Administrative Systems Recording Policy, Standards, and Criteria

Regional Policy for Northern Ireland Health and Social Care Trusts

September 2010

Revised version as 14 September 2010

ACKNOWLEDGEMENTS

The Administrative Systems Recording Policy, Standards and Criteria issued in 2008 was written by NSPCC Consultants Richard Green and Jenny Myers in consultation with Martin McGrath and Mary Logan on behalf of the Reform Implementation Team (R.I.T.). It was issued as a follow up to the Child Protection Inspection published by the Social Services Inspectorate in January 2007.

This revised Policy has been written by the Change Co-ordinators in each of the Trusts on behalf of the Reform Implementation Team (R.I.T.):

Edel McKenna, Belfast Trust

Maura Dargan, Northern Trust

Francesca Leyden, Southern Trust

Linda McConnell, South Eastern Trust

John Gillespie, Western Trust

It has been developed and agreed by the Health and Social Care Trusts in Northern Ireland.

FOREWORD

In February 2008, The Department issued to Trusts the 'Administrative Systems Recording Policy, Standards, and Criteria; Regional Policy for Northern Ireland Health and Social Care Trusts' which was to be gradually implemented across the region.

The implementation of the February 2008 Policy posed challenges to all five Trusts particularly in light of the ongoing development of Gateway; the UNOCINI assessment framework and the IT infrastructure to support UNOCINI.

This led to an interim review and the development of this revised Policy. This Policy sets out to address the more critical implementation difficulties experienced by Trusts whilst retaining the high quality standards outlined in the original Policy.

This version provides additional benefits by providing one set of agreed recording documents (REC 1-9) which are to be consistently applied throughout the region.

It is expected that these recording templates **Appendix 2** will replace all existing recording templates used in each of the five Trusts.

This interim Policy reflects the required management of records at a particular point in time. It is acknowledged that this is a changing environment and the HSC Trusts will gradually move from a paper based administrative system to an electronically based system as a result of IT developments.

This Policy will be reviewed to reflect these changes once this system is available and implemented within Trusts.

CONTENTS

1. INTRODUCTION

This policy sets the framework and minimum standards for Health and Social Care Trusts to implement an effective and consistent approach to administration systems with particular reference to recording. The legislative framework informing this policy is outlined at **Appendix 1**.

This Policy applies specifically to children's services staff within the five Health and Social Care Trusts within 'community based, fieldwork' type settings e.g. Looked After Children Teams; Family Support Teams; Gateway; Children's Disability Teams; 16+ Transitions Teams etc.

It relates solely to the child/family file held within these teams and does not meet the needs of those teams whose focus is the assessment and support of carers for example Family Placement Teams.

This Policy could however be developed to meet the needs within other areas of children's services e.g. Family Centres; Residential Facilities etc. In addition, the principles and standards within it may be equally applicable to staff who fall outside of these parameters (e.g. specialist teams, health, mental health, adult care etc) but who come into contact with children.

There are a number of elements to this document: a recording policy based on best practice; a set of standards to ensure high quality administrative systems and a suite of recording documents including exemplars which will replace all existing recording tools.

Quality recording is central to good practice within children's services and is an integral part of a social worker's responsibility. Good recording helps to focus the work undertaken with children and families and assists with continuity when workers are unavailable or change. It is an essential monitoring tool for managers and provides evidence for investigations and enquiries. Clear and accurate records are vital in providing documented evidence of social work involvement with children and their families. Recording enables service users to hold the service to account in terms of the work being undertaken with them.

Recording is used effectively by social workers and managers to:

- Plan work with service users
- Aid assessment and decision making processes
- Monitor staff's involvement with service users
- Monitor and review progress of set objectives and goals
- Monitor and review plans for children
- Provide an accurate account to a child as to the decisions made in relation to them and why

2. AIMS

The aims of this policy are to:

- Define a framework for consistent, coherent and compatible record management
- Provide a single format for case records
- Provide guidance on their use including the provision of exemplars
- Promote a common approach to the keeping of records which enables effective information retrieval
- Outline minimum recording standards which will provide a baseline to enable the auditing of recording practice

3. SCOPE

This is a mandatory policy; which incorporates the following significant key Legislative documents:

- Public Records Act [Northern Ireland] 1923
- Freedom of Information Act 2000
- Data Protection Act 1998

