



## Report Writing – Maybe boring but essential

Report writing is perhaps not the most interesting of subjects that staff in residential care home have to address yet it becomes of ever increasing importance not only to good practice but to ensuring that regulatory and legal requirements are also met.

Providers not only have to ensure that what is written by their staff is factual and correct but is suitable for different audiences namely residents, relatives, the employer, the regulatory bodies and in some cases the courts.

It would be fair to say that most staff entered the residential services to undertake care tasks and not to write reports. Most employers will find that the care staff who have to undertake the writing of reports do not find it one of their easiest tasks as they are poorly trained to carry out the task and in some cases do not have English as a first language.

A failure to recognise and address the importance of providing evidenced report writing will lead to more providers and individual staff being subject to health and safety prosecutions, civil actions and importantly incorrect assessments of need in relation to care plans and risk assessments. With this in mind the Residential Forum dedicated one of its workshops to the subject which was attended by 40 invitees from all four countries of the United Kingdom and representing statutory bodies, non governmental organisations, service users and relatives, providers, training organisations, professional associations, the law and the press.

It is not only providers but also regulators who must ensure that their 'own house is in order' when writing reports. Inspections must include an examination of the factual base of records in homes.

What are the problems facing providers and their staff when it comes to providing evidenced residential care?

- A failure to understand the purpose for which many of the reports will be used
- A lack of understanding about what needs to be recorded
- Failure to provide appropriate systems to facilitate good record keeping and report writing
- Illiteracy of some staff
- The blame culture inherent in social care
- Lack of time
- Mistrust of what happens to information that is recorded
- Limited funding
- Tick box culture

It cannot be overstated that once something is written in a resident's file it is likely to have a profound effect not only on his/her immediate life but also for many years to come.

Here is an example of how one incident recorded in a certain way affected one person for the whole of their life.

'Stephen is 44 – he is a man with learning disabilities who has lived all his life in various care settings: residential special school, long-stay hospital, residential care, supported community living and so on. He has been problematic for his various carers – because his records showed that he was an arsonist – and all the additional supervision, support and dilemmas that go with that. Ultimately, each care setting would move him on because of increasing fear for everybody's safety because of the arson.

In his most recent setting – a small voluntary supported living scheme – his keyworker decided to take a few days to read through Stephen's huge file. And he discovered that when Stephen was 12 and in a residential special school – he had got up in the middle of the night, gone to the school kitchen and tried to make himself some toast. He burnt the toast which in turn set the curtains alight. Somewhere along the way as summary sheets were drawn up that incident became recorded as arson. And so Stephen from then on was an arsonist. And the record summaries repeated and repeated it. His whole life had then been dictated by a recording error.'

Providers of residential services and their staff have become accustomed to writing a view or an opinion without providing any evidence or justification in their reports or assessments.

- 'Mary had a good day' – without saying why it was a good day
- 'Change from using 'X' hoist to 'Y' hoist – without giving a reason
- 'John's behaviour today has been unacceptable' – why was it unacceptable and to whom was it unacceptable

The personalisation agenda in social care should enable an improvement in evidenced residential care but to date it does not seem to have done so. Report writing and recording are an integral part of personalisation and yet the views of many residents are blatantly ignored. It will certainly be the case that some residents will have little ability to directly contribute to their records but this is no cause for complacency. There are any number of ways establishing a person's needs and wishes through conversation, observation, discussion with relatives and discussion with other professionals.

The important issue is to address the subject under discussion and justify any decision, no matter how minor, that is taken.

Fatal accidents in a residential care home lead to thorough investigations and providers and staff might now find that their reports and record keeping are examined to the 'nth' degree to establish if there was neglect or poor practice. It is worth examining who in these circumstances might examine the reports and records

- The employer
- The police
- Health and Safety Officials
- CQC Officials
- The Coroner
- Crown Prosecution Service
- Residential Care Experts
- Solicitors
- Barristers
- Judges
- Juries

Of these people only the employer and CQC officials will have any knowledge of the people involved in the case and they all need to know why certain decisions were taken. Contrast this with a case conference where the majority of those reading the material will have a good knowledge of the person being discussed. Also contrast it with the new care assistant desperate for information from the records before undertaking some vital tasks.

It does not really matter who the reader is the justification for opinion and decision making remains paramount.

What is it that is needed to assist providers, staff and regulators to ensure that record keeping is accurate and justified and report writing is factual, evidenced and promotes good residential care?

- Ensure that there is understanding of all staff of the reasons for the different types of records and reports that are required.
- Emphasise that central to all record keeping and reporting is 'communication'.
- Make sure all reports and care plans have evidenced findings
- Person centred care can provide a route to change how those involved on the residential services think and therefore behave in respect of record keeping and report writing.
- Technology is available and can be further enhanced to make the perceived chore of record keeping easier and more consistent although it must not further the 'tick box' culture but provide a means of enhancing the information that should be available.
- Seek and use where appropriate methods of record keeping used by other professions.

- Greater attention to record keeping and report writing must be given in vocational training, other qualifying courses and induction.
- Consistent questioning by staff of contents care plans to ensure that what is written is making a difference and improving people's lives.
- Involve residents and families and other appropriate interested parties when writing care plans and assessments.
- Investigate whether the most appropriately skilled staff are being used to undertake record keeping.
- Set up a national framework for record keeping.
- Home managers and the management level above have a particular responsibility to ensure that record keeping in residential care homes is accurate and reports are well written.
- Regulatory bodies should have a consistent and thorough approach to record keeping and care plans.
- Regulatory bodies themselves should ensure that their reports are evidenced
- For those providers who have an additional management structure external to the home it is vital that such managers check whether the policies and procedures of the company are monitored to ensure that all record keeping is undertaken accurately and with evidence. Such monitoring by external and homes managers needs to be part of the professional supervision that is provided

The Residential Forum recognises that 'Evidenced Residential Care' can be seen as a low key priority in times of economic stringency but it should not be. We believe that for the enhancement of good practice, the protection of residents, the support of staff and other good employment practice providers of residential care should be given every assistance to improve record keeping and report writing. Failure to do is likely to lead to further fatalities, more prosecutions and an inability to develop person centred planning.

For its part the Residential Forum will return to the subject and seek to offer further guidance.

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