Scoping review

Recording practice and accessing records

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Overview

This is a summary of findings from an initial scoping review addressing how practice is recorded within social work in Scotland. It also considers how care experienced adults access and understand records written about them. As part of this scoping work, Iriss hosted a workshop with practitioners from East Ayrshire Health and Social Care Partnership to carry out an initial exploration into the reporting that they do. The scoping review was undertaken through the end of 2018, with the workshop with East Ayrshire taking place in January 2019.

The scoping review was undertaken in response to an initial call from East Ayrshire HSCP to address how care experienced people access and understand their records, and how practitioners could use co-production tools to make recording practice a more inclusive and accessible process.

In order to respond to this request, it was felt that an initial review should take place, in order to ascertain an initial understanding of current record keeping practices within social work, and how care experienced people access, and are supported to understand, their records.

We looked at a range of sources, from periodical journal articles, to local authority guidelines and sector tools. The following review comes from a selection of the most relevant sources. It should be highlighted this this was deliberately not a full systematic literature, but instead a first delve into the issues to help inform work that we will look to develop in the future.

Summary

It was clear from the very beginning of this scoping that there were two very different processes going on, with their own sets of challenges and issues. There is recording practice which encompasses what is captured, collected and written about a person receiving support. This is usually recorded by the social worker. Then there is access to that information by the person, usually through the process of contacting the local authority. The diagram below tries to show some of the relationships between these:
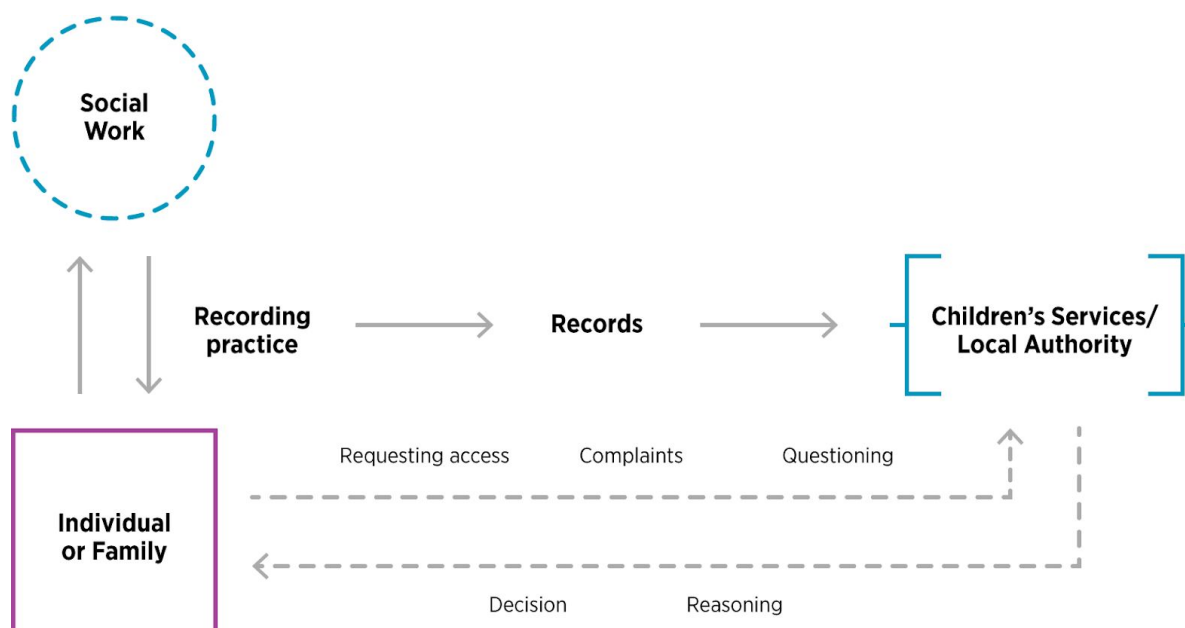

Image 1: Recording and Access diagram. A summary of the process from an initial scoping review

The initial review highlights that each subject (recording and access) is influenced by a range of factors that have a powerful impact on the experiences of the individuals (care-experienced and social workers) involved in each of the processes, and the information that is being collected.

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These factors include and are not limited to:

- Differences in approaches by different localities in Scotland (over small geographical spaces)
- The time of recording and access (shifts in approaches and the understanding of role and remit between different areas)
- Implications for people of different ages accessing their records now – one-size-fits-all (especially with age) will not necessarily work
- What process is being recorded (eg adoption versus care)
- Guidance and framework for social workers – at the time of education or entry into practice
  - Individual approaches to how information is collected can vary hugely between each practitioner

It is, therefore, important to consider when going forward with this exploration that recording and accessing should be considered as individual experiences and processes, but that both influence each other.