It applies to all children's services and administrative staff within the five Health and Social Care Trusts within 'community based, fieldwork' type settings e.g. Looked After Children Teams; Family Support Teams; Gateway; Children's Disability Teams; 16+ Transitions Teams etc. and includes:

- All social work staff (including social workers, family support workers and other multi-disciplinary members of child care teams) who work directly with children and families
- Administrative staff whose responsibilities include the filing of records as well as the storage and retrieval of case files
- Senior practitioners/ team managers whose responsibilities include ensuring adherence to the policy and standards
- Senior managers who are responsible for monitoring and auditing practice

4. CONTEXT

This policy has been informed by a range of reports such as:

- Good Management; Good Records (DHSSPS, 2002)
- Inspection of Child Protection Services in Northern Ireland – Overview Report (SSI, 2006)
- Internal Trust audits and case management reviews
- Southern Health and Social Services Board draft recording policy Write Enough (DH, 2003)

The Inspection Overview Report (SSI, 2006) stated that records should:

- Contain a range of significant information required for effective planning
- Identify the relevance and source of information
- Have a clear plan for each child which:
    - ✓ Addresses the child's developmental needs, parental capacity to meet needs and the impact of family and environmental factors
    - ✓ Specifies the service to be provided and the rationale
    - ✓ Specifies desired outcomes and how progress towards these is to be monitored
    - ✓ Contain summaries, histories, chronologies and clear analyses of interventions
    - ✓ Be an important measure of accountability and effectiveness

A number of themes were identified in the *Inspection Overview Report* (SSI, 2006) which was critical of:

- A lack of accurate family information sheets or summaries of key developments (a particular problem with files containing a lot of information)
- Too much detail - where succinct summaries would have been better
- The absence of professional judgement – a possible reflection of a misplaced concern regarding user access to records
- A lack of direction by managers as to the actions and outcomes required in assessments
- Little evidence of the monitoring of case records
- A lack of supervision records on file

The *Inspection Overview Report* (SSI, 2006) was also critical of assessment practice. This is relevant to recording policy and standards as recording is the principal means for practitioners to demonstrate the quality of their assessment.

5. PRINCIPLES

Good Management/Good Records (DHSSPS, 2002) indicates that records are created, received and used in the conduct of business activities. All Health & Social Care Trusts must ensure they have a comprehensive record management programme which includes issues such as:

- Determining what records should be created in each business process, and what information needs to be included in the records
- Determining requirements for retrieving, using and transmitting records between business processes and other users and how long they need to be kept to satisfy legal and regulatory requirements
- Deciding how to organise records so as to support requirements for use [Refer to Section 8 - File Format and Contents]

These are the **principles** underpinning recording practice:

- The explicit outcomes for children are integrated into plans and progress against these is monitored
- The records are child-centred
- Key information is made readily available via e.g. chronologies, summaries, genograms
- The UNOCINI Assessment Framework is used appropriately; using all 12 domains to conduct initial & pathway assessments (domain specific for some family support cases)
- *The Freedom of Information Act* does not prevent practitioners from recording their judgements, provided these are distinguished from fact
- Assessments are multi-agency i.e. the contributions of disciplines other than social work are considered, accessed and integrated into plans
- Fact, opinion, judgement and hypotheses are clearly distinguished
- Records are duly respectful of service users
- There is a presumption that records will be shared in an appropriate manner with service users (unless there are clearly stated reasons to the contrary)
- There is also the presumption that they will be read (and readily understood) by colleagues e.g. a practitioner needing to grasp key information at short notice in the practitioner's absence, a manager wishing to audit the quality of practice
- All records are typed or written using black ink
- Staff are trained and supported to record according to this policy and standards
- Supervision records relating to case discussions are placed on case files
- All Trusts will seek to utilise technology to support the administrative task

6. GENERAL RECORDING REQUIREMENTS

Taking the principles of recording practices into account, staff should:

- Write records contemporaneously
- Use clear, straight forward language
- Avoid abbreviations and jargon
- Be concise. As a general rule succinct analytical summaries and the use of bullet points are preferable to extended narratives. However there will be occasions e.g. child protection investigation interviews when the recording of detail is crucial
- Be accurate
- Differentiate between fact and professional opinion
- Clearly identify decisions taken and the rationale
- Type all records as a preference but where this is not possible, The Family and Professional Information Record (REC 1) and The Significant Event Record (REC 4) must be typed as the minimum standard
- Be legible (if hand-writing is illegible; records will need to be typed)

