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**Adult Care**

**Recording Guidance**

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| **Document Category:** | Guidance |
| **Version Number:** | 4.0 |
| **Target Groups:** | Adult Care |
| **Lead Author:** | Revised by Stacey Kemp |
| **Role:** | Practice Lead. |
| **Active Date:** | August 2024 |

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# **1. Introduction**

## **Why is recording important?**

Effective and timely case recording is pivotal to the work of Adult Care. It is vital to the people we work with and the integrity of our practice both individually and as an organisation. Our recording provides the evidence base for peoples experience of Adult Care including the basis of any decisions made, determination of eligibility for support, our compliance with our statutory duties, capturing outcomes and measuring the effectiveness of our involvement in people's lives.

"*Good quality records underpin safe, effective, compassionate, high-quality care. They communicate the right information clearly, to the right people, when they need it. They are an essential part of achieving good outcomes for people"* (CQC, 2020).

## **Who does this apply to?**

This guidance applies to all County Council staff working in/or with Adult Care that are responsible for recording personally identifiable information about adults, their families and carers.

This guidance aims to provide a robust set of recording standards which enable all staff to record personal information in a clear and consistent manner. The standards apply to records in any format.

Our recording practice is rightly subject to scrutiny from a number of sources.

* All customers have access to their records through the subject access process.
* Cases giving rise to complaint will be subject to rigorous review by managers, independent reviewers or auditors and potentially the Local Government and Social Care Ombudsman.
* Increasingly more complex cases may require legal oversight with the necessity for recording to be integral to court proceedings.
* Quality Assurance measures include regular audits and review of case work evidenced in peoples’ records.
* External audit and inspection processes.
* Cases may increasingly be subject to critical or serious Safeguarding Adult Reviews and Domestic Homicide Reviews.

Ensuring that excellent recording is integral to excellent practice should therefore be a shared aim of all people employed in Adult Care.

## **What are our roles and responsibilities?**

* **The Director of Adult Social Services** is responsible for ensuring that the Council meets its legal responsibilities corporately and so has overall responsibility for case recording in the Council. As the accountable officer s/he is responsible for the management of the organisation and for ensuring appropriate mechanisms are in place to support people who meet its eligibility criteria.
* The Adult Care **Caldicott Guardian** (see [Caldicott Guardians (sharepoint.com)](https://lincolnshirecc.sharepoint.com/sites/InformationAssuranceHub/SitePages/Caldicott-Guardians.aspx)) has a particular responsibility for reflecting customer's interests regarding the use of personally identifiable information. They are responsible for ensuring personally identifiable information about people and carers is shared in an appropriate and secure manner.
* **Heads of Service** are responsible for the quality of recording undertaken by staff in their service area. They are responsible for ensuring compliance with recording procedures and ensuring data quality exceptions are addressed.
* **Area / General Managers/ Locality Leads** are responsible for ensuring that Quality Practice Assurance Standard 8, 'The quality of our recording', is adhered to and that Quality Practice Assurance Reviews (QPAR) are undertaken in line with the Directorates QPAR Process.
* **Line Managers/Supervisors** are responsible for ensuring:
* The quality of case recording.
* That case records are up to date and completed in accordance with this guidance.
* Audits and QPARs of case records are carried out as per guidance.
* Monitoring the use of ‘restricted access' ensuring this is only authorised when appropriate.
* **All staff who create, receive and use records** have case recording responsibilities. In particular, all staff must ensure that they keep appropriate records of their work, and manage and maintain those records in keeping with this guidance and all associated guidance and protocols.
* **All staff who have access to a person’s record**, have responsibility for recording all their work relating to people and carers in the person’s record, in accordance with relevant guidance and protocols.
* **All Council staff and partner agencies,** will only access a person’s information on a 'need to know' basis and where a legitimate relationship exists between the social care professional and person. An Adult Care professional should only access a person’s record in their professional capacity as an LCC employee. Any none legitimate access of a person’s information may be subject to disciplinary action.
* **All Council staff and partner agencies** shall maintain agreed requirements in relation to confidentiality of both the verbal and written communication and information relating to the people they are working with.

# **2. Recording in a strengths-based way**

## **Assessment and Care and Support Planning:**

We follow a strengths-based approach as per Quality Practice Assurance Standard (QPAS) One: Strengths based practice and engaging with people. This is a way of working which focuses on a person’s strengths, abilities and resources. It aims to empower the person by maximising their independence, wellbeing and overall quality of life, by listening to the person as the expert of their own lives. Our roles is to build that personalised picture, understanding what’s important to them, what they want to achieve and how they want to live their lives.

This may include understanding where and what home is to them, who and what’s important in their lives? This could be their relationships and support networks, pets, understanding their story from childhood into adulthood, what they did or do for a living, hobbies and interests, faith, culture, sex and sexuality. It may be how important their routines are, their appearance, what food and drink they like but also any preferences as to how these are prepared or presented. How do they manage in their home environment? It may include understanding the persons finances, do they have any money worries, are they receiving all the money they’re entitled to? Does the person use or want to use technology to assist them with their care and support?

The other consideration when building this picture is understanding if they or any relevant others have any concerns or worries. Understanding risk and the potential for risk is an important element to our conversations with the people we work with, but balancing this with anything that may be working well to mitigate or reduce the risk too.

To listen and understand, involving the person in decision-making and working collaboratively, ensures that we can support in a more personalised and effective way. Furthermore, the conversations we have with people should be captured in our recording to reflect this, demonstrating how we have listened and understood what’s going on for them, their strengths and what they would like to achieve.

## **What is an outcome?**

When it comes to recording a person’s outcome within support planning, it is important that this reflects the conversations had as previously mentioned.

Personal outcomes are:

“What a person **wishes to achieve** in order to lead their day-to-day life in a way that maintains or improves their wellbeing.” (Care Act 2014, Statutory Guidance).

What we should be mindful:

* To not mistake outcomes for eligibility outcomes (such as managing and maintaining nutrition, maintaining personal hygiene etc).
* To not confuse aspirations (which are long term wishes) as outcomes such as “Mrs Jones wishes to remain in her own home”. These are very broad, hard to quantify and should be more realistic.
* To not include the solution, as we may limit options, as you have already decided what you are going to do, in turn you are:
* Led by the service you describe.
* Have less choice of how to meet the need.
* Have less creativity and flexibility.
* Deliver a less personalised support plan.
* Limit your ability to incorporate the persons strengths and assets.

If we fully understand what the outcome means to the person, why it isn’t currently achievable, what the impact of achieving it would be, we can be more creative in meeting the outcome.

Example one of a restricted outcome:

**Daycare Services to be put in place.**

**Mrs Jones wishes to attend daycare so she can meet more people.**

Improved example of an outcome:

**Mrs Jones wants to be able to meet more people, so she does not feel as lonely.**

**Technology**

**Daycare Services**

**Local community groups for hobbies/interests**

**Direct Payment**

**Is a support service required such as for bereavement or loss?**

**Volunteer opportunities**

**Family / friends**

**Peer support groups**

**Social Prescribing**

Example two of a restricted outcome:

**Complete referral for an adaptation/Disabled Facilities Grant.**

**Aleksy would like a level access shower.**

Improved example of an outcome:

**Aleksy wants to be able to wash himself.**

**Self-purchase of equipment for existing facilities.**

**Referral to the well-being service.**

**Information on self-funding bathroom adaptions.**

**Occupational Therapy assessment.**

## **Reviews:**

The purpose of a strengths-based review is to build upon the positive aspects of an individual's care and support, while evaluating the effectiveness of the existing care and support plan. It aims to identify and reinforce the person's strengths, capabilities, and achievements while assessing any changes in their circumstances or needs. The review process provides an opportunity to assess the impact of the care plan on the person's well-being, their level of independence, and their overall quality of life. By adopting a strengths-based approach during the review, it allows for the identification of strategies that have been successful and should be continued, as well as areas where adjustments or additional support may be needed.

