

*Please note that this information provided in this template is a guide. This template can be adapted to reflect your own policies, procedures and values. Whilst WSAB try to ensure this policy reflects current legislation the responsibility to keep this up to date is on the group who choose to adopt it.

Wigan Safeguarding Adult Board (*Template)

Case Recording & Use of Appropriate Language Guidance

What this session will give you:

- Introduction to Case Recording
- Our legal duties
- What we mean by the Standards and why do we need them
- Understanding of who will monitor case recording
- Examples in Practice
- Understanding the importance of appropriate language
- Understanding Defensible Decision Making /Clinical Reasoning
- Resources for further guidance and training

The guidance has been reviewed by Information Governance and Happy Smiles.

Introduction

Remember we work in a caring profession, therefore it's important to write with kindness, compassion and integrity. [Warmth and kindness to bring dignity in care - SCIE](#)

The guidance can be used across the system, inclusive of partners and providers to provide to promote good care recording and the use of appropriate language.

Case recording / record keeping ensures our records are of a high quality, easy to read, clear and accurate.

It covers both our written and electronic records. Our records should:

- Be easy to understand.
- Explain the reasons behind our professional decisions.
- Show that we're meeting our legal requirements.
- Be factual
- Be written in a way that puts the person at the centre.
- Help us understand the person's life and our involvement in it.

It is important to remember that the person has data subject rights under UK GDPR, therefore they can request copies of all their records at any time. Certain exemptions can be used when sharing this information, but when writing on the persons care record, it is important to write with an understanding the person may see this at any time.



Our Legal Duties

Our Legal Duties spread across the partnership and with key providers. [[organisation to amend the following where appropriate](#)]

This includes but not limited to:

The Care Act 2014	Mental Health Act 1983	Police and Criminal Evidence Act 1984 (PACE)	Data Protection Act 2018	Health and Social Care Act 2008
Mental Capacity Act 2005	Care Quality Commission (CQC) Regulations	Criminal Justice and Public Order Act 1994	Health and Care Act 2022	Offender Management Act 2007
NHS Act 2006	Police Act 1996	Human Rights Act 1998	Probation Service Act 1993	Equality Act 2010
Health and Care Professions Council	Royal College of Occupational Therapists' Professional standards for occupational therapy practice	Housing Grants, Construction and Regeneration Act 1996	Housing Act 1996	Domestic Abuse Act 2021

Recordings should be:

Person-Centred Approach: Recordings should reflect a strengths-based and person-centred approach. This means considering the individual's preferences and ensuring the recording is respectful and accurate.

Purpose of Recording:

- **Framework for Good Care:** Provides a structure for delivering effective care and support.
- **Continuity of Care:** Ensures consistent communication with other agencies involved in the individual's care.
- **Accountability:** Serves as evidence for audits, inspections, and legal purposes.
- **Evidence:** Useful for court cases, complaints, and investigations
- **GDPR Compliant** all recording must be done in line with the [Principles in Article 5 of the UK GDPR](#)

Content of Recordings: Should include personal details, communication preferences, and any support required, such as independent advocacy.

The Standards



Standard one: Our record will be written for the individual.



Standard two: We will be clear in terms of what is fact and what is an opinion.



Standard three: We aim to keep our recording up to date.



Standard four: We aim to be curious and analytical in our practice and show this through our recording.



Standard five: We will always aim to use concise and precise language in our recording.



Standard six: We will consider where and how information needs to be recorded and be mindful of both confidentiality and risk.



Standard seven: We will be respectful in what we record and how we record it.



Standard eight: We will be clear in our recording about the legal basis for our decision.

Why do we need standards?

Record keeping is a crucial part of our work, showing the type and quality of our involvement.

The contents can be challenged by adults or carers, and records are legal documents that can be used as evidence in court or scrutinised during complaints. They provide a record of agreed actions (and those considered but not taken) and the reasoning behind these decisions.

It's important to understand why we record, examples include:

- To provide the person with information about their history and our involvement in their lives.
- To facilitate communication among all those involved with the person.
- To ensure seamless transitions if workers change.
- To evaluate the outcomes achieved by the person effectively.
- To manage risk and keep people safe.
- To show that care packages follow a logical sequence of assessments and care planning, justifying the expenditure of public funds.
- To provide evidence for court, inspections, investigations, complaints, best practice, and enquiries.
- To check the quality of our work.
- To be legally compliant.
- Enhance practice and the support you can offer people if you can make good recording a central part of your work.

