RECORDING SKILLS AND DATA PROTECTION

Course Workbook

Abstract

This workbook is designed to accompany the Dialogue training course on Recording Skills and Data Protection and will cover key issues around the essence of what makes for effective recording in social care. It does this within the context of thinking about issues around Data Protection.

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Contents

Introduction

This workbook sits alongside the Dialogue course on Recording Skills and Data Protection. It offers some key learning points and practice guidance which is covered in the course as an ongoing reference resource for participants. Staff will be able to refer to this workbook and could use it alongside their recording as a prompt for promoting best practice. In this workbook you will find a variety of tools including a 3 step framework for recording, tips for best practice in recording, an alternative guide on what the Data Protection Act could mean for your practice.

Workbook Aims

- To enable the practitioner to understand recording, confidentiality and the impact these have on the people we work with.
- To understand the different types of recording and what makes for effective recording
- Establishing the role of fact, opinion and analysis in our recording.
- To understand the implications of the Data Protection Act 1998 and Human Rights Act 1998 as they affect recording in Public Authorities

Recording and the Impact of Recording

Here are just a few overarching principles which are relevant to recording information about the people we work with. They are worth holding in mind as we think about what we are going to record and when we reflect on what we have written.

- Whenever we record we edit to our perspective and to meet the purpose of the recording. The priority we give to certain aspects may not be the priority accorded by the data subject. Sometimes this is essential, but it should always be handled with sensitivity and good practice would encourage us to use the data subject's own words in recording.
- We should be clear about the rationale behind asking questions and then why we are recording the answers which are given, for example to ensure everyone gets a fair service and the organisation isn't excluding particular people or groups. This relates particularly to how we collect and hold personal information such as questions about ethnic identity, religion, sexuality or age.
- Writing something down fundamentally changes the nature of information. Informal discussions suddenly become quite loaded.
- We need to be explicit about the boundaries of confidentiality in collecting information.

The last point here is about confidentiality and there is a broader issue to think about in relation to the rights of the person that we are writing about. We need be aware when we are writing that when we are doing this what we do fits within the requirements of the Human Rights Act;

> ARTICLE 8 RIGHT TO RESPECT FOR PRIVATE AND FAMILY LIFE
>
> 1. Everyone has the right to respect for his private and family life, his home and his correspondence.
>
> 2. There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

particularly Article 8 of that Act which is about the Right to Respect for Private and Family Life

Recording – what's the point?

It is recognised that there is a broad range of recording activity which takes place and that a broad range of care records exists. The Social Care Institute for Excellence (SCIE) have a set of benchmarks for recording and defined care records as "any paper or electronic-based record which contains information or personal data pertaining to people's care[1]".

In thinking about why we record there are a number of reasons which we can identify for this.

- Focus the work of your organisation.
- Support effective partnership with clients.
- Help with continuity.
- Provide an essential tool for managers to monitor work.
- Provide evidence for investigations and inquiries.

Basics of Recording

1. Begin by working out what to record and where to record it
2. What is to be recorded is framed by the context of the report, and the purpose of the work. Record what is relevant to the purpose of the observation or visit, related to the objectives in the plan. Only record additional information if it is 'significant'.

In thinking about these two principles above we can look at a 3 step model which can be used in most situations for recording:

• **Fact**	Clearly record the facts given on which you are basing your opinions and decisions. Note the source of any facts you use.
• **Opinion**	Record opinions given, whether those of the family or other professionals, clearly attributing any comments. Record your own professional judgement – there is a myth that we should not record opinions on file, but it is often these opinions that shape case decisions so they are crucial in almost any record.
• **Action**	Make a clear note of any actions to be undertaken. Remember the SMART acronym to ensure your record is Specific, actions are Measurable, Achievable, Realistic and make a note of any Timescale.

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216701/dh_119965.pdf

Fact or Professional Judgement

In our recording we can often think that we need to be get the facts down and there are going to be times when there will need to be a clear focus on the detail of what has happened, such as when there has been an incident in a particular setting involving a service user and we will need to be clear about exactly what happened, what went before, and how we dealt with that incident. This should involve an accurate factual description of events which for examples includes reference to specific interventions in line with organisational policies and procedures.