​Considerations at review:

* What is important to the person and why?​
* Who is around the person and what do they do?​
* Has anything changed?​
* What has worked well and why?
* What has not worked so well and why?​
* What would they like going forwards?

This conversation record should explain how things are going and what the person feels about their situation. Remember, we are not ‘reviewing the care package’ but having a conversation about a person's situation, what is important to them, what may have changed and any progress towards achieving their outcomes. ​

Throughout the conversation consider the 9 areas of wellbeing and the impact on the person's daily life​:

A diagram of a wellbeing

Description automatically generated

## **The language we use:**

It is important that we consider the language in our recording, ensuring it relates and has meaning to the person. We need to be mindful that our language doesn’t become too professional and full of jargon, so it makes no sense to the person it relates to.

Poor example of recording:

“Barbara wishes to mobilise independently in her home”.

Did Barbara describe her situation to you using these words? These tend to be how professionals may describe a person rather than how someone would describe their own situation.

Improved example of recording:

“Barbara wants to be able to walk around her home without fear of falling”.

This simple change is much more personalised and is likely to be more reflective of the conversation had with Barbara. Further still, if you can use the person’s own words where required, this will be much more powerful and meaningful than any professional language or stock statement made.

## **Narration in recording:**

It will depend on the person you are working with as to whether you record in either first or third person. In some situations, you may choose to use a combination.

Example of writing in the first person:

“I would like to be able to make my own meals and drinks”.

Example of writing in the third person:

Barbara would like to make her own meals and drinks.

If a person does not have capacity and is not able to communicate their views and wishes, we need to ensure that we work in their best interests in line with the Mental Capacity Act 2005.

This may mean having conversations with the people that know the person best such as family, friends, care providers.

If the person previously documented what their wishes or preferences were, it is also best practice to refer to this to help ensure this is taken into consideration.

You can also include any non-verbal responses or if a person was able to say a few words, you can directly quote this in your recording to demonstrate how you have engaged with the person.

## **Timescales for our recording:**

Case notes should be recorded within 2 working days of the event unless a specific Adult Care procedure includes a different time scale.

It's important that we schedule time in our day to record, completing case notes and all documentation as close to the event as possible, as this helps us to record conversations and actions accurately.

# **3. Case Notes**

## **What should I consider and include in case notes?**

*(This is not an exhaustive list and should be used as a guide only. Professional curiosity is crucial to support the people we work with and ensure their safety and well-being).*

* What is the purpose of the case note? This helps us to be clear and concise. Use clear headings to support this.
* Who was involved? Have you seen the person face to face? If the person was not involved, you need to record the reason why. This is important to demonstrate how we have tried to engage the person.
* If you have had a conversation with someone other than the person you’re working with, have you ensured you have recorded their full name and contact details? Do you need to record the personal relationship on Mosaic? It's important that you record any contact details in case you need to speak with the person again, or if you are absent, a fellow colleague would be able to find details easily.
* Confirm how you may have supported communication.
* What information was gathered and why? This allows us to understand what we are recording which will make it become meaningful and valuable.
* Clearly document conversations you have had that are relevant to the person's situation. If it's not recorded, there's no evidence that it has happened.
* Are your case notes clear, succinct and able to distinguish fact from personal opinion?
* Ensure that all documentation is professional, even if there may be occasions where you disagree with certain decisions/ actions taken. This is the person’s record; it would be more appropriate to record any disagreements within supervision records. If however, there is disagreement/ professional challenge that directly affects the person and their care and support, this will need to be captured in their recording as evidence of what concerns/issues have been raised, and what actions have been taken. This may form part of case notes, but also contribute to assessment, care planning, review and Risk Assessment and Management Plan work.
* If someone was to read your notes, would they be able to understand the current situation? It's important to regularly summarise and complete case closure / transfer summaries, so the persons situation is easily ascertained.
* If you've referred to a source of evidence, ensure you have provided the details of this.
* Are there any outcomes/ decisions/ actions resulting from the contact? Are they SMART? (Specific, Measurable, Achievable, Realistic and Timely).
* Have you provided analysis in your decision-making? This is important as it evidences what you have taken into consideration and arrived at a decision.
* Have you explored the persons and any other relevant view on outcomes/ decisions made? This ensures a strengths-based, holistic and whole family approach is achieved.
* Have you recorded how and when outcomes/ decisions/ actions will be reviewed and by who? This ensures that information can quickly be understood, and we are clear on who is taking responsibility for this.
* Have you followed up on any decisions/ actions and confirmed this in your recording? This is important so that you can evidence what has been done.
* Consider how the records will read to the person. Keep language simple and avoid the use of abbreviations. If you do have to use an abbreviation, please write this out in full first as there can be many abbreviations with different meanings. See the [TLAP Care and Support Jargon Buster (thinklocalactpersonal.org.uk)](https://www.thinklocalactpersonal.org.uk/Browse/Informationandadvice/CareandSupportJargonBuster/)
* To avoid jargon and ensure you proofread records, ensuring that names used are consistent, with job titles and relationships clearly recorded to ensure clarity.
* To ensure that you complete your case notes, ensuring that they are "finished" within Mosaic.

## **Recording legal advice:**

Legal advice and any emails which record legal advice should not be copied and pasted within case notes. The reason for this is that any legal advice to you is privileged and should not be disclosed to others.

Any legal information should be safely stored within your emails and can be discussed and captured within supervision sessions.

If however, there is pertinent information that does relate to the person and needs to be held within their Mosaic record, this should be clearly highlighted and summarised within a case note. The legal department often have to go through case records to formally redact this information from your records before disclosing within legal proceedings and other forums which is time consuming and costly.

Therefore, the benefit of isolating legal advice brings many advantages not least of course:

* Avoiding disclosure by accident.
* Having it all in one place ensures easy recall for all who need to see it quickly, particularly for managers.
* It reduces legal time and cost in redacting weighty case records.

# **4. Emails**

Email is an integral aspect of communication, correspondence, conversation and information flow both within and outside of Adult Care.

Practitioners are required to use discretion when determining what information contained within emails should form part of a person’s record. Practitioners should carefully read any email they wish to use in case notes and be aware of email trails containing information that should not be shared.

Case notes within the person's record should be used for concise recording of case activity. Therefore, case notes should not be used for the routine copying and pasting in full of all email conversations into the person’s record.

Where the full text of an email is required as part of a person’s record, the email should be indexed to the document store, with a case note summarising the content of the email and referencing the stored document.

Emails of the following nature should be retained in the document section in Mosaic and referenced in Case Notes.

* Emails from external sources received as correspondence.
* Documents received as attachments to emails.
* Emails that support practice decisions.

In other cases, it is acceptable to record part of an email in a case note which may include use of copy and paste, but it is worth noting the following:

* Do not copy and paste entire emails including signatures, pleasantries, disclaimers etc.
* If all of an email is needed, index it.
* When copying and pasting or paraphrasing part of an email, ensure that the sender's name and date received is noted and that you have edited the full email.

Every Practitioner is responsible for a person’s record once they are working with that individual. This will include ensuring all the person’s basic details and relationships are accurate.

# **5. Considerations in your recording**

## **Informal Carers and our recording:**

We know that caring affects one in three of us. It can happen to anyone at any given point in time, in which every experience can look so different from one carer to another. Further still, many carers do not even view or consider themselves as a carer, because “it’s just what you do” for a loved one. As a practitioner, we may be having the first conversation with a carer, whether they may be new to the role, or have cared for another for most their lives. We should never underestimate the role we have and the significant impact to support them in their caring journey, which in turn usually supports the cared for person too. We need to make sure that we record these conversations, which is highlighted within our Quality Practice Assurance Standards.