> *"Recording should cover anything that contributes to a decision and should be recorded by the person making the decision. How much is recorded depends on the complexity of the situation"*
> (Nosowska and Series, 2013)

Over the past few decades the practice of record keeping within the social work profession has changed dramatically. Social Work Scotland's (SWS) reflections on the 1968 Adoption Act, highlights that since 1968, the process of documenting a person's journey through care has changed from a two-page description of a child's physical and health suitability for adoption or care, to a seventy-two page statutory document in more recent years (SWS report only references up to 2014). SWS highlights a shift within this period towards evidencing problems for legal and social work processes. Records become conduits for decision-making rather than a vessel that retains a person's narrative for future access by care experienced individuals or families.

Often, recording practice is viewed by professionals as a time-consuming activity, hampered by the systems and processes that underpin it (Lynch, 2009; O'Rourke, 2019; SWIAS, 2010), stating that 'failing to keep accurate records of decisions you have made and actions you have taken can put people at risk' (Social Care Institute for Excellence, 2015).

> *"It can also be viewed as a process necessary for performance or management information requirements rather than a tool to promote quality of life"*
> (Johnstone and Page, 2014)

Many local authorities and social work regulatory agencies highlight good practice guidelines, citing the need to be analytical, using appropriate language that is person-centred, lawful and proportionate to the complexity of an individual's situation (Nosowska and Series, 2014). Inconsistencies between authorities persist and the range of styles of record keeping is extensive between different practitioners; formal reports, typed or handwritten notes, digital files, drawings, and filmed interviews.

This range of approaches means there is not a one-size-fits-all solution to how records should be recorded and accessed, as suggested in many of the guidelines and much of the literature. Instead, the process should be proportionate to the needs of the individual, and in turn, the practitioner.

With regards to accessing records, it is difficult to find more historical notes on how this was undertaken. However, there has been an increased number of agencies – [Who Cares Scotland?](#) as one – and local authorities trying to improve the way individuals can gain access to their files and be supported through that. This goes hand-in-hand with a move towards an electronic approach to record keeping, and also reflects international studies, notably the Australian Historical Child Abuse enquiry, which highlights some important issues that may be mirrored in Scottish practice.

Recording practice overview

The following notes have been collected from sources that discuss topics pertaining to how practice is recorded in social services in Scotland, with particular emphasis on social work practice.

What is it and why is it important?

There is a huge amount of nuance involved in what recording practice is, what it entails and how exactly it is defined. For the purposes of this review, and to begin our exploration, we worked with the definition that social work recording is any written material in the social work files of people who use social work services (the focus was social work and not more broadly social care/support). These may take the form of electronic or hard copy files. Recording therefore involves:

- Writing down the work that is done
- Noting the progress people make towards their desired outcomes
- Including the views of the person
- Analysis and assessment
- The life history of the person and its interpretation

(Adapted from [On the Record – getting it right, Social Work Inspection Agency, 2010](#))

O'Rourke (2010), in her book *Recording in social work*, advocates that recording is important for three main reasons:

1. Evidence policy, process and practice have been followed appropriately, demonstrating professionalism and competency
2. Provide the rationale behind professional judgement
   a. Making it clear how a decision was arrived at
   b. Being accountable for why a particular course of action was taken (or not)

3. Give a clear picture of the person's story, their wishes, views and preference which can be used by them, and or others to empower and better understand their situation and any care or support needs

There needs to be accuracy, accountability and information that leads to evidencing decisions that have been made in situations, either to service users and others, or to courts. Alongside this, recording should assist in the reflection and analysis of work. Finally, these records are a source of personal information and of that person's story and should be treated in such a way.

This, therefore, has implications for practitioners, individuals who receive care and support, and organisations.

What is good practice?

This can be split into different levels and there are a number of outlines that bring together the principles of recording practice that are very much embedded within the values of social work and social care and support.