Even in these situations it is important to distinguish where the factual account ends and professional judgement comes into play however. Moreover within our general recording activity it is important to recognise both the difference between professional judgement and facts and the value of a combination of these within our recording processes.

It is essential to distinguish between 'facts' and 'professional judgements' and conclusions based on observations and research reports. Hypotheses may also need to recorded, provided it is made clear what information they are based upon. Nevertheless, they may still have to be shared if a family member seeks formal access to their file.

But it is very important not to think that you can 'stick to facts only': the key task is to substantiate any non-factual information - of which there will always be a great deal.

By 'non-factual' information, we mean 'assessments' and other information about which you will have to make certain judgements - but remember that 'using your professional judgement' does not mean 'being judgmental'.

Not distinguishing between 'facts' and 'professional judgements' can lead to a considerable amount of labelling, as the following 'record' of 'parents' problems' illustrates:

- *Drug use*
- *History of abandonment and institutional upbringing*
- *Financial/material insufficiency*
- *Inability to prioritise the needs of the children (beyond physical care)*

These are all listed as 'facts' - as indeed some of them might be - but, equally, they may be based on a considerable amount of third-hand information.

8 Pitfalls of Recording

This section will look at 8 pitfalls for recording. For each of these it will consider what the pitfall is in terms of what the recording will look like if this pitfall exists and then it will consider some ways in which this pitfall could be avoided. As you will see later on there is clear overlap with the best practice tips.

8 Pitfalls for Practitioners	*Avoid the pitfall*
1. Case records are out of date • The practitioner does not see recording as a high priority activity • Recording is unplanned	• Recognise that recording is an important task, not just for the agency but for the service user or carer. • See recording as an integral and important part of your practice. • Plan your recording. Allocate time to record and minimise interruptions and diversions. • Record information as you go along. Keeping information in your head to record at a later date may result in key information being forgotten. • Allowing recording in complex cases to accumulate can result in you being confronted by a seemingly impossible amount of paper work. • When planning a significant contact with a family or individual include recording as part of your time allocation.
2. The child is missing from the record • Parent's needs dominate at the expense of the child • The practitioner is trying to protect the child • The practitioner has found the child	• Ensure that you regularly see children and young people alone. • Sessions must be planned to meet the needs and abilities of the individual child. Where interpreters, specialist workers or tools and activities are used to facilitate communication, this should also be clearly recorded. • Record what the child tells you, in the child's own words. You may wish to encourage older children to make records for the file. • Ensure that the child's views are clearly marked in the file. This will make them easy to find. You may wish to highlight them or to record them on separate detailed records. • Ensure that each child has a separate file, or section within the file, and that the needs and views of

uncommunicative, or expressing different views at different times.	each child are recorded individually.

3. Facts and professional judgements are not distinguished in the record • Opinions are recorded as fact • Opinions are not substantiated • Facts and opinions are not differentiated • Only facts are recorded	• An easy way to avoid this pitfall is to share records with families. Research has shown that practitioners substantiate opinions more clearly if they know that the family will be seeing what they have recorded (10). • Separate facts and opinions in your recording. Record the facts first and then record your analysis of them. Remember to include any research evidence you have used. • Where another professional or family member gives an opinion, ensure that this is recorded as such.

4. The size of the record makes it difficult to manage • The record is unfocused • Records are kept to protect the	• Maintain a clear focus in your recording. The record should identify the child's developmental needs, parental capacity to respond to the child's needs and the impact of family and environmental factors. It should also specify the service to be provided, why this particular service has been selected, the desired outcome as a result of this service and how progress towards this goal will be monitored. • Records should record significant information if they are to meet the needs of the child, the practitioner and the agency. However, they should also identify the significance of the information recorded. Use information from research and supervision to assist you to identify the significant

worker • Minimal records are made • Practitioners are unclear what is significant • Records are duplicated in the file • Records are narrative rather than focused	information for the particular circumstances of the child and family. • Ensure that you have a clear plan for each case and use this to structure both your intervention and your recording. • Social work records are an important tool for practitioners. Like any tool therefore, they should be regularly maintained if they are to fulfil their function. Audit your records regularly to avoid duplication and use summaries, case histories, chronologies or other analytical tools, such as movement charts, to assist in identifying the key issues and maintain a clear direction in the case. • Cross reference rather than duplicate.