Standard 7 “Informal Carers” outlines some of our responsibilities and duties which are that:

*“Carers are supported to actively participate in conversations and assessments, decision making, care and contingency planning and reviews for the person they care for if the cared for person consents to this.”*

It is important that we listen, understand and record:

* **the nature, frequency, intensity of the informal support provided.**

*What care and support does the carer provide? What does this involve? How often do they do this?*

* **the impact on the carers and whole families physical and mental wellbeing.**
* **the impact on any children.**
* **the sustainability and willingness to continue the caring role.** We need to ask if a carer is able or willing to continue caring, having a real open and honest conversation. Sometimes people turn into a carer overnight or it is assumed that someone will continue to care as they always have done. However, it is important that we always ask the question and check in to see how carers are managing throughout our involvement. You never know that you may ask the question at the right time for them. In doing this, we are working proactively trying to prevent carer breakdown and implementing contingency plans.
* **what matters most to them.**
* **that their voice is heard**. This is one of the most important factors for many carers, being listened to. They often have more information about the cared for person too and being involved and supported in their own right as part of this journey, really supports a more effective and strengths based approach in our work with improved outcomes.
* **and establish if carers needs have been met as part of the conversation/assessment/review.** Often carers will feel that by supporting the cared for person, this provides them with all the reassurance and support they need. They may not wish for additional support, but it’s important that we ask, have this full conversation and “check-in” with them throughout our interventions in case this changes.

Some other useful tips when considering informal carers in our recording:

* We need to make sure that we record all carer relationships on Mosaic, check that they are up to date, and link related people within families.
* If a carer declines any carer support, it is important that this is captured with their rationale in our recording. This evidences what conversations we’ve had with them.
* If required, carers should be given information and advice about sources of further support, community resources and preventative services to promote sustainability of care and support arrangements.
* Agreed actions taken in relation to the carer should be clearly recorded and followed up.
* Where appropriate, there will be recorded evidence of a referral for Adult Carer’s support to the Lincolnshire Carer’s Services, or Young Carers Support to Children’s Services which will include a brief background, the urgency, reason for the referral and areas of support required. We need to make sure that we provide a thorough onward referral, which we can do when we’ve captured all of the above in our conversations. This supports the carer to have a seamless transition without needing to tell their story again.

## **Children and Young People and our recording:**

Young Carers regularly let us know that they wish someone had spoken to them when they were younger about their caring role. You can help this happen.

Whole family working is essential to identify young carers early. If the person you are assessing has care needs – what makes you think there isn't a caring role for the young person?

Lincolnshire County Council has a statutory obligation to identify young carers and to offer them an assessment of their needs. This doesn't just apply to young carers for whom we have a worry or concern – but all young people who are helping or supporting. This no longer needs to be for a family member or for someone they live with. Neither does it depend on hours of care provided or for a specific caring role. By having an open and honest conversation we have the opportunity to really hear this young person's experience.

Some questions which may be used:

Do you live with or have regular visits with anyone aged under 18? Does this person try to help and support you because of your illness/disability? This might include practical, personal, medical, physical or emotional support as well as translating, supporting with siblings, helping with writing/budgeting.

How do you think your illness/disability impacts on your child? When you are having a bad day, how does this affect your child? How does it impact the way you parent (as much looking for positives). How do you think your child's life may look different to their friends?

Is there anything you think this young person might need some help with? Have you spoken to anyone about this before – has the young person been involved? Are you worried about your child's health or wellbeing at all?

Has there ever been a time when you/your family have coped with things better? Tell me what was happening then?

It is important that you capture these conversations in recording to evidence your working.

## **NHS Continuing Healthcare and our recording:**

Whilst overall responsibility for NHS Continuing Healthcare (CHC) sits with the Integrated Care Board (ICB) it’s an integral part of Adult Social Care practice. Practitioners need to ensure that the person’s assessment reflects their presentation in detail, as this will assist the practitioner in deciding whether a CHC Checklist should be completed. Ambiguous statements such as describing the person as “confused”, “aggressive” or “emotional” should be avoided as each person’s presentation will be unique to them.

For example:

The recorded detail of a person’s aggression should include whether it’s verbal, physical or both. If it’s verbal, record what the person says. If it’s physical describe what they actually do, is it threatened e.g. making a fist but not actually hitting someone? Or is it contact aggression that does or could cause injuries? Record any identified triggers that cause the aggression, how often these episodes last for, how often they occur and how they are managed? Do the behaviours affect other people such as informal carers, residents or staff? Does the person’s mood fluctuate rapidly, such as appearing calm and then suddenly becoming verbally and/or physically aggressive? Are there care plans and risk assessments in place to minimise risk to the person and those around them? If the person is in a placement, are there incident reports and ABC charts being completed?

Some examples of other words/phrases to be avoided in our recording:

* **“Needs regular repositioning”.**

*What does “regular” mean? Once a day, once a week? Why do they need regular repositioning? Have they slipped down the bed? Do they become agitated? Is it happening during the night? Are there any additional issues that make repositioning complex, e.g. contractures of limbs, pain or anxiety? Is emotional reassurance needed before/during/after any moving and handling process, and if so how long does the entire process take?*

* **“Assistance with feeding”**.

*Why? Is this due to physical difficulties or cognition? What assistance do they need and how long does this take? For instance, some people may need support to eat in several sittings. Is there any dietary requirements such as soft diet and thickened fluids? Are there choking risks due to poor swallow reflex? Are there any concerns regarding weight loss? Are supplements prescribed? Is the Community Dietician involved?*

* **“Several times a day”**.

*What does “several” mean? Specify how many times a day. Does it happen during the night? How many members of staff are involved? Are they needing a room that is close to the staff office or nursing station so that close monitoring and rapid response can be provided?*

* **“Poor sleep pattern”**.

*Describe the sleep pattern as to what makes it poor? Is this every night? How many nights in a week? Is the person attempting to get out of bed? Are they very restless and walking in/out of other residents’ rooms or attempting to leave? Is their regular monitoring in place, if so how often? Are sensor mats needed?*

* **Person is “anxious”**.

*Describe how their anxiety presents, any triggers, how it’s managed? Is medication prescribed? Are healthcare professionals involved and monitoring the anxiety? How many times does the anxiety manifest and how long does it take for the person to calm? Does this affect other areas such as breathing if anxiety leads to panic attacks? What measures are in place to prevent the anxiety escalating?*

* **“Responsive to reassurance”**.

Describe the reassurance provided, how long it takes, what effect it has?

CHC Checklist:

When completing a CHC Checklist the details gathered should be recorded under each care domain as evidence to support the selected descriptor. Doing this is especially important where the practitioner believes there is a significant change in the person’s needs that requires another Decision Support Tool (DST) to be completed to reconsider their eligibility for CHC, if previously found not eligible.

Adult Social Care Assessment:

The content of a proportionate assessment provided to the ICB CHC Team is taken into consideration in determining a person’s eligibility for CHC. Decisions on CHC eligibility are made by professionals who have never met the person or had any involvement with them. A lack of detailed evidence can be the reason the person isn’t found eligible which is why it is important to capture a thorough picture of the person, what they can do, their strengths as well as areas in which they need support. A level of professional curiosity is needed to build that picture to understand daily life of the person as highlighted above.

In some instances, the CHC Case Manager involved in arranging the DST may access MOSAIC to review information held within the person’s record, but we should not rely on this and ensure we complete and send in pertinent information prior to the DST taking place.

Adult CHC Monitoring step, emails and case notes:

Practitioners must ensure, where appropriate, they complete the Adult CHC Monitoring step within the person’s MOSAIC record. Where a practitioner has considered completing a Checklist and decided not to do so they should record their decision and the reasons for not completing one in the person’s MOSAIC case notes/ My Assessment.

Where practitioners engage in telephone conversations with members of the CHC Team the content of the conversation should be recorded in MOSAIC along with who they spoke to and their job title.

If practitioners receive emails from CHC they should follow the email guidance outlined in this recording guidance, which confirms that pertinent emails to/from CHC for ongoing cases should be indexed onto MOSAIC and a case note adding to reflect this with a brief overview of the relevant points within the email for reference.