Social Work Scotland ([Governance for quality social care in Scotland](#)) outline a broader underpinning of the quality to be strived for in overall practice with social care – one that is fundamentally rooted in a strong value and belief system. This takes the view that there should be a:

- Holistic view of the individual
- Socially constructed and crafted understanding of the presenting problem
- Attempt to understand the complexities of how an individual interfaces with their wider environment
- Acknowledgement of the relevance of different elements of the person's whole life
- Place for individuals shaping their own support and services

Much of this can be related to the [SSSC Codes of Practice for Social Service Workers](#), and within recording practice the values behind the Codes are often closely aligned with how records are formed. For example, [East Dunbartonshire Council Social Work Department Procedure and Guidance on Case Reporting](#) states:

> *"The overall value base is that expressed in the SSSC Codes of Conduct for social work and social care staff and employers. Records must be kept in a way which is honest, using respectful language, and which differentiates fact from opinion, judgement or speculation. It is expected that the service user will see their record, if possible near the time the record is written, unless a decision is made, at the designated level of authority, to restrict information on the basis of one of the legal grounds for this. Any area of restricted access must be clearly recorded as such in the file so that future professionals are aware of this and the reasons. If records kept are on infants or children too young to read or understand them at the time, it should be borne in mind that that child will be able to see what is written in due course. Each child must have their own independent record."*

Research in Practice for Adults (RiPfA), developed a [Good Recording Practice Tool](#) in 2017 that sets out a comprehensive list of principles behind recording practice. These are:

- Ethical – non judgemental, respectful language, consent and confidentiality, inclusive
- Joined-up – involves other relevant people
- Lawful – adheres to relevant policy and law
- Proportionate – reflects the person's views of what's important and what is needed, and the complexity of the situation
- Person-centred – accurately reflects the person's circumstances, tells their story, shows person was fully involved as they wanted to be
- Accountable – clear about what is fact, opinion, hearsay and where these originate from, explains rationale behind opinions and decisions and action / inaction
- Strengths-based – looks at a person's individual strengths, resilience and capacity and networks

- Analytical – weighs up information, explains meaning and is informed by evidence
- Appropriate – Information is gathered and recorded in a way that is suited to the person's circumstance and involves them
- Useful – includes clear outcomes for the person (needs, impact, outcomes and actions)
- Being mindful of your audience and the purpose of recording

Alongside these principles and values go a practicality that is more applicable to professional writing and note-taking in general. These should be that recording is formed in clear English, is accessible, logical, concise, and avoids repetition or jargon. The content should be clear in what is contained, and there should be clarity in what is fact, opinion or analysis on the writer's part.

As has resonance with other professions that take notes (such as police or GPs), there is an acknowledgement that it is challenging to talk to someone, formulate meaningful connections and questions, and take notes at the same time. This takes practice and techniques suited to a social care and support context. There is some reference to the [Cornell Note Taking](#) system that splits recording into full notes, keywords and comments and summary points sections. Key to any method is the need to reflect and review notes.

What is recorded?

> *"Failing to keep accurate records of decisions you have made and actions you have taken can put people at risk. It also puts the organisation you work for in a difficult position, and risks its reputation"*
> (Social Care Institute for Excellence, 2015)

When talking about case recording in particular there should and can be a range of types of information recorded:

- Individual and family background
- Input and views from the service user

- Information from other practitioners, such as health professionals or the police
- Assessments, plans, services, outcomes and reviews
- Events, reports or legal orders
- Contact with service user, family members, professionals and other services
- Chronologies of personal history and intervention
- Summaries which assist continuity, especially when intervention is lengthy or complex
- Notes on supervision and auditing events related to the care

The range of styles of records can also be extensive and go beyond just traditional hand written notes or electronically written notes or formal reports. These may also include photos, drawings, diagrams, worksheets, audio/film or interviews ([East Dunbartonshire Council Social Work Department Procedure and Guidance on Case Reporting](#)).

Pitfalls in case recording

With social work case recording, there are a number of issues that often come up. One of those issues is that recording is sometimes not valued as highly as it should be.

Often, it is easy to overlook the significance, value and complexity of case recording, and to treat it merely as an administrative task (Holmes and colleagues, 2009). This may take the form of the recording being done too quickly, or without the required time to reflect and review what is being recorded. There can be a blurring between what is professional opinion (based on knowledge, observations and judgement) and fact.