- Sign them using a full identifiable signature, not initials, and dated by worker and manager (if required) and identify the designation of the signatory. For typed records it is acceptable for the full name to be typed and a signature is not required.
- Evidence a link between fact, analysis and planning

Case records should be regularly monitored by managers. Staff should be supported and guided by their managers to record as per the requirements detailed above. Social Work Managers need to evidence they have read and monitored the child's file by signing the records and utilizing the regionally agreed auditing tool

7. RECORDING DOCUMENTS (REC)

7.1 List of recording documents

A total of nine recording documents **Appendix 2** have been developed and are as follows:
REC 1 – Family and professional information record
REC 2 – Chronology of significant events record
REC 3 (I) (II) (III) – Contact record
REC 4 – Significant event record
REC 5 – LAC statutory visit record
REC 6 – Child protection visit record
REC 7 – Closure/transfer record
REC 8 – Transfer process record
REC 9 - Case supervision record

7.2 Recording documents - formatting

The recording documents provided at **Appendix 2** can be saved to your computer and typed on. The documents have been formatted in such a way that as you type, the boxes will continue to lengthen as and when you need it to. The lines themselves can be moved up (or down) so as to avoid lots of blank spaces when it comes to printing the completed recording. Your administrative support should be able to show you how this can be done if you are in difficulty.

For those who will be hand writing on the recording documents it has been suggested to make available a range of documents to cater for short or long recording. Therefore, blank copies of Contact Record (REC 3) should be made available to record one contact per page; 2 per page or 3 per page; depending on the length o f your recording (See Appendix 2 - REC 3(I), REC 3(II) and REC 3(III).

A number of the recording tools require a signature by the author or the author and their line manager. It is however recognised that in some Trusts as a result of for example, electronic transfers that signatures will not always be possible e.g. REC 8.

7.3 Family and professional information record – REC 1

Every file should have a fronting sheet which is updated immediately as information changes. The fronting sheet should be the first document on a file and immediately visible on opening the cover.

A new fronting sheet should be completed for each continuation file.

The only exception to this is client information stored by Gateway. As the period of involvement within Gateway is brief the completed UNOCINI Initial Assessment is accepted as providing the necessary requirements of REC 1 in a stand-alone document and there is no expectation for this information to be repeated on REC 1.

Individual files will exist for Children 'Looked After' or for those whose names are placed on the child protection register but 'family' files will exist for family support type cases. Therefore for Family Support files the 'client' details should refer to the eldest child subject to the family support service.

Other children of the family in receipt of the family support service should be noted under 'others in household' and an astrix* should be used to identify the client and denote them from others in the household not subject to social work services.

It is essential that key information i.e. addresses, contact telephone numbers are kept up to date. The fronting sheet is also used to record known risk factors, e.g. violence or potential for violence towards staff, risk of self harm etc.

Both the SOSCARE number and the Health and Care Number (HCN) need to be recorded on REC 1 and all the recording documents.

Appendix 3 provides an exemplar of each of the REC documents including REC 1.

7.4 Chronology of Significant Events Record – REC 2

The chronology of significant events provides a brief reference to key events and refers the reader to the relevant file section if further details are required.

The purpose of completing a chronology of significant events is to help social workers and managers identify patterns of vulnerability and risk in families with children. If a pattern is observed, the future planning of services to the child/family may have to be revised or amended to meet identified needs.

The UNOCINI Guidance refers to a **significant event** as *"one in which the outcome of an action/inaction or incident has, or may have a major impact on the future health and well-being of*

the child/family. A significant event may also impact on the family support, child protection plan or looked after care plan."

The chronology of significant events document REC 2 should be completed whenever a significant event occurs but does not replace the need to record the detail of this information elsewhere.

REC 2 should be placed at the front of the file.

All significant events recorded using REC 4 must be included in the chronology (REC 2) at the front of the file although not all events recorded using REC 2 will automatically have a REC 4 completed e.g. a decision to place a child's name on the child protection register will not require the completion of REC 4 but REC 2 will instead refer the reader to the case conference report and minutes for further details.