If further advice and support is required as to what should be recorded in relation to Adult Care’s involvement with a person’s journey through the CHC process, you can contact the Adult Care CHC Coordinators through Microsoft Teams or by email [AdultCareCHC@Lincolnshire.gov.uk](mailto:AdultCareCHC@Lincolnshire.gov.uk).

Learning Disability Service CHC process:

Under the section 75 service agreement between Lincolnshire County Council (LCC) and NHS Lincolnshire Integrated Care Board (ICB) the CHC process is undertaken by LCC Learning Disability Service Practitioners.

Practitioners undertake the completion of CHC checklists and Decision Support Tools (DST) and provide the relevant evidence to support the eligibility recommendation. This process is required to be completed within 28 days from the completion of the checklist.

The DST is required to be sent to Lincolnshire ICB whereby this will be ratified by the ICB and the confirmed eligibility is provided within the 28 day time frame to both the person, next of kin and the practitioner that completed the process.

The reviews of eligibility for Continuing Healthcare are completed initially 3 months following the outcome and annually thereafter. These reviews are completed by the Practitioners within the LCC Learning Disability Service. The reviews are then submitted to the Lincolnshire ICB for confirmation.

LCC Learning Disability Service Practitioners are not responsible for Funded nursing care reviews or the completion of any fast-track applications and these would follow the normal processes by NHS Lincoln the ICB.

## 

## **Housing and home environment within our recording:**

It is important we understand what home means to a person, from where they may live, for how long, what the property type is, who lives with them? What they need from their home to be a safe, comfortable environment? If they are happy with where they live and why, or if there are any concerns or worries? Home is not only shelter but a sanctuary to many people, and understanding what a home means to that person, is part of how we begin to work in a personalised and strengths-based way.

Housing and the home environment can also have a significant impact on the person in achieving and maintaining independence as well as providing a working environment for those caring for them if they need this support.

Practitioners need to ensure that they have discussions with the person to establish their current housing situation and any observations of the person's ability to move around their home. This includes recording these discussions and any observations, highlighting potential risks, any mitigating factors but also what is currently working well. This may include what equipment has been provided or is in place, if referrals have been made to Occupational Therapy or other agencies to support potential adaptations to the property, if alternative housing options have been discussed and what other information has been provided.

It is necessary to establish if the person lives in a home they own, partly own or rent. If they don’t own their home, it should be established who does. This is important information, as it may assist the financial assessment and also provide insight on what support and care we can provide, particularly if Occupational Therapy teams are involved and exploring potential equipment and adaptations. This can also be recorded on the person’s summary page on Mosaic.

## **Recording our conversations about technology:**

We should be routinely considering technology and talking to people about it whenever it is relevant to them and their situation. It is important that we capture these conversations within our recording in the most relevant place for the type of conversation we are having. This might be as part of an adult conversation, assessment, review or when agreeing a care and support plan and we would usually record this within the appropriate workflow. It could also be a conversation that takes place at another time, and we would then usually record the conversation in the person’s case notes.

Our recording about technology should be proportionate to our discussions with the person about technology but this may include:

* How the person already uses technology to achieve relevant outcomes within their life.
* Any information and advice we give to them about how they might use technology moving forwards.
* Any information and advice that we have given the person or those around them about using technology safely. This might be in relation to their general use of technology, such as social media, or it might be in relation to technology that they are planning to use to achieve an outcome, particularly if there maybe risks associated with this.

What to remember when recording conversations about technology?

* Use the same principles for recording conversations about technology as we would for recording other types of conversations.
* We should record our discussions with the person or those around them about how they could use technology even if they decide not to use technology.
* If there are risks around use of technology or a decision not to use technology this should be fully documented along with any actions and information or advice to reduce or manage these risks. This might include suggestions about other alternatives or ways they can use technology more safely. We should record this even if the person decides not to take our advice.
* If there is a barrier that prevents the person from using technology, we should record the conversations we had about this and anything that we tried or suggested to support them to overcome the barrier.
* Where we have referred or signposted the person to other organisations or given them information, we should record that we have done this including detail about what we did and how we did it.
* We should avoid the use of brand names within our conversations and our recording of them, so for example use the term video doorbell rather than “Ring doorbell” and smart speaker rather than “Alexa”.

## **Finance and our recording:**

It's important for us to record if the person can manage their own financial affairs or if they have support from another person. If the person does not have capacity to manage their own financial affairs, is their representative with legal authority in place? Is this information recorded on Mosaic? Is a nil assessment required whilst the representative applies for Court of Protection?

Practitioners need to remember to record all actions and discussions in relation to finances on Mosaic detailing what information (e.g. Charging Policy, factsheets) have been provided and when, and to whom. A record of "discussed finances" is too vague. It is essential that all conversations relating to finances are recorded detailing what was discussed, who was present and responses. It is important that the person and/or their representative fully understand all aspects of the financial assessment process.

Practitioners need to ensure that all conversations and actions undertaken in regard to assessed financial contributions are recorded thoroughly and accurately on Mosaic.

The above are key elements of case management and vital evidence if there are challenges, discrepancies or complaints. Recording this information will also safeguard all participants and evidence work undertaken which can be strengthened further by written communication which can avoid any ambiguity and discrepancies.

If you require further information you can access [An Introduction to Adult Social Care Charging in Lincolnshire](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Flincolnshire.learningpool.com%2Fcourse%2Fview.php%3Fid%3D2093&data=04%7C01%7CStacey.Kemp%40lincolnshire.gov.uk%7Cae63d84c8f8a4bf61e1f08d9dbf5d182%7Cb4e05b92f8ce46b59b2499ba5c11e5e9%7C0%7C0%7C637782671090718745%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000&sdata=IBxs89RKyUNl55Cnu2r5evWsgKlgMuWDLGY900PoqWQ%3D&reserved=0) via Lincs2Learn.

# **6. Assessing Risk**

Assessing risk is the cornerstone of Adult Social Care practice. Risk or the potential for risk, is what we have to consider throughout all our interactions and observations with the people we work with.

## **Definition of risk:**

Risk can be defined as “the possibility of beneficial and harmful outcomes, and the likelihood of their occurrence in a stated timescale” (Alberg et al in Titterton, 2005).

In Adult Social Care a risk can present in many forms and the skills we have to identify them are often paramount to be able to support the person to give them choice and control, in efforts to manage, reduce or mitigate those identified risks.

## **Breaking risk down in “My Assessment”:**

Practitioners should use their assessment skills to probe concerns and potential issues, which may often be vaguely implied or assumed, to build as clear an understanding as possible about risk, any dangers or hazards and what you believe could occur. In doing this, we should consider:

* Who is at risk?
* Who or what poses the risk?
* The nature, frequency and impact of the risk? *(Considering if a chronology would support to help identify patterns and trends of risk).*
* What is the person's view of the risk?
* What are the views of relevant others, including family, friends, carers or other professionals?
* How severe is the risk? *Using the risk rating scale (Appendix One).*
* What is in place to reduce and mitigate risks? Are there any protective factors? Is there anything working well?

Limited example:

*“Risk of medication mismanagement”.*

This does not tell us what the actual risk is, as it can be interpreted in many ways. Is the risk because of dexterity or cognitive issues? Is it because the person is at risk of overdosing due to mental health problems? It leaves more questions than providing a clear overview of the risk you have identified.