Who will monitor?

We all have responsibility for our work, but it is helpful for managers or those who supervise to use this guidance as part of induction, ongoing training, and supervision.

Managers or those who supervise should use this guidance when reviewing case recording or completing practice audits, to make sure the standards are met. If not, managers should consider with the staff member what action needs to be taken to support recording or manage performance.

We will monitor through seeking feedback from staff (through supervision, audits, and team meetings) that these recording standards are helping us to provide a more consistent approach.

Always remember: If it isn't written down, it didn't happen!

Examples in Practice

More examples can be found in the case recording guidance....

Initial Recording	Revised Recording
Email sent: [copied and pasted text] Dear Dan, I've attached the report. Kind Regards	Copying and pasting emails runs the risk of key information being lost. You must obtain the persons permission before uploading an email from them to a record. Do not copy and paste emails. Transfer only the relevant data that is required.
Peter needs support with his medication.	Peter has difficulty with his fine motor control so needs support with getting tablets out of the packaging. Otherwise, he is independent in this.
The property was in a terrible state.	There was an odour of urine in the living room which appeared to be from Mrs Wilsons pets (she has three cats and a rabbit which lives indoors). The bins in the living room and kitchen were overflowing and food left on the table in the living room appeared to be rotting.
I visited Mr Jackson on Monday afternoon, and we spoke about the concerns. He did not wish me to take further action as he feels that they are dealt with following his conversation with the care agency. To do: Ask agency for records to continue enquiry	I visited Mr Jackson on Monday afternoon. We discussed the disclosure that his daughter, Marie, had made about care staff making medication error. I saw no reason to doubt Mr Jackson's capacity throughout our discussion – he showed good recall and understanding of events. He stated that he did not wish me to enquire further into the errors as he had spoken with Dawn Price, care provider manager and she had promised this would not happen again. I explained that this was an issue of public interest as others use the care provider so we would need to investigate further.
He wouldn't engage	He was unwilling to participate
Her husband couldn't cope with her anymore.	Her husband found it difficult to manage her care.
Her children never visit her.	Her children are unable to visit often.
He will never regain capacity.	He is not expected to regain full capacity.