All significant events should be briefly referenced within the chronology of significant events REC 2 and summarised in the Pathway Assessment for the family support meeting, case conference or looked after child review.

The UNOCINI Guidance states, *"Under no circumstances should a significant event be left without appropriate action until a review meeting. All significant events must always be reported to a designated manager to consider investigation."*

UNOCINI Guidance offers examples of significant events as follows:

- Death of significant relationship figure (e.g. parent, carer, sibling)
- Change of school (including exclusion of over a week)
- Change of carer and/or placement change (including one parent leaving a household)
- Change of another child in placement (arrives or leaves)
- Change in birth family (e.g. another child born or removed, teenage pregnancy, miscarriage or termination)
- Change in any agreed contact arrangements
- Change of social worker
- Contact with someone who has been convicted of sexual offences
- Court proceedings
- Major conflict with (birth) family or peer group
- House move
- Physical illness or injury requiring hospital treatment
- Victim or perpetrator of crime with or without police involvement
- Significant person enters or released from prison
- Thoughts and/or actions of self harm
- Involved in an investigation or complaint

Other examples may include:

- Interviews associated with the reporting of non accidental injuries
- Disclosures of abuse (domestic/physical/sexual/emotional) by young person or parent
- Threat made by a parent or young person towards a social worker or other professional
- Referrals to LAPPS / MARAC
- Care Proceedings information
- Case Conference decisions
- Admission/discharge to/from care with note of current address
- Absconding incidents
- Outcome of criminal proceedings in respect of young person and or the parent

This does not constitute an inclusive or exhaustive list. Whilst defining an event as 'significant' is subjective, the debate and discussion within supervision and at team level will negate differences in approach and will greatly enhance consistent practice.

It is important for managers to monitor the use of REC 2 (chronology of significant events record), REC 3 (Contact record) and REC 4 (Significant event record) to ensure the appropriate use of these by the staff they manage.

It is important to note that, reviewing the chronologies held in a file does not negate the need for a social worker new to a family to read all of the records held in respect of the child/family in order to gain a full history of social work involvement.

In completing the Chronology of significant events record REC 2, social workers must ensure to complete all sections:

- The Client Name, SOSCARE and The Health & Care Number (HCN) is self explanatory
- The Date of Significant Event is also self explanatory and should refer to the date the event occurred not the date the event was reported to social worker or another professional
- The Nature of Event/Interview is a brief description using minimal words to summarise the event or interview e.g. Incident of domestic violence by Mr x– Mrs x and children move to Hostel accommodation
- Identify where detailed recording of significant event can be located This section should direct the reader to the location of the more detailed account of the incident as recorded in file e.g. Case Conference Report dated 01/01/2010 within x section of file number 2
- Signature and Date The worker should sign and date the record to verify when the event was recorded

7.5 Contact Record and Significant Event Record – REC 3 and 4

The contact record and significant event record are similar. Section 7.4 above should assist staff in deciding which recording document to use to record a particular discussion or event.

Contact records should be utilised to record all contacts made about or with a family that are made on a daily basis that are not significant and therefore not appropriate to record on a REC 4 (significant event).

Contact records can be used to record assessment type interviews if these are not already being captured on the REC 5 and REC 6 i.e. during the course of the social workers visit to a looked after child or a child whose name is placed on the child protection register.

Contact and significant event recordings should reflect the facts as reported or witnessed.

The traditional process recording style is not required for the completion of contact records. A contact record should evidence succinct summaries of the purpose of a contact, the issues discussed and action required or taken.

Staff need to avoid recording unnecessarily and need to be supported by their managers to produce brief and concise recording. The use of bullet points should assist staff to record succinctly.

Both the contact record and significant event record require 3 dates to be recorded:

- The date and time reported – this refers to the date and time the incident or information was made available to the author
- The date of contact/significant event refers to the date the contact/significant event actually occurred and not the date reported
- Signed and Date refers to the date the recording was completed by the author.

For example, if a health visitor phones the social worker on 3rd January 2010 to advise of an incident which occurred on 1st of January 2010 and the social worker records this information on the 5th January 2010 then the date and time reported would be the 3rd January, the date of event would be 1st January and the signature and date would be 5th January.

As events or interviews recorded using REC 4 are considered to be **significant** social workers may need an opportunity to provide a full description of the event/incident including some narrative.