Improved example:

*“John does not remember to take his medication as prescribed due to his symptoms of dementia. John was able to independently manage his medications up until a few months ago, but his wife Sharon has reported that the situation has deteriorated as his memory has become poorer. Sharon says that John will easily get frustrated when she prompts to support him take his medication, as he feels he has already taken it. Sharon has tried to talk to him, showing him the dossette box to prove that he hasn’t taken any for the day, but he does not believe her. Sharon is concerned as the medication does help reduce his anxiety as well as help him sleep at night and without it, she has noticed how this affects him. Sharon is needing to spend more time trying to settle John, particularly at night-time and she also confided that she is starting to feel overwhelmed by the whole situation”.*

In the assessment you will also need to consider:

**What is working well with managing or mitigating the risk?**

* *Are there any protective factors?*
* *Are they sustainable?*
* *Are there any support networks?*
* *Is the person at risk resilient?*
* *Have you included the views of the person and that of relevant others such as friends, family, carers, care providers and other professionals?*

**Actions - What needs to happen next?**

At assessment stage, you may identify several areas of potential support or plans to address the risk(s) highlighted. So you can summarise in this section, the many options that may be explored. *In the example of John, this may include consideration of a care package, medication review, carers referral for Sharon, any other informal support that could be provided by friends and family, respite options, TEC options that may support him to take his medication more independently etc*.

Points to consider:

1. At assessment stage, some people may not meet the eligibility criteria, so they will still require the opportunity in their assessment, to record and evidence how risks are managed.
2. The risk section of the assessment **does pull through** when a Risk Assessment and Management Plan (RAMP) is required.
3. The risk section of the assessment **does not pull through** to the care and support plan for various reasons firstly for formatting reasons on Mosaic which supports people to read their documentation more clearly when printed.
4. The Care and Support Plan is the next stage after the assessment, which may take place at the same time, but for others it will be another conversation at another time. Some people may want to have some time to think about what support they would like, so your assessment would be a summary of **potential next actions. You do not want to pre-empt decisions or next steps in your assessment, as this is what the care and support plan will evidence.**

## **Care and Support Plan risks:**

It is not expected that you copy and paste risks from the assessment to the care and support plan, and it is not expected that you spend lots of time having to re-write risks in the care and support plan when you have already done this in the assessment. It is advised that you summarise the risks highlighted from your assessment and provide detail on **what has been agreed** at the Care and Support Plan stage.

Care and Support Plan risk example:

**How am I/ Others at risk?**

*Risk of not taking medication due to symptoms of dementia.*

**Managing/reducing risk?**

*John’s wife Sharon has agreed to trial a package of care to prompt and assist John to take his medications each day, as she feels if this is prompted by someone else other than her, he might be more receptive to take this. John will need x3 care calls a day to support with this (morning / lunch/ evening). Sharon feels this will also support her in her caring role. Sharon is aware that it may take some time for John to get used to carers and to build a relationship, and we will request if a male carer is available as she feels he may respond better to a male than a female. Sharon informed that this will be requested but will be down to staffing capacity which we cannot always guarantee. Sharon will continue to support John to be reviewed by his GP and Community Psychiatric Nurse as and when required. A multi-disciplinary meeting has been arranged for 3 months time to review how John’s support has been going, but this can be convened earlier if there are more immediate issues that need reviewing. These decisions have been made in John’s best interests as he does not have capacity to make decisions regarding his care and support.*

You can see in the above example that the risk has been summarised from the assessment, but there is more detail on what has been agreed to support manage the risk at the Care and Support Plan stage.

Defensible decision-making:

*“Critical, reflexive and careful judgements… with the fully considered evidence of incomplete knowledge so that you can defend and justify your assessments, plans and interventions” (Cooper, 2011).*

Defensible decision making can often be confused with defensive practice, “the need to cover our backs” or “needing hindsight to make the correct decision”. However, defensible decision-making does not mean we avoid positive risk taking or uncertainty as these are things beyond our control. When assessing risk, we often do not know what will happen and may have made a decision that “wasn’t correct”. However, if we can justify our decision making, what information or evidence we used, providing rationale which is captured within our recording, this will be a defensible decision.

To ensure defensible decision making, we need to evidence:

* What information has been evaluated and analysed?
* Have we included the views of the person and relevant others?
* Have we used our professional curiosity to understand the situation?
* What other information/ direction has informed our practice? This may include multi-agency decisions which we need to capture within our records (such as within case notes, but also by ensuring we have received a copy of any minutes or paperwork, as confirmation of attendance and how decisions have been made).
* Have we communicated any disagreement/ professional challenge to a situation (if required) and recorded this in our work? What was the response or follow up? Have we recorded this in our work? Have we considered escalation if required?
* Have we been clear about our legal literacy, understanding what law, legislation, guidance, policy, frameworks we have worked within?
* Did we weigh up the advantages and disadvantages of all available outcomes and options? Are there any associated risks?
* Have we recorded how and why a particular outcome or decision was made?
* Have we ensured there is a robust plan in place to review the risk/ plan? Is there a clear lead professional that is taking responsibility for monitoring and reviewing a person’s care and support?
* Is our recording effective to capture our defensible decision-making?

For example:

Prior to a person returning home from emergency respite, it is important that we re-assess someone’s ability / safety to return home. This may form part of a scheduled or unscheduled review, but this may also be linked within a Risk Assessment and Management Plan (RAMP) depending on the circumstances of the emergency respite.

It is important that we work collaboratively, involving the person and relevant others, considering historical information and what has changed to mitigate or reduce the risk for the person to return home safely? Our recording needs to show this working out with the considerations highlighted above.

## **When do we complete a Risk Assessment and Management Plan (RAMP)?**

On occasions we may need to consider completing a Risk Assessment and Management Plan (RAMP). This is a separate risk assessment from risks recorded in routine assessment workflows.

It is not expected that RAMPs are competed as part of everyday practice, but only when there are more significant or sensitive concerns that warrant a separate and thorough exploration.

This decision will rely on assessment and professional curiosity skills of the practitioner, as every circumstance may differ. However, these are some considerations of when a RAMP may be required:

* Where circumstances dictate a more detailed exploration of risk issues not covered in routine assessment and support planning.
* Where risks require a shared Multi-Disciplinary Team approach.
* Where risks are more complex.
* Where there are severe or substantial high risks not reduced by measures already taken. (Using the risk rating scale- in appendix section).
* Where there may be alleged perpetrators.
* Where a person has returned home from hospital/ emergency or crisis placement. (RAMPs may be required if not explored within routine assessment/care planning. The RAMP in this circumstance will provide opportunity to evidence exploration of previous risks and how they may be minimised/ mitigated to allow the person’s safe return home).
* Where risks remain due to an unwise decision or lack of capacity which may support Best Interest decisions.
* For individuals subject to a Community Treatment Order under the Mental Health Act 1983.
* For individuals subject to a s.41 restriction order under the Mental Health Act 1983.
* Those identified at risk of hospital admission due to mental health concerns.
* Consideration should be given when Team Around the Adult are involved.
* When individuals may be subject to Multi-agency Public Protection Arrangements (MAPPA) and Multi-agency Risk Assessment Conferences (MARAC).

*(This is not an exhaustive list. If you are still uncertain if you need to complete a RAMP please ask your line manager/supervisor for additional guidance).*

We must be able to evidence in our work how we have identified, considered and assessed risk. The RAMP can form part of our evidence of how we have done this, supporting us to demonstrate how decisions have been made.

## **What do we include in the RAMP?**

What are we worried about?

* You need to provide a brief outline of the risk identified.
* You should provide context to this risk, explaining who is at risk and what / who poses this risk? How it affects and impacts the person? Exploring any relevant history and if there are any patterns? This includes looking at the frequency and nature of the risk.
* It is paramount that you include the views of the person if this is possible, or show how you have tried to engage them, or what you have done to try and understand what their views may have been previously.
* This is opportunity to gather and record other’s views such as the person’s informal carer(s), family, neighbours or any other relevant person pertinent to the risk assessment.
* This is an opportunity to record other professional views such as a care provider and/or health professional.
* This is your opportunity to record YOUR concerns as the person’s adult social care practitioner.

Limited risk example of Albert:

Albert has found out that his grandson has taken additional money out of his bank account without his knowledge. He is worried about paying his bills but doesn’t want his grandson getting into trouble.