[Social Work Scotland, in their 2018 review](#), explored the changing nature of adoption work since the Social Work (Scotland) Act 1968. With this focus on adoption records, these were seen to have 'become more fragmented and

shaped by the need for institutional accountability'. In that paper they quote Wastell and White (2014):

> *"Social care records have thus become primarily ways of achieving accountability, providing an electronic audit trail showing that correct procedures have been followed. This privileging has subordinated a crucial part of the professional sense-making process, namely reading and understanding complex cases, unfolding across time and space"*
> (Wastell and White, 2014, p144)

There is a skill in combining information, to get the right balance in a record to reflect the complexity of lives, events and evidence (Rai and colleagues, 2014). Throughout this, there should also be the use of empowered language, avoiding disrespectful wording or stepping into 'ventilation' where frustrations of the person writing may come through. Core to avoiding this is remembering that the person being supported is central to the record, both in content, in being involved in the formation of that record, and as a potential audience for what is written in the future. This [Write Enough](#) training pack, although dated (2003) explores a lot of these areas in more detail.

Exploring recording: East Ayrshire workshop

We spent a day with ten practitioners from East Ayrshire Health and Social Care Partnership (predominantly those with social work experience, but there were also others from connected services), exploring their experiences of recording. Beginning by outlining some of the scoping work described above we asked questions around the most prominent issues for them in recording practice, and where they would like to work towards in the future. We need to thank that group for their openness and willingness to discuss these areas with us, and the valuable insight this gave us that went beyond the literature found online. Four of the key themes that emerged are explored below.

For some context, when we first discussed access and reporting interest with senior managers from East Ayrshire HSCP, they contextualised some of this by referencing the _Improving institutional responding and reporting final report_ and the _Recordkeeping and information sharing final report_, compiled by the Royal Commission into Institutional Responses to Child Sexual Abuse in Australia. The reports are huge and the focus is on child sexual abuse, but the learning from the reports are still highly relevant and there were some key things that resonated with practitioners in East Ayrshire. The reports made some specific record keeping recommendations:

- Institutions that care for or provide services to children must keep the best interests of the child uppermost in all aspects of their conduct, including recordkeeping.
- Records created by institutions should be clear, objective and thorough. They should be created at, or as close as possible to, the time the incidents occurred, and clearly show the author.
- Records relevant to child safety and wellbeing, including child sexual abuse, should be maintained in an indexed, logical and secure manner.

- Individuals whose childhoods are documented in institutional records should have a right to access records made about them. Full access should be given unless contrary to law. Specific, not generic, explanations should be provided in any case where a record, or part of a record, is withheld or redacted.

Ultimately, as can be seen in these reports, records were important in alleviating the impact of child sexual abuse for survivors. East Ayrshire wants to make sure that it can build on and improve existing practice to make sure that their current recording fits with an environment where care experienced people can access and understand their records and be supported in doing that.

1. Time

Unsurprisingly, the biggest challenge, especially pertaining to case recording, was the amount of time that was able to be given to truly reflect on a case and write it up. There was a perception that 'recording was not seen as important as doing' and due to workloads often there was a delay between note-taking and full recording that could diminish the quality or accuracy of notes over time. There was general agreement that it was best to do a full write-up as soon as you can, while at the same time having given yourself space to reflect on what you put in there. There was a call for more protected time to do this work and more continual support and training in taking notes and then expanding on them. It was compared to the way police officers collect notes, doing so methodically and comprehensively, but coming back to them to weave into a evidence-informed story. Often, it was felt that writing up could take the form of 'just getting it out your head' and that could result in less clarity in what was written and erode the usefulness of the account.

2. Audiences and expectation

Practitioners were very aware that they were potentially writing for multiple audiences, whether that be managers, colleagues or for use in court – there

was always a consideration of the reader. Case notes were seen as having to be evidential (with conclusions from that evidence), and they always needed backed up, even if that involved professional interpretation.

Beside this was balancing not wanting to miss out information, but also not wanting that to be duplicated. However, underlying that was the knowledge that the ultimate reader of this could be the person who was being supported. There were some extremely rich and meaningful discussions around wanting a child who was being supported and cared for in the present, to know that, if they read this in the future, that they were loved and cared for.

From the experience of the participants, different managers and services have different understandings for what good practice in recording is, and what that record should contain and look like. One person mentioned that often the 'thinking is in procedures and not values'.

3. Style

Most participants agreed that professional social work jargon in recording may look good, but actually can be pretty meaningless. It is easy to fall into using this language to try and keep 'right and formal' in what you do, but it does not necessarily contribute to what you are trying to communicate. There was also a debate around whether the record should be recorded in first person ('I believe that…') or third person ('The writer believes that…'). The latter style was seen as coming from a more formal approach, in a attempt to be seen as giving a professional, possibly objective, view of the situation that was being presented. However, it was open to being critiqued as too removed and distant. It was interesting hearing that there was not much direct training around recording style and techniques and much was absorbed informally, while seeing how other colleagues from social work wrote on shared records.

