Northumberland County Council

Northumbria Healthcare NHS
NHS Foundation Trust

Care Management Case File Recording Standards and Audit Process

- These standards relate to written and electronic recording of case files for adult care management users (including Social Work, OT, LD Nurses, Mental Health Teams, CPNs etc).
- They have been taken from and adapted from the Trust's Health and Social Care Documentation Policy [1], the Care Quality Commission's Essential Standards[2], guidance produced by the Nursing and Midwifery (N&M) Council[3] , and from the 'Recording with Care' document produced by the former Commission for Social Care Inspection (CSCI).[4]
- The principles of good record keeping apply to all kinds of record including case files, electronic recording on SWIFT, emails, letters, incident reports etc.
- These standards will be audited on a regular basis via supervision and via centrally selected random sampling of case files. A copy of this guidance should be kept in each supervision file and all new members of staff should be given a copy of the standards.

1) 'Health and Social Care Documentation Policy', Northumbria Healthcare NHS Foundation Trust, 2012
2) 'Essential Standards of Quality and Safety', CQC, 2010
3) 'Record Keeping: Guidance for Nurses and Midwives', NMC, 2010
4) 'Recording with Care', Social Services Inspectorate (SSI), 1999

Version 4 – Updated September 2012* further updates may be made and circulated to staff

Contents

1. Importance of Good Quality Case File Recording

Good case recording is an important part of the accountability of staff working in social care to those who use the services. It helps to:

- focus the work of staff and supports effective partnerships with service users and carers;
- support service user care and communications;
- show how decisions related to care and support were made;
- makes continuity of care easier;
- improves accountability;
- ensure there is a documented account of involvement with individual service users, families and carers;
- supports audit, research, allocation of resources and performance planning; and
- becomes a major source of evidence for complaints, investigations and enquiries.

You need to assume that any entries to the client case record will be scrutinized at some point. Clients have a legal right to see their records. The approach to record keeping that law courts tend to adopt is "**if it is not recorded, it has not been done**".

2. Standards Relating to Written Recording Only

2.1 Recording Style

Ref	Standard
1.	A service user identifier must appear on each document in the case file (for example, this may be the SWIFT ID number or their NHS number)
2.	All entries in the record must be legible and written in black ink
3.	Each handwritten entry must be signed and dated
4.	Any alteration to the record must be made by a single line through the entry and should be initialled and marked “error” with the date and time of correction
5.	Sheets should never be removed or replaced and correction fluid must not be used to cover an incorrect entry
6.	Lines must not be skipped and any blank spaces must have a line through them
7.	All entries must be made in the appropriate space on the record and extra words must not be squeezed onto a line

2.2 Structure

Ref	Standard
1.	The file should be structured as follows: • A Paper File Checklist • Front of file should include a sticker including the client name, address and SWIFT number • Inside front cover should include an alert label (if necessary) to indicate where an individual or a family member has the potential for violence or abuse towards staff – which corresponds with any hazard labels listed on SWIFT • Initial Information and Assessment • Contact Record • Care Planning and Review • Correspondence • Legal, Registration and Audit • Restricted Information

3. Standards Relating to Written and Electronic Recording

3.1 Basic Information

Ref	Standard
1.	Records should include a current print out of the SWIFT front sheet containing: • The client's full name • The client's preferred name • Address • Post code • Telephone number • Date of birth • Gender • Ethnicity • Religion • Language (they feel most able to communicate in – on SWIFT this will default to English unless changed) • Disability • General Practitioner • Person to notify in the event of an emergency (next of kin) • Identification of main carer/carers • Key Worker

3.2 Recording Style

Ref	Standard
1.	Records must reflect that the practitioner acted reasonably to: • Assess and identify the client's needs • Plan the expected outcome and the interventions or actions required to achieve this • Put the plan into practice • Evaluate the actual outcome with the expected outcome making changes to the care plan and reassessing as necessary
2.	All Contact Notes of 'face to face' contacts should include: • Date of contact • Time of contact (the time of face to face contact with the service user/carer etc. should be recorded in the 'Start' and 'End' fields on SWIFT. The times should only reflect the actual time spent with the client/carer etc. and not travelling or other time) • Location of contact • List of people present during contact • Purpose of contact • Outcome and actions of contact (including any problems identified, disagreements and resolutions, referrals and reasons for referral, and any other decisions made and the reasons why) These should be listed as separate and distinct headings.

Ref	Standard
3.	Records should not include abbreviations (unless explained on first use), jargon, meaningless phrases, irrelevant speculation or offensive subjective statements
4.	Records should be written in terms that the patient/client or their representative can easily understand
5.	All entries must be in a chronological order (within whichever section they are filed)
6.	Records distinguish between facts and opinions. Where it is an opinion, the basis and rationale for the opinion should be documented on the case file
7.	There should be no inconsistencies between the paper file and SWIFT
8.	A base record must always be maintained where patients / clients hold records
9.	Entries to SWIFT must only be made under the individual's own log-in. Passwords must not be shared with other users (it is important to inform IT at the earliest opportunity if new members of staff, or students are going to be working in the team so that their access to SWIFT and log-in details can be set up)

3.3 Interventions

Ref	Standard
1.	The assessment should consider details of the individual's past and current level of functioning both physically, psychologically, socially and spiritually
2.	Written consent from the patient / client to share information should be evident in the file on a CP2 and there should be a corresponding contact note on SWIFT
3.	The views of service users and carers must be evident on case files and related to the sequence of decisions taken and arrangements made
4.	Files must contain details of when service users and carers have seen and been offered and/or given copies of papers
5.	Case recording should identify any special needs arising from ethnicity, race, culture, gender, age, religion or belief, language, communication, sensory impairment, disability, sexual orientation, gender reassignment, pregnancy or maternity
6.	There is a record of service user agreement to proposed actions or of a best interests assessment
7.	There is evidence that if a carer is involved, they have been offered a separate carers assessment and their response to this offer is noted

Ref	Standard
8.	There is a note that an Information Pack has been given to the service user
9.	For cases being transferred to another worker, there is a full transfer summary
10.	For closed cases, there is a full closing summary
11.	The needs assessment must be at an appropriate level and explicitly based on the fair access to care standards
12.	All files should contain a risk assessment. If no risks are identified, it should state so
13.	If a service user has asked to see a piece of information and has been refused access, the reasons for this should be clearly documented
14.	It is clear how service user outcomes are to be achieved
15.	The SWIFT record must include all financial information about the costs of the care plan
16.	Costs to the service user or the Council should be promptly recorded on SWIFT
17.	The file should record that the service user has been informed about any charges of the services to be provided

Ref	Standard
18.	The file should record that personal budgets / direct payments have been considered
19.	If any decisions have been taken on someone's behalf, there should be a formal best interests assessment on an MC1 or equivalent format
20.	If a service user or carer disagrees with an assessment this should be clearly recorded in the current assessment summary on the CP1 and the reasons why their objections have been overruled should be clearly stated
21.	It should be clearly recorded if something that was once considered as a need is now considered not to be. The reasons for this change of opinion should be clearly documented and show that this has been communicated to the service user

3.4 Timing & Responsibility

Ref	Standard
1.	Records should be made contemporaneously. Case notes should be made as soon as practicably possible, and be no later than 5 working days after a contact has occurred

Ref	Standard
2.	Case notes in Adult Protection cases or cases where a clinical risk has been identified (e.g. thoughts of suicide) should be recorded within 2 working days after a contact has occurred
3.	The date of allocation should be correct
4.	There should be an allocated key worker on SWIFT
5.	Date of next review must entered on SWIFT