Improved risk example of Albert:

Albert has found out from a recent bank statement that additional money from his bank account has been taken out over the last 3 months, without his knowledge. Albert said that the only other person that has access to his bank card, is his grandson, Charlie Brooks (aged 24). Albert says that Charlie will go and buy his food every week as he is unable to get out himself. Charlie will withdraw £50 out for him every week on top of his shopping, to pay for the cleaner and any other bits he will need in the week. The bank statement however shows that £100 has been withdrawn every week for the last 3 months, rather than the £50 he receives. There are also additional withdrawals, in £250 amounts each time, totalling £2250 over the 3 month period. Albert has looked over his previous bank statements with Claire Turnball (care provider) and confirmed there was no further, unknown withdrawals, going further back, than this 3 month period. Albert is upset that Charlie could do this to him, he says he feels angry but then he feels sad as he wonders if he should have paid him for helping him anyway. Albert is really worried about paying his bills, especially as he only receives a small pension. Albert is really worried and doesn’t want to get Charlie into trouble so has refused to go to the police.

**Strengths – What is working well?**

This is an opportunity to write what is currently in place to reduce the risk? Is this sustainable?

Include views of the person and that of relevant others.

## **What are the timescales to complete and review RAMPs?**

The Risk Assessment and Management Plan should be reviewed annually at a minimum. It is the practitioner's responsibility to decide when reviews should take place, which will be dependent on the severity of the risk and actions in place. RAMPS can have scheduled and unscheduled reviews in place.

## **Warning / Hazard Notes on Mosaic:**

* It may be necessary to record a hazard/ warning onto Mosaic. Warning notes should always be discussed with your manager first before being recorded in Mosaic.
* Any warning should be specific and factual. It should clearly outline the risk and context to the risk (including nature, frequency and impact). There should be information on any actions or measures required to reduce risk in order for practitioners to risk assess and consider impact.
* It may be required for these warnings to be considered further in Need Assessments or Risk Assessment and Management Plans (RAMP).
* The Key Worker is responsible for monitoring and reviewing Warnings attached to their allocated cases. The Manager is responsible for cases without an allocated worker.
* It is important that a Warning is removed (ended) as soon as the reason for its existence has expired. This is to ensure that information held about the person is accurate and that workers are fully informed of the person's current situation. For this reason, warnings must be reviewed regularly, as per agreed timescales. Managers must monitor warnings to ensure that none are overlooked.
* The need for a warning to remain open must be reviewed prior to closing the case. If there is a reason for the warning to remain in place, the case should not be closed and should continue to be reviewed regularly.

## **Alleged perpetrators:**

If a perpetrator or alleged perpetrator is identified, where possible full names and any contact details should be recorded (and if not known recorded as such). This may include creating a MOSAIC ID for them as well as the link towards the person being evident in MOSAIC relationships, within our assessments, reviews, case notes or Risk Assessment Management Plans if this is applicable.

*(Where this information is recorded in our work, will be dependent on each situation and our own professional judgement. If in doubt, please ask your line manager / supervisor for further guidance).*

It is important that we can identify perpetrators and/or alleged perpetrators and review risk easily and clearly. We must update the alleged perpetrators record with any outcome to a safeguarding enquiry or further information we receive in relation to this risk.

# **7. Legislation and Guidance**

Guidance is written with reference to relevant legislation, setting out what we should be capturing and how we should manage people's information. More specifically, the pieces of legislation or additional guidance that set out Adult Care’s requirements for recording and managing information are:

[Information assurance – Lincolnshire County Council](https://www.lincolnshire.gov.uk/directory/34/policies-strategies-and-plans/category/24)

[Data Protection Act 1998](https://www.legislation.gov.uk/ukpga/1998/29/contents)

[Data Protection Act 2018](https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted)

[UK GDPR guidance and resources | ICO](https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/)

[Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents)

[Disability Discrimination Act 1995](https://www.legislation.gov.uk/ukpga/1995/50/contents)

[Human Rights Act 1998](https://www.legislation.gov.uk/ukpga/1998/42/contents)

[Freedom of Information Act 2000](https://www.legislation.gov.uk/ukpga/2000/36/contents)

If you require any further advice or guidance please visit the [Information Assurance Hub - Home (sharepoint.com)](https://lincolnshirecc.sharepoint.com/sites/InformationAssuranceHub).

## **Quality Practice Assurance Standards:**

The [Quality Practice Assurance Standards](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Ftrixcms.trixonline.co.uk%2Fapi%2Fassets%2Flincolnshireadults%2F2ebd5d73-0af3-424c-a644-072d91399a8d%2Fquality-practice-standards-december-2022.docx&wdOrigin=BROWSELINK) are a vital element of Adult Care’s strategy for driving excellence in Assessment and Care Management practice. The quality standards, alongside our professional capabilities and corporate behaviours frameworks, are integral to our continued drive for excellence, and provide the basis for best recording, reflective practice and continuous professional development.

Standard 8 refers to "The Quality of our Recording" which sets out some key considerations for best practice in recording *(this is not an exhaustive list.* *Correct as of February 2024):*

|  |
| --- |
| **Standard 8 – The quality of our recording** |
| * The quality of the case recording conforms to the Adult Care Recording Guidance. * All recording should be of a good written standard, including grammar and spelling. * Recording should be clear, concise and factual and proportionate with any opinion expressed clearly distinguished and attributed. * Recording shall be person centred and recorded in a way that would be meaningful to the person if they were to request access to their record. * Records will show where there has been information and advice given in relation to care and support arrangements, including financial implications for receiving proposed care and support. * The record will show clear rationale of all key decisions made with record of people involved in the decision and their rationale. * Where a management decision and direction has been given relating to case work, this will be recorded clearly in the case notes. * Case notes will include only information which is relevant to that case. * Where emails are copied into case notes, they only include information relevant to the person and the case note does not include long or repeated conversation trails. |

## **Care Quality Commission – “We Statements”:**

The Care Quality Commission (CQC) is responsible for assessing Local Authorities delivery of their Adult Social Care duties under Part One of the Care Act 2014.

The CQC Framework comprises nine quality statements mapped across four overall themes which are: working with people, providing support, how we ensure safety within the system and leadership.

**Quality Statements:**

Quality statements are the commitments that local authorities must commit to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

Assessing Needs:

We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Supporting people to live healthier lives:

We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce future needs for care and support.

Equity in experiences and outcomes:

We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this.

Care provision, integration and continuity:

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Partnerships and communities:

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Safe systems, pathways and transitions:

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safeguarding:

We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people’s lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.

Governance, management and sustainability:

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Learning, improvement and innovation:

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

**8. Professional Bodies**

The Health and Care Professionals Council Standards of Conduct, Performance and Ethics states:

* you must respect the confidentiality of service users.
* you must treat information about service users as confidential and use it only for the purposes they have provided it for.
* you must communicate properly and effectively with service users and other practitioners.
* you must keep accurate records.

The Royal College of Occupational Therapists (RCOT), [professional standards for occupational therapy practice, conduct and ethics (2021)](https://www.rcot.co.uk/publications/professional-standards-occupational-therapy-practice-conduct-and-ethics) state:

* Good practice in keeping records protects the welfare of those who access the service. As such, it forms part of your duty of care. Your records are also your evidence that you have fulfilled your duty of care in your practice.
* You create and maintain a comprehensive written or digital record of all that has been done for/with, on behalf of, or in relation to those who access the service.
* Your records are comprehensive and accurate.
* Your records are completed promptly, as soon as practically possible after the activity occurs.
* All records, whether written or digital, are legible, understandable, clearly dated, timed, kept chronologically and attributable to the person making the entry.
* You demonstrate that your practice is appropriate by recording your clinical/professional rationale.
* You identify the evidence that informs your practice, where available.
* You include all your risk assessments, actions taken to manage the risk and any outcomes.
* Your records demonstrate how you meet your duty of care.
* Your records demonstrate that your practice is effective.
* You process your records according to current legislation, guidance and local policy.
* You explain your reason for recording and processing information to those who access the service.
* You comply with any legal requirements and local policy in relation to confidentiality, the sharing of information and any individual’s request to access their own records.
* You keep your records securely, retaining and disposing of them according to legal requirements and local policy.

