happen to the child but could result in a change of their circumstances which then has positive or negative consequences for them. It is important to remember that what might be a key event in one child's life, such as a period of good health or good school attendance after a long period of absence or exclusion, will not even be relevant to another child.

The chronology should be factually based and it should be clear what the source of the information is. It does not replace existing case records which will include much more detailed information. The chronology should be succinctly recorded and child-focussed. Each event should have an action or an outcome that has had a significant impact on the child. It is not appropriate to only record dates of meetings, visits etc without the outcome that therefore details the significant event. When reading a chronology there should be no apparent gaps in information.

Chronologies are important because they record the circumstances and experience of the child and milestones in their life including those positive events usually celebrated by a family. Some significant experiences and events may be less positive but are important in the life of the child. These all need to be recorded in a chronology to identify at a glance the key patterns indicating needs, risks, evidence of resilience and the family's potential to support its own needs or progress with minimal intervention.

Remember.....



A chronology which is not reviewed and analysed serves little if any purpose.

Report writing

Common criticisms of reports submitted to child protection conferences by the range of practitioners and professionals involved is that they are too structure-led, more concerned with the format than the content, unfocused, repetitive and descriptive.



- It is important that, from the outset, you are clear about the purpose of your report. Why have you been asked to provide it? What do you need to focus on? What do you need to leave out? Remember, child protection conferences are essentially about analysing information and planning.
- Take the time to plan your report. If there is no prescribed format or template, how will you structure your report? How long does it need to be? How will you organise the information you want to present? Writing an outline will help ensure you include everything you need to and help decide what you can leave out. Planning should also help to ensure your report is written in time.



- Be accurate throughout. The topic of accuracy has cropped up several times in this *Rough Guide* but it cannot be stressed too many times that you should check your report for accuracy in the child's and family's details and then check again. Are names spelled correctly? Are names spelled consistently throughout the report? Are the dates of birth correct? Are any other dates in the report accurate?
- Refer to the case records. Don't rely on your memory for the content of your report. Information in case records and reports should match.
- Make it clear when you are speaking from your own knowledge or observations, and when information is from a third party.
- Don't repeat or duplicate information in your report. Decide what you need to include and write it once.
- Share your report with the child (if appropriate to do so) and the family in advance of the child protection conference, preferably giving them sufficient time to properly understand the content. Whilst you may be very busy, it is poor practice to give them your report to read just prior to a conference when anxiety levels are likely to be high. Remember that children and parents cannot participate in decision making effectively if they do not have a clear understanding of the information practitioners and professionals have gathered, the conclusions drawn, the recommendations being made and the rationale for those recommendations.

What to include in a child protection conference report

Generally, when thinking about what you need to include in a child protection conference report, the rule of 'no surprises' should prevail, i.e. nothing should be included in the report that you do not feel able to say directly to the parents and which you have not already discussed with them.

You should aim to include the following:

- **A chronology of significant events and agency involvement:** You should include both positive and negative key events in the child's life to date
- **A summary of your assessment of the child's needs:** How is the child growing and developing? Are any of the child's health and wellbeing needs currently unmet?
- **A summary of your assessment of risks, protective and resilience factors:** What is getting in the way of this child's health and wellbeing? What are the child's and family's strengths? What are the protective factors and resources available at child, family and community levels? If you think the child is at risk, why do you think that?
- **The focus of your agency's current involvement** (if appropriate): What is the plan? What are the desired outcomes? How is the plan progressing? What is working well? What isn't working and why? What additional support has been provided to minimise risks?
- **The child's and family's views:** These may be different to yours but, without families' perspectives on the children's difficulties and assessed risk, practitioners' information is incomplete. They should also be recorded in the child's and parents' own words. Avoid interpreting
- **Your conclusions and recommendations about what will improve the child's outcomes:** Based on your analysis of the information, what are the implications for the child or young person's future safety, health and development? What is needed to make a difference to the child's health and wellbeing outcomes?

What makes a good report?

It is written in simple, clear and lucid language

Reports should be easy to read and understand. There should be no ambiguity or confusion. Avoid using long sentences which can result in the points you are trying to make being lost – aim for sentences no longer than about 15 to 20 words. Don't use slang, jargon, acronyms and abbreviations, especially those which are agency or service specific. For example, to some practitioners, G&T may refer to gifted and talented children; for other people, it probably means a pleasant drink with a slice of lemon.

It is grammatically correct

Grammar, punctuation, spelling and word choice may not be your strengths but they are important. Something as simple as improperly using or omitting a comma can change the meaning of a sentence. So can the use of a wrong word. You can use spell checkers but don't rely on them totally as they tend to use American spellings and don't pick up words which are spelt correctly but used inappropriately e.g. there instead of their.

It is accurate

Most inaccuracies are due to simple spelling errors and typos. Double check the spelling of names (this really important) and be consistent throughout the report. Children and families will read your report and they may well reasonably question, if you didn't get their names right, what else did you get wrong. (It's surprising how many reports contain different spellings of the same name.) Proof read your report several times before submitting it. Remember that being accurate also means being specific. Don't be vague in your writing.