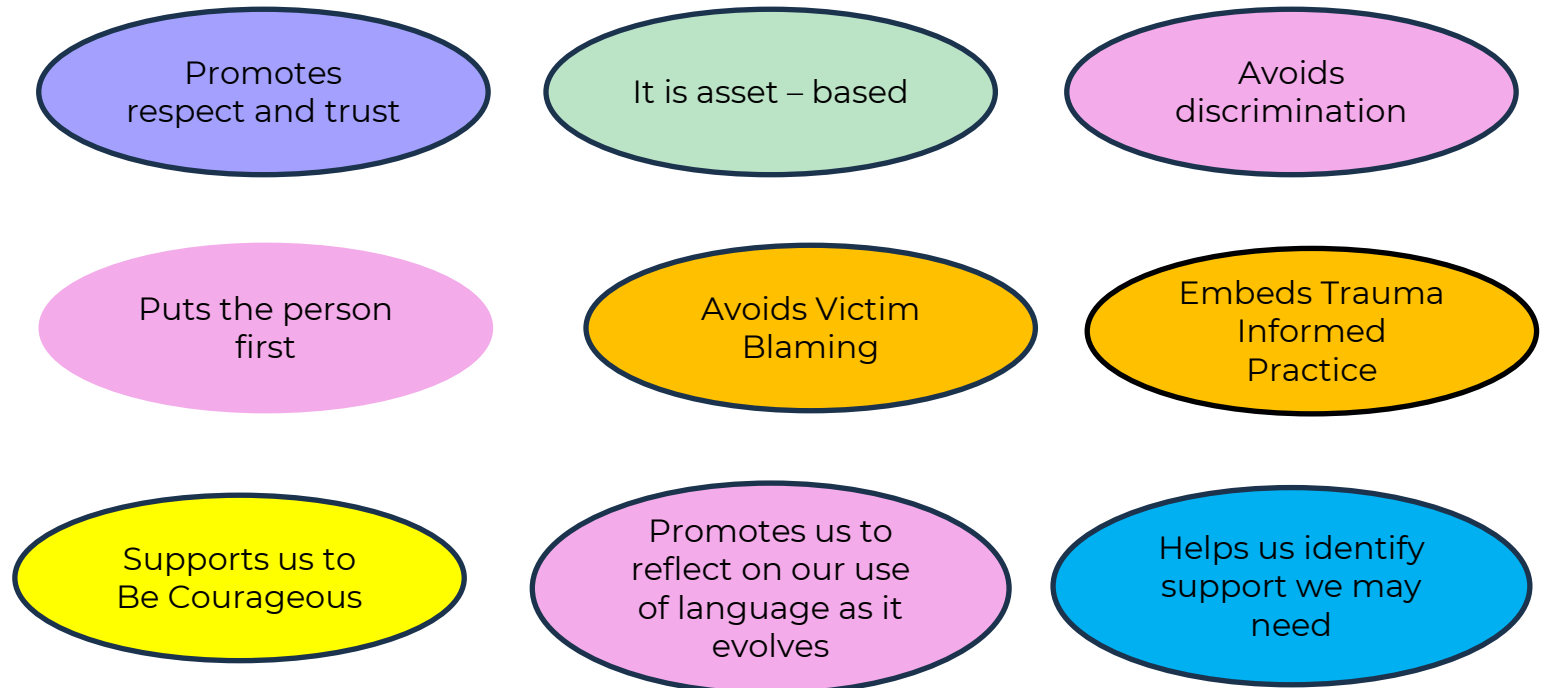
Appropriate use of Language

Why is appropriate language important:

Working in line with the six ways of working, the use of appropriate language plays a crucial role in creating a safe and inclusive environment.

- See the person
- Listen deeply
- Do the right thing
- Know this place
- Connect to neighbourhoods
- Show our love and pride

Creating an atmosphere where people feel comfortable expressing themselves without fear of judgment is essential for early intervention and prevention.



Appropriate use of Language Examples:

More examples can be found in the case recording guidance....

Inappropriate Term	Suggested Alternative
“Commit” implies suicide is a sin or crime, reinforcing the stigma that it’s a selfish act and personal choice.	Using neutral phrasing like “died by suicide” helps strip away the shame/blame element. • Died by suicide • Attempted suicide • They are experiencing suicidal thoughts
Client or Patient This can imply or create a perceived imbalance of power.	• Person • Individual • ‘Their Name’
Hard to Reach This implies individuals choose not to engage and fails to recognise the structural inequalities and barriers people may encounter.	• Underrepresented communities • Communities that face barriers to participation
They continue to remain in the abusive relationship.	The person was drawn back into the relationship due to coercive control.
‘Failed to engage’ This sentence blames the person and overlooks the complexities of why victims might not want to interact. People may feel overwhelmed when support agencies approach them or may not feel safe in relationships as a result of coercive control and trauma.	The person may be overwhelmed by the assistance provided and will need some time to process the available support.
Mr P has autism	Mr P is an autistic man

Defensible Decision Making / Clinical Reasoning

When making a Defensible Decision you must consider the following:

- Getting the facts
- Evaluate Alternative Actions
- Make a Decision, Reflect and Act

Clearly record the above on the persons care record. , where appropriate, ensuring all information which informed the decision is recorded.

Resources for further guidance and training

[organisation to amend the following where appropriate]

Further Guidance can be found at www.scie.org.uk/social-work/recording , where they suggest 11 key considerations: 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.

Person-centred

Accurate

Real

Timely

No jargon – plain English

Evidence-based

Reading the previous record

Succinct

Holistic

IT compliant

Professional

Other useful resources can be found here:

- <https://www.scie.org.uk/social-work/recording#importance-recording>
- <https://www.cqc.org.uk/guidance-providers/adult-social-care/what-good-looks-digital-records-adult-social-care>
- [Warmth and kindness to bring dignity in care – SCIE](#)
- Wigan Safeguarding Adults Board: [Learning and development](#)
- [Our expectations for your record keeping | The HCPC](#)
- Royal College of Occupational Therapists: [PCrown_A](#)

Any Questions?