5. There is no assessment on file • Information is gathered but not evaluated • There is no plan of intervention • There is no systematic framework for assessment	• Ensure that each child has an up to date assessment on file. That the assessment has been shared with the family and is easily located in the file. • Ensure that Closing and Transfer Summaries include evaluations of progress made and the conclusions of family members and practitioners about the effectiveness of interventions. • Use the assessment findings and subsequent plan to focus your recording

6. The record is not written for sharing • Access to files is regarded with suspicion	• Use plain language not jargon • Provide families with a copy of your agency's access to records policy and explain it to them • Share early drafts of assessments, plans and reports with the family to enable you to incorporate the

• Parents and young people are not involved in recording	family's views in the final document. • Provide the family with copies of the final assessment, plan or report • Share your recording as you go along • Encourage the family to contribute to the record

7. The record is not used as a tool for analysis • Record is written to impress other professionals • Record is narrative, not focused • Record is not referred back to	• Do not record simply **what** is happening, use analysis to move beyond this to hypothesise and explain **why** particular situations and events are occurring. • Use genograms, ecomaps, chronologies and assessment records to help you to organise and to analyse information. • Use case summaries as a way of reviewing progress and evaluating the effectiveness of interventions. • Use training, journals and articles to keep up to date with developments in research to inform your practice.

8. The record is disrespectful to the service user • Failure to distinguish between fact and opinion • Simple errors in spelling, date of	• When you record ask yourself, 'What would I think if I was the service user and read that?' • Ensure that there is a record in the main file which lists where all other parts of the case record are kept. • Check out basic details, such as dates of birth and the spelling of names, with parents and the young person at an early stage. • Use the Audit Sheet to review your files

birth… • Poor presentation or loss of records	

It's just a word

We have different understandings of the words that people use and we make assumptions that other people will understand what we mean. Our understanding of key phrases (such as serious, significant, reasonable) or other descriptors used in referrals and assessments are enormously important. In the text box below there is an example how important it can be to be thoughtful about the language we use when communicating with colleagues through our recording.

> In the case of Victoria Climbie Consultant Dr R felt Victoria was being abused but she confused colleagues by writing "able to discharge" on her notes.
>
> Victoria was again sent home to her abusers.
>
> Dr R told the inquiry: "I have thought about Victoria on a daily basis... and I feel very distressed that I did not keep up to my own standards."
>
> http://news.bbc.co.uk/1/hi/uk/2700427.stm

We also need to be aware that the families we work with might well not know what we are referring to and so we need to be careful there about the language we are using. Just as an example here are some of the results from a survey carried out amongst service users which indicate how the meaning of words can be misinterpreted.

Commonly used words	**What service users thought…**
Voluntary Agencies	People with no experience, volunteers
Maintain	Mixed up with maintenance – money paid for children in divorce settlements
Sensitive	Tender & sore
Encompass	A way of finding direction
Agencies	Second-hand clothes shops
Common	Cheap and nasty – don't talk about common values
Eligibility	A good marriage catch!
Allocation process	Being offered re-housing
Function	Wedding (party), funeral
Format	What you wipe your feet on!
Gender	Most did not know this word
Criteria	Most did not know this word

Equitable manner	Most did not know this term
Networks	No one knew this word
Advocacy	Some users thought this word meant that if they did not agree with the assessment they would have to go to court. They wondered who would pay the bill

From a survey of 100 service users in '*Getting the message across'*

Good practice guide to recording

Agreed person-focused outcome

People benefit from records that promote communication and high quality care

Factor	Best practice
1. Access to care records	*People* are able to access their care records in a format that meets their needs
2. Single records	*People* have a single, lifelong, multi-professional and multi-agency (where appropriate) care record which supports integrated care
3. Practice and evidence	*People's* care records demonstrate that their care is evidence-based
4. Security	*People's* care records are safeguarded

Figure 1 Best Practice Guidance from SCIE Essence of Care 2010 Benchmarks for Record Keeping

10 good practice tips for recording

1. Know **why** and **where** you are going to record it.
2. Distinguish **fact** from opinions
3. Be accurate, **relevant** and concise while still providing a complete record.
4. Be clear **what** you are going to write.
5. If recording manually, write legibly in ink. Do not use correction fluid. If you cross something out make sure that it can still be read.
6. Use plain and **respectful** language.