4. Tools

There was a discussion around using different tools and techniques when capturing a person's views and recording them, with particular consideration given to the view of children and young people. Some of the practitioners spoke about using different tools and techniques to help them, one mentioning the How it Looks to Me child impact tool and practitioner guidance notes. Others spoke about the Wizard/Fairy tool on Signs of Safety and the Talking Mats tool which has helped them have conversations with people they were supporting. Often this would give an added visual aspect to the recording and help them express what the person valued and was looking for in their life.

What would success look like in the future?

Following these discussions we explored what success would look like if recording practice was perfect in the future. The participants:

- Wanted to see a recognition of the importance of recording reflected in workload and the pressure on staff time.
- Wanted a move towards more co-produced records, forming the story, where possible and appropriate, with individuals, families and young people.
- Agreed that it would be extremely useful to have a resource for practitioners and for students on exemplars of recording and real-life informed guidance on note-taking and writing-up that showed how dynamic the process truly is.
- Expressed a hope that in the future there would be a marrying of analysis, substance, reflection and care. This would show itself in truly holistic observation of people's lives, alongside caring but critical assessment and observation.

- Wanted to see a place for openness, transparency and truthfulness, where practitioners could have the confidence to express their professional opinion, but there was also an acceptance from others that this may not always be the perfect or ultimate truth.

Accessing records

Everyone in Scotland has a right to see the social work and social services records that are held about them. However, this happens in different ways across Scotland, with processes managed through local authorities. The issue around access and receiving historic records, whether it be about time in care or adoption is one that is becoming more prominent. The issues that emerge from this are multiple. Initially, there are the different routes to access and who to contact in relation to accessing records. There is then the availability of what is there, with standards around the way records are kept around time in care having recently been changed for local authorities to align with records around adoption. Much more of the background around this and associated bills and legislation can be found on the Looked After Children section of the Scottish Government website. There is then the issue of what people can see. For example, Aberdeen City Council stipulate the circumstances in which individual social work records may be redacted or elements withheld due to data protection laws. Examples of these circumstances are:

- Information which may be seriously harmful to you or some other person
- The information identifies another person who has not agreed to it being passed to you
- Special rules apply to information provided by health professionals, the Children's Reporter and the Education Service
- Information given and held for the purposes of preventing or detecting crime, or for prosecuting or apprehending offenders
- Information, which is, restricted by another law eg adoption agency records

(Aberdeen City Council, *How to access your social work file*, 2019)

There are various wordings of restrictions across local authorities on information that may be withheld (see also Accessing social work records, East Renfrewshire Council). Often this results in a long wait to receive files, and then heavily redacted files once they do arrive at the person who has requested them. Finally, there is differing support for people once they do receive that information.

This is very much the focus of work from Who Cares Scotland? and Ryan McCuaig, one of their care experienced Directors. You can see more of his story accessing his own records here.

> *"We can do better. These files are our stories. Our lives. Care Experienced people deserve a process – consistent across all local authorities – which respects their rights and provides adequate support while they seek that narrative and sense of identity"* (Ryan McCuaig Twitter thread @Ryan_McCuaig, Nov 2018)

There is often very little support to a person then reading this story of their time in care, to help them reflect and think through what those records mean to them and how to process the feelings that emerge from that reading.

Connecting recording and access

There is a connection between access and recording that contains a shared recognition that the local authority and other care and support organisations are stewards for the information that is collected about a person's life. People should be included, involved and supported at each of these stages. The idea is that both processes should be part of the compilation and that the recording should be captured with the future person in mind (as well as the other potential audiences). There should be a thread running through the whole process, viewing the journey a person makes in their life as one that sits within and across the whole process. This gives opportunity for approaches like coproduction, and health and social care integration to reframe how we view and manage this journey as a sector and a society.

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Policy and guidance

Records Management Code of Practice for Health and Social Care 2016
Source: https://bit.ly/2KbECn6

Records Management: NHS Code of Practice (Scotland) Version 1.0
Source: https://bit.ly/2QqmA8b

SSSC Codes of Practice
Source: https://bit.ly/2l0zpSY

Citizens advice – Records about child abuse
Source: https://bit.ly/2SAZQyP

Scottish Government (Looked after children)
Source: https://bit.ly/2G3LGCU

Health (NHS) Access to records
Source: https://bit.ly/2UtOA97

Social Work Scotland Governance for quality social care in Scotland
Source: https://bit.ly/2UiMSen

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