**West Sussex – Practice Guidance**

IROs are qualified social workers with at least five years’ experience, and who have acquired the right skills to carry out this role.

**Case recording**

* *Please also refer to the Access to Records guidance which details further requirements in relation to transferring children’s files when they leave a children’s home.*

**Legal requirements**

* The Children’s Homes Regulations (2015) outline the records that need to be kept in children’s homes. It may feel that we are recording lots of information, but all the information we record is used to help plan and develop the support we provide to children, and allows us to keep a record of the child’s life as they grow up.

**Important things to remember:**

* All children’s case records must be stored securely whilst they remain in the home.
* Children’s case records must be kept for 75 years from the date of birth of the child, or if the child dies before the age of 18, for 15 years from the date of his or her death.
* Records kept on children living in WSCC children’s homes should be specific and focused on the individual child at all times. This approach is known as ‘Person Centred Practice’ and allows residential staff to write records that reflect the individual personalities, character, habits and interests of all children.
* Records on the child also help staff by keeping an account of who did what in a particular situation. This protects and safeguards staff.
* Children’s files will be audited monthly by the management team and key workers will be required to show progress to any actions identified.

**Children’s Files**

* A child’s file should include all relevant information pertaining to family history, involvement with the local authority and progress that is relevant to their placement.
* A child’s records should be written in a clear and concise way that is objective. Accurate, comprehensive and well organised records are essential to good practice.
* Staff should record information on individual children in a non-stigmatising way that distinguishes between fact, opinion and third-party information.
* Keyworkers are responsible for the maintenance of a child’s file. These will be regularly checked by management and reviewed in supervision.
* Each file should contain the following essential information:-
* all recent ‘Looked After Children’ forms (Care Plan, Delegated Authority, Review reports)
* all written reports concerning the welfare of the child; this will include family history, reports made at the request of a Court and any health reports.
* notes from Planning Meetings
* all documents used to seek information or recorded views in the course of planning and reviewing the child’s case and review meetings.
* individual plans and documents describing how to support the child: Support Plan, Safety Plan, Positive Handling Plan, specific risk assessments and other documents specific to the needs of the child
* details of arrangements for contact orders and any other Court orders relating to the child
* key addresses and telephone numbers, updated on a regular basis
* key working sessions and any 1:1 work carried out
* Any other documents that monitor and record the child’s progress
* The records should be kept in a way that it is easy to trace the process of decision making and in particular so that the views and wishes of the child are available.

**Why we keep records:**

* The ultimate goal of accurate record keeping is to maintain the safety of the child by protecting them from any potential mistakes in their care. Case recording helps by allowing services to:
* Record progress against individual goals
* Track any patterns or themes in behaviour or presentation
* Identify any triggers for negative behaviours
* Measure impact of new ways of working/new medication
* Evidence the difference we are making
* Gather data to back up requests for changes
* Track evidence of trying new things
* Continuity in service
* Evidence of compliance with legislation, policies and procedures
* Contribute to improving client care

**Recording systems**

* Children’s Homes have many different ways of logging or recording information about a child. There may be hand written forms, electronic records, emails, telephone calls, log books, tick box documents and many other means of capturing information.
* Sometimes, it can be unclear what should be recorded where. The most important thing is that information is written down somewhere; it can always be moved to the correct format at a later time. However, the table below shows the purpose of some of the main recording systems in WSCC children’s homes:

|  |  |
| --- | --- |
| Recording tool | Purpose |
| Admission and discharge book | Annually inspected by Ofsted; records all new placements and placements that have ended |
| Daily log/diary sheets | Records day to day presentation and activities of the child and logs information in key areas to inform planning |
| Case notes | Records important conversations with family or professionals involved with the child; significant events will then be added to the residential chronology |
| Night Care observations | Records the night time patterns of behaviour and sleep of the child |
| Home Diary | Records important dates and appointments for the child |
| Medication Administration  Record sheets (MAR) | Records details of all medication that has been given to the child |
| Home Log book | Records the day to day activity of the home including visitors and a summary of any incidents. |
| Home-School communication book | Helps the home to share information with schools and/or parent/carers. This resource is most frequently used for children with additional needs where handovers are more complex. |

**Principles of good record keeping:**

* Daily records should be completed throughout every shift by a staff member, ideally alongside the child themselves (dependent on their age and understanding).
* Content must include all aspects of the child’s day (including their views, presentation, mood).
* Staff completing the report should elicit all relevant information from colleagues before completing the record.
* Records are to be accurate and concise. Particular attention is to be paid to the accuracy of recording times, dates and signatures, as recordings may be used in court as evidence.
* Clear, legible handwriting must be used.
* All entries must be signed by the person writing them.
* Use a full signature unless policies allow for the use of initials.
* Entries should include the date and time using the 24 hr scale
* Records must contain information which is factual, accurate, relevant and comprehensive.
* Risk assessments must identify potential risks and outline actions taken.
* Records must communicate effectively at all times.
* Do not alter or destroy records unless authorised to do so.
* Amendments must be signed and dated. Original entries must be clear and readable.
* Avoid medical jargon; language must be understood by all.
* Records should be readable when photocopied or scanned.
* Sarcasm or humorous abbreviations should not be used. Use authorised abbreviations only.
* Records must never be falsified or tampered with.
* Black ink should be used at all times.
* Don’t use correcting fluid, cross through errors with a single line, sign and date.
* Entries must be written in chronological order and as soon as possible after the episode of care / activity.
* Staff are to ensure the utmost protection of ‘third party’ information. That is, information given to staff from an alternative source. Young people accessing their files must not be able to identify the original source of such sensitive information passed to staff in confidence.

**Links to related documents:**

Access to records

Child file audit form

Tips for writing effective Safety plans