7. **Sign** and **date** each piece of recorded information, including messages.

8. Be aware of **confidentiality** and understand the law on access to information and data protection.

9. Indicate **who** or **where** the information has come from.

10. Show your working out!

Developed from Walker, Shemmings & Cleaver (2003) *Write Enough*, www.writeenough.org.uk

Data Protection Act and Access to Records

Here are a few details about the Data Protection Act

- Came into force 1st March 2000
- Repeals
    - DPA 1984
    - Access to Personal Files Act 1987
    - Access to Health Records Act 1990 (most)
- Single regime of access for social work records.
- Applies to all personal data, no matter how compiled
- Retrospective – which means that it applies to information about people which was in place before the Act came into force.
- Based on 8 Data Protection Principles

Data Protection Act Principle	What this Means	Alternative Guide to the DPA[2]
1. Processed fairly and lawfully	Ensure records are fair, specific and lawful. Participants must therefore be clear about the legal mandate of their work. In Social Care the main legal backdrop is the Children Act 1989 – section 17 referring to children in need, section 47 in relation to children at risk of significant harm, sections 20 and 31 relating to children	Be honest. You must gain permission to use any collected data and let the individuals know exactly what it will be used for.
2. Obtained only for specified and lawful purposes		Don't be cheeky. Only use the data that you have collected for the reasons you promised.

[2] https://www.clouddirect.net/insights/business/data-protection-act-summary/

	accommodated and in care. The regulations and guidance set out specific information that must be collected, for example the Essential Information Record, Care Plan, running records and so on.	
3. Adequate, relevant and not excessive	It is actually unlawful to record enormous or minimal records. What is adequate, relevant and not excessive is dependent on specific cases.	Don't be greedy. Collect only data that you need to know and not additional data that may be useful to you in the future
4. Accurate and kept up to date		Make sure your data is true. If any suspicion exists that the information is inaccurate – check with the individual.
5. Held no longer than necessary	This will depend on this who the information relates to and the type of information but in some cases this can mean information being held up until the age of 75, for example for Looked After Children and Child Protection or for a period of 3 years in the case of Family Support. The timescales are necessarily long as often people want to return to their records years later for a variety of reasons, whether tracking family trees or later reporting on mistreatment suffered. The adults reporting abuse by priests in the American Catholic Church were usually aged over 40 years.	Don't hoard. Only keep hold of old files if really needed or if you are required to by law
6. Processed in accordance with the rights of data subjects	Processing information includes how information is obtained, organised, used or transmitted. Obtaining information again relates back to the legal mandate social care workers have: if they cannot justify why they are asking for information, then they shouldn't be asking.	Give the individual access. It is their data you're holding, they should have a say in how it is used

	This principle also relates to the transmission of information. With email becoming increasingly convenient it is important practitioners are aware that this is not a secure form of communication, and would not meet these standards. Internal email systems are more usually secure, but participants should make themselves aware of their agency's IT and Data Protection policies.	
7. Adequately secured to protect it from unauthorised use or from damage/destruction	The 7th principle refers to adequately securing records. How secure are the records about your clients? Are they all locked away each night? Do you have a clear desk policy? Are records taken home?	Don't be careless. You must ensure that measures exist to keep the personal data you are responsible for out of the wrong hands
8. Retained within the European Economic Area, unless adequate security protection can be assured by recipient	Finally, the 8th principle is less relevant to social care workers, except around inter-country adoption where specific precautions and agreements should be in place before data is shared.	Keep your customers informed. Don't store their data in grey areas without their specific consent.