It is comprehensive but concise

The report should give a complete picture with no gaps in the information presented. Don't leave readers with unanswered questions. It may seem contradictory to say that a report should be both complete and concise. However, being concise does not mean leaving out important details. Concise doesn't mean short, either. Rather, it means using words economically and omitting words and information that do not add value. Your writing should be free of the excessive wordiness that interferes with readability and information which might be included to pad out your report but which is irrelevant.

It is logical

The different parts of the report should be arranged in a logical order so as to make it an integrated document. Poorly organised reports can leave readers feeling lost and confused, so it's important that the information in the report flows and is well-organised. Sometimes the format of the report is dictated by the required use of a template or specified structure but you should still try to ensure that the content in each section flows in a logical sequence. For example, your conclusions and recommendations should not be a surprise to the reader and should logically follow on from the earlier sections of the report. Planning the report will help.

It differentiates between fact and opinion

As with case recording (see page 5), the information presented in your report should make very clear what is factual and what is substantiated opinion and professional judgement.

Example

Mr and Mrs B are of low ability and this has been a factor in their neglect of their children. The family home is often untidy and is badly organised. Mr and Mrs B have been unresponsive to attempts to help them.

This part of a report raises major questions: what does 'low ability', 'neglect' and 'unresponsive' actually mean? Also, perfectly ordinary events - houses which are untidy or not well organised (and how is yours today?) - become extraordinary when written in a case record or report. The overall effect of the above extract is to label the person - but not with universally understood meanings, because the terms used are not clarified. Ultimately, this piece of writing tells us more about the practitioner than the family members.

It includes analysis

Don't present a report which simply summarises the information you have collected or provides a narrative of what has happened. Avoid writing reports which contain what is essentially a list of negative statements about the child and family. Knowing that there are 'problems' doesn't tell us very much: we need to know the relative weight, connection and importance of the problems in respect of the child's needs and the parent's capacity and resourcefulness. What is the significance of the statement or information you have presented? Analyse, don't just describe.

Remember.....



Well-written reports require some effort. They should not be something you merely throw together between other tasks. As difficult as it might be in a busy working week, try to set time aside for your report writing and carefully review and edit each report before you submit it. Remember that, once submitted, your reports become a permanent record.

Other records

Remember that your emails, letters, memos and notes of meetings and telephone conversations about individual children and their families will become part of the permanent record. Formats for letters and memos should generally follow agency procedures and guidelines and should be proof read for accuracy and use of language prior to sending.

When recording telephone conversations:

- Include the date and time, and the name, number and, where appropriate, role of the other party
- Feedback and agree with the other person the key points from the conversation before the call ends
- Record the key points and try to ensure that the other person does the same
- If action is agreed, record who is doing what and when

E-mails

E-mail is a common method of communication between practitioners and professionals, both within and between agencies. It is important to use the right tone in e-mails and give the same consideration as other forms of correspondence:

- Always check that the e-mail address is correct. Often there can be two people in the agency with the same name
- It is best to open and close e-mails with 'Dear' at the beginning and 'Best wishes' or 'Regards' at the end. 'Hi' is generally considered inappropriate for business e-mails
- Write e-mails with the same care used to write a formal letter
- Proof read e-mails before sending and correct spelling and grammatical errors
- Do not use the shortcuts of text messaging language in e-mails
- Be concise
- Ensure that e-mails are titled clearly in the subject box. This helps the reader to refer to your e-mail at a later date. Keep titles short
- Ensure that an e-mail signature is set up that states name, job title, team, organisation, address, postcode, telephone number, fax number and work mobile number
- Think twice about whether or not the e-mail is the most appropriate method for communicating the information

Records of meetings

Minutes of meetings provide a clear and accurate record of what was said and agreed and are usually taken by a designated minute taker. It is more difficult to make records of meetings when you are also a participant but the following tips may be helpful:

- Make notes throughout the meeting which you can refer to later. If you miss something or are unsure what has been said, check and clarify at the time
- Write the record of the meeting as soon as possible afterwards. The sooner they are written, the more accurate they will be
- At the start of the meeting, circulate a sheet of paper for attendees to sign and give their contact details. This information is helpful when distributing the minutes
- List the people who attended and those who gave apologies or who were absent
- Record the name of the person chairing the meeting and the person making the notes

- Record the reason for the meeting e.g. 'Core group meeting regarding'
- and the place, date and time of the meeting
- Before the meeting ends, check for accuracy with participants the key action points agreed
- For each item on the agenda, record the principal points discussed, decisions taken, any areas of disagreement, action agreed, the person responsible for progressing the action and the deadline
- Present the record of the meeting concisely, clearly and in an easily readable style
- Record the time, date and place of the next meeting
- Ensure that the chair reads and checks the minutes for accuracy before distributing them
- Distribute the record to attendees and those people who gave apologies as quickly as possible after the meeting so that people are aware of actions to progress

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Sources and further reading

Walker, S., Shemmings D. and Clever H. *Write enough: Effective recording in children's services*. Useful resource which includes practical exercises and is available online: <http://www.writeenough.org.uk>