[The Nursing and Midwifery Council Code](https://www.nmc.org.uk/standards/code/) (2018) states, “As a professional, you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions”.

* you must respect people's right to confidentiality
* you must listen to the people in your care and respond to their concerns and preferences
* you must keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been
* you must complete records as soon as possible after an event has occurred
* you must not tamper with original records in any way
* you must ensure any entries you make in someone's paper/ electronic records are clearly and legibly signed, dated and timed
* you must ensure any entries you make in someone's electronic records are clearly attributable to you
* you must ensure all records are kept securely.

[Social Work England Professional Standards](https://www.socialworkengland.org.uk/media/1640/1227_socialworkengland_standards_prof_standards_final-aw.pdf) (2021) state the requirement to "be accountable for the quality of my practice and the decisions I make… to maintain clear, accurate, legible and up to date records, documenting how I arrive at my decisions".

In 2005 Brigit Dimond (Member of the Mental Health Act Commission) wrote:

"Failure…to maintain reasonable standards of record keeping could be evidence of professional misconduct and subject to professional conduct proceedings. Such failure could also lead to disciplinary action by an employer and have very strong influence on any action brought in the civil courts by a claimant who alleges that he/she has suffered harm as a result of inappropriate care or treatment possibly as a consequence of failures to maintain reasonable standards of record keeping." (Dimond, 2005, p. 460)

Effective recording is a cornerstone of our practice and a fundamental requirement for all staff. The ethos of the Adult Care’s approach to quality is that excellent practice and excellent recording go hand in hand – you cannot be an excellent practitioner without being an excellent recorder.

# **9. Data Protection and Information Sharing**

Individuals have a number of rights under Data Protection legislation, including right of access, for more information see the [Individual rights and recognising requests (sharepoint.com)](https://lincolnshirecc.sharepoint.com/sites/InformationAssuranceHub/SitePages/Individual-rights-and-recognising-requests.aspx). Front line practitioners must bear this in mind when they are writing in records. This can require some professional sensitivity and consideration when practitioners write down what they consider the necessary information about a person. They should be aware of how it would feel for that person to read what they have written.

Effective joint working depends on practitioners sharing personal information with other agencies. Practitioners should be open and honest with the person, family and carers, where appropriate, from the beginning about why, what, how and with whom their information will be, or could be shared. Our [privacy notice](https://www.lincolnshire.gov.uk/privacy) holds all of the necessary information that you should communicate with individuals and the people involved with their care and support. The rules governing access to information about a person 16 and over who lacks capacity are covered in section 16 of the Mental Capacity Act Code of Practice.

There are a number of service specific information sharing agreements between Lincolnshire County Council and external partners. Adult Care will work within these at all times and should be familiar of the details within these.

When considering sharing information about an individual you should consider why you are doing this, we rarely look to rely upon consent when it comes to these types of services, for example:

* where there is reasonable cause to believe that a vulnerable adult may be suffering or may be at risk of suffering significant harm
* where the individual may cause significant harm to others
* where there is a statutory duty
* where it is part of our public task
* to assist with the prevention and detection of crime.

Details of all discussions must be recorded in the adult’s case record. Employees must record their decision and the justification for not seeking consent to share information. This should include details of the relevant legislation or LCC policy referred to.

In these cases, employees should refer to their local [Adult Safeguarding Policy and Procedures](https://www.lincolnshire.gov.uk/downloads/file/3272/adult-care-safeguarding-policy-and-procedures) for further guidance. The Information Assurance Team have also produced an [information sharing checklist](https://lincolnshirecc.sharepoint.com/sites/InformationAssuranceHub/SitePages/Sharing-Personal-Data.aspx) for ad-hoc circumstances. This document takes you through, step by step, what must be considered before sharing personal data with a third party.

When making decisions on sharing personal information, you can discuss with your manager or if you are unsure, you can seek guidance from the Information Assurance team or Legal Services (following usual approval routes).

[IA@lincolnshire.gov.uk](mailto:IA@lincolnshire.gov.uk)

[LegalServices@lincolnshire.gov.uk](mailto:LegalServices@lincolnshire.gov.uk)

## **Storage & Security of Information**

All employees must consider how they store Council information, e.g. files, laptops, workbooks and diaries, to keep them secure whatever their working environment. Information on how to be vigilant in relation to information recorded, transported or stored can be found at [Information assurance – Lincolnshire County Council](https://www.lincolnshire.gov.uk/directory/34/policies-strategies-and-plans/category/24). All information held about a person must be stored and disposed of securely, in accordance with the current Information Assurance Management policies.

All LCC employees have a duty to minimise the risk of information falling into the wrong hands when transporting, whether this is in paper form or electronic records. Laptops or other electronic equipment issued by LCC must be kept secure at all times; this is to ensure unauthorised access is not gained to information that should be restricted to employees with authorised access to LCC systems. This duty extends to ensuring that the recipients of information are correct to avoid accidental release to unintended recipients. Care must be taken when using auto complete in emails for example to avoid the inclusion of an unintended email address.

Additional care must be taken when working outside of official premises to ensure the increased likelihood of loss or compromise of information and equipment is managed. LCC documents that have sensitive content must not be left in view of unauthorised individuals whatever your working environment. If you are working at home, access to LCC information and systems must be restricted from family, friends and anyone visiting your home, to ensure confidentiality is maintained. Whatever your working environment, unattended laptop screens must be locked when you are logged into LCC systems; it would only take a minute for an unauthorised individual to view restricted information.

## **Secure Data Transfer**

Rather than encrypting individual emails Lincolnshire County Council encrypt the route the email takes. This is because it allows an almost seamless method of sending email securely from point A to point B.

Lincolnshire County Council do this using a technology called TLS (Transport Layer Security). Using TLS significantly reduces the risk to email so we have it turned on by default.

More information about secure email can be found [here](https://lincolnshirecc.sharepoint.com/sites/InformationAssuranceHub/SitePages/Secure-email.aspx).

LCC Information Management Portal (IMP) allows for the sharing of documents such as Care Plans with providers in a secure way. It is used by areas such as Brokerage to securely share information with external providers.

## **Removable Media**

There are high risks to the Council if information is stored on unencrypted memory devices, such as memory sticks, if the device was lost or stolen.

You must only use removable media when absolutely necessary.  **It must be encrypted**. Removable media includes: CDR, DVDR, portable hard drives, and USB sticks.

You must not introduce removable media from an unknown source to our ICT.

You must always keep passwords used to authenticate removable media separate from the media.

You must only remove ICT, removable media, and hard copy information from official premises when there is a clear business need.

When removable media is no longer required you must return it to the issuing department, or securely destroy it.

No other memory sticks or unencrypted memory devices are to be used to store, create or transfer Council information. There are high risks of Council information falling into the wrong hands if unencrypted devices are lost or stolen. Loss of information has serious consequences that can impact on the Council's reputation and lead to fines. The Information Commissioner's Office is the governing body that oversees how the Council manages information and has the power to investigate authorities and impose fines of up to £500,000 for information breaches.

## **File Retrievals**

Accessing historically held information should be routine in case management where the circumstances of the case dictate. This is especially important where there is any suggestion of historic concerns of a safeguarding nature.

Whereas increasingly historic information will be held in electronic systems, historic paper files should still be accessed where information is required to inform current case activity.

There will be occasions when it may be necessary to retrieve records which have been sent to off-site storage. Business Support are responsible for completing the Restore retrieval e-form to retrieve file(s) from offsite storage on your behalf. A list of staff able to retrieve files is available from: [recordsmanagement@lincolnshire.gov.uk](mailto:recordsmanagement@lincolnshire.gov.uk).

Retention timescales can be located via: [Retention schedule – Lincolnshire County Council](https://www.lincolnshire.gov.uk/directory/59/retention-schedule).

There are costs associated with retrieving files from off-site storage. The costs for routine retrieval (within 3 days) are negligible (50pence) and costs should not be prohibitive where there is a sound practice reason for retrieving the file. Files requested for same day retrieval are considerably dearer (£33.60) and same day retrievals should only be used in exceptional circumstances with agreement of a Locality Lead.

When a record is requested, Restore will return all files relating to the individual. This ensures that records are not separated. Restore staff will remove requested files from the box and leave the original box on the shelf. Files returned will be re- filed in the original box at Restore using the barcode reference number. Once files are received from the Mosaic movement field within the Paper file tab must be updated with the current file location.

NB. Please retain the box/grey envelope which the files arrive in as these need to be reused for returning files to Restore. For further information please see [Records Management (sharepoint.com)](https://lincolnshirecc.sharepoint.com/sites/InformationAssuranceHub/SitePages/Records-Management.aspx).

## **Mosaic User Guide: Recording Paper File Locations**

The Paper File Details section must be completed when recording the File Location for the first time in Mosaic. Where a file has already been recorded in the Paper File Details section and requires moving on a temporary basis, you must complete the Paper File Movements section. This will stop the duplication of records.

A case record:

* will assist others in the continuity of support when practitioners are unavailable or change.
* will provide an essential tool for managers to monitor a workers practice and competence.
* record appropriate authorisation from managers/supervisors.
* is a major source of evidence for assessments, investigations, enquiries and allocation of resources.
* is the main source of information we hold about an individual.
* is a vital source of statistical and managerial information for the purpose of planning and reporting.
* assists in planning and structuring practitioner interventions.

The content of a person’s record will be spilt into the different sections of the person’s electronic record including; case notes, contacts, assessments, outcomes, plans and reviews.

It will also include:

* all personal details including the person’s details, relationships, employment details and warnings.
* case notes record all interactions including visits, telephone calls and discussions with anyone related, concerned or involved with the person.
* the person’s most recent assessments, plan (including outcomes) and reviews.
* all l safeguarding information recorded and/or stored in Mosaic is now visible to all Mosaic users

All correspondence and written information which is deemed to be significant to the person’s care and support should be uploaded to their electronic record. The paper version is not destroyed; it is filed in their paper file.

A person’s information is confidential, but there may be circumstances where it is necessary to restrict access to specific information or reports which Practitioners consider to be sensitive or harmful. This decision must be agreed by a manager/supervisor and recorded in the case notes the electronic or paper documents can then be stored with restricted access. The information would be accessed on a strict need to know basis, and, where appropriate, managers may restrict employees' access to whole files which contain a large amount of this type of information.

## **Information Security Incident Reporting Procedure**

A security incident is defined as any fact or event that results in the compromise, misuse, or loss of council information, ICT services or assets. As an LCC employee you have a duty to report incidents of this kind to your manager, and the Information Assurance team as soon as possible using a [Security Incident Reporting Form](https://forms.office.com/Pages/ResponsePage.aspx?id=klvgtM74tUabJJm6XBHl6Wl0OQJRQi9PkDlS4-jn_U9UMEpOV0M4RzE5NVdKQTc4M1JVODcyVUw2Uy4u). It is important that all security incidents, including near miss or suspected incidents, are reported as soon as possible to ensure that they are managed effectively and that we are able to comply with statutory requirements set by the Information Commissioner’s Office (ICO), who are the governing body that oversees how the Council manages information and has the power to investigate authorities and impose fines for certain data breaches. There may also be a need to report to the police if a crime (theft of a device or information) is suspected.

For further information you can contact the Information Assurance team at [IA@lincolnshire.gov.uk](mailto:IA@lincolnshire.gov.uk)

# **10. Quality Assurance**

## **Who monitors the quality of records?**

* Practitioners have primary responsibility to ensure that their record keeping meets the standards outlined in this guidance and fulfils professional body regulations (if applicable).
* Line managers have responsibility to oversee the quality of the work completed which may take place in form of authorising workflows, ad-hoc checks, supervision sessions and Quality Practice Audits.
* Records may also be subject to quality assurance exercises as result of internal and external review.

# **11. Resources**

## **When considering recording, consider:**

Adapted from *Rolfe et al (2001)*

This critical reflection model can be used as a guide to support us be clear and succinct in many areas of practice, such as how we record our case notes, what we discuss in supervision, how to write reports and how we communicate with people.

Exercise:

**What?** Can you explain the current situation? What has happened?

**So what?** Can you make sense of the facts, implications, theories and your knowledge base of the situation?

**Now what?** Have you identified the next course of action and why? Have you found new solutions or learnt anything from this situation?

**Lincolnshire County Council honeycomb models on strengths-based approaches in practice and recording (2023).**

A yellow hexagons with white text

Description automatically generated

A diagram of a company's process

Description automatically generated with medium confidence

* [Social Care Institute for Excellence](https://www.scie.org.uk/social-work/recording) (SCIE) provides a number of resources to support improvement of recording skills for Social Care staff. One resource is based on the concept of PARTNERSHIP – the principle that "recording should be done, as much as possible, in conjunction with the person you are working with" (SCIE, August 2019).

**Person-centred**

**Accurate**

**Real**

**Timely**

**No jargon**

**Evidence-based**

**Reading the previous record**

**Succint**

**Holistic**

**IT compliant**

**Professional**

* Lincolnshire County Council Adult Care - [Risk Rating Quick Guide](https://trixcms.trixonline.co.uk/api/assets/lincolnshireadults/d4aa0740-34a2-4cf6-a74d-05e946090a86/risk-rating-quick-guide.pdf)
* Keeping Records - [*Guidance for Occupational Therapists* (Third Edition)](https://www.rcot.co.uk/sites/default/files/Keeping%20records%20-%20guidance%20for%20occupational%20therapists%202017_0.pdf)

Royal College of Occupational Therapists.

* Professional Curiosity Pack: [Lincolnshire Safeguarding Adults Board – LSAB resources - Lincolnshire County Council](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.lincolnshire.gov.uk%2Fsafeguarding%2Flsab%2F4&data=05%7C02%7CStacey.Kemp%40lincolnshire.gov.uk%7C55b1d39e24574e4036ac08dbfa411d91%7Cb4e05b92f8ce46b59b2499ba5c11e5e9%7C0%7C0%7C638378929789711542%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=pdbCgKQUrXBuQrA19NpIIqA3B8LM9H%2Fbv6vSZedJ%2FRg%3D&reserved=0)
* [Lincolnshire Conversation Practitioner Guide v3](https://trixcms.trixonline.co.uk/api/assets/lincolnshireadults/be08d6e2-f6a6-4cfe-9062-19c29b0dc10b/lincolnshire-conversation-practitioner-guide-v3.pdf) - A guide to carrying out, and recording initial conversations.
* [Independence, choice and risk: a guide to best practice in supported decision making](https://webarchive.nationalarchives.gov.uk/ukgwa/20130105035347/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/%40dh/%40en/documents/digitalasset/dh_074775.pdf) (Department of Health, May 2007)
* Leicester City Council Recording Standards with practice examples:



* Research in Practice (RiPFA) resources:

[Good recording: Practice Tool (2017) (researchinpractice.org.uk)](https://www.researchinpractice.org.uk/adults/publications/2017/june/good-recording-practice-tool-2017/)

[Recording strengths-based conversations | Research in Practice](https://www.researchinpractice.org.uk/adults/content-pages/videos/recording-strengths-based-conversations/)

[Skills and techniques which support good recording (researchinpractice.org.uk)](https://www.researchinpractice.org.uk/adults/content-pages/training-and-development-programmes/online-learning-packages-tailored-support/skills-and-techniques-which-support-good-recording/)