Again because of the significance of an event or interview recorded using REC 4, social workers must provide an analysis of it taking account of the detail of the event/interview itself within the context of what is already known about the child and/or family.

The ongoing analysis of significant events and interviews during the course of social work involvement with a family will assist in the completion of Pathway Assessments and the development of appropriates plans to meet the needs of children and their families.To assist staff, exemplars of a contact record and a significant event record are provided at **Appendix 3.**

7.6 LAC Statutory Visit Record – REC 5

This recording document is only ever to be used to record the social work statutory visit to a looked after child. It is **not** the document used to record all contacts made about or with a looked after child as they will have their information recorded on a range of documents; contact record (REC 3), significant events record (REC 4) as well as REC 5.

This recording document is to be used to capture the social work visit to the child within their placement.

REC 5 is designed to record the requirements of a statutory visit so that once a social worker completes the recording, their manager will be able to easily confirm if the statutory requirements have been met or not.

Within REC 5 there is also an opportunity for the manager to record their comments and to state if the visit recorded meets the statutory requirements.

As with the analytical requirements of significant events, analysis is a key feature of the LAC statutory visit record (REC 5). It is expected that this ongoing analysis during the course of social work involvement with the child, their family and their carers will assist in the completion of the child's LAC Pathway Assessment and the development of an appropriate care plan to meet their needs.

In the instances that a child's name is on the child protection register and at the same time is in the care of the Trust – social workers must ensure that the legal statutory requirements to visit and record a visit to a looked after child are met using REC 5 and all other visits could be recorded on REC 6 (what REC document to use in a particular case should be individually agreed between the social worker and their line manager)

Should a significant event occur during the course of the LAC Statutory Visit, REC 5 should be used to record the event but reference to it must be included in REC 2 (Chronology of significant events record).

An exemplar of REC 5 can be found at **Appendix 3.**

7.7 Child Protection Visit Record – REC 6

This recording document is to be used to record the social workers visit to a child whose name is placed on the child protection register

Similar to REC 5, the child protection visit record (REC 6) is designed to evidence that the child is seen and spoken to alone.

The emphasis on the assessment of progress as it relates to the child protection plan will assist Social Workers to focus on assessment and analysis and to consider actions which need to be taken following the visit. It is expected this ongoing analysis of the progress made in relation to the child protection plan will assist in the completion of the child's Child Protection Pathway Assessment and the development of an appropriate child protection plan to meet their needs.

In the instances that a child's name is on the child protection register and at the same time is in the care of the Trust – social workers must ensure that the legal statutory requirements to visit and record a visit to a looked after child are met using REC 5 and all other visits **could** be recorded on REC 6 (which REC documents to use in a particular case should be individually agreed by the social worker and their line manager)

Should a significant event occur during the course of the child protection visit, REC 6 should be used to record the event but reference to it must be included in REC 2 (Chronology of significant events record).

An exemplar of REC 6 can be found at **Appendix 3**.

7.8 Closure/Transfer Record – REC 7

Any case which is to close or to transfer between workers and/or teams a closure/transfer record must be completed by the social worker and signed by their manager.

The only exception to this is in the case of closures made by Gateway or transfers from The Gateway service to receiving teams. As the period of involvement within Gateway is brief the completed UNOCINI Initial Assessment is accepted as the closure/transfer record and there is no expectation for this information to be repeated on REC 7.

The majority of the sections detailed are self-explanatory but care should be taken at the end of the document to record that the child/family has been informed of the closure/transfer; their views on this decision and to record the identity of those issued with closure/transfer letters.

If REC 7 is being used to record the closure of a case, there is also a requirement for the Team Manager to enter the date the file is due for destruction. The Disposal Schedule outlined in Good Management; Good Records sets out the minimum retention periods for HPSS records.

For children/family files held within children's services community teams there are different timescales permitted for different types of cases and the following is a summary of these:

- "One-off records" (subject to risk assessment) e.g. straightforward requests for advice, financial assistance, benefit enquiries, housing enquiries, inappropriate referrals - Three Years after closure of the case

- Family Support including records relating to public and private law records (**Excluding** Looked after Children) e.g. Article 4/Article 56 reports to court – Twenty years after the closure of the case

- Child Protection case files from initial referral through to closure – Seventy five years after case closure or fifteen years following the child's death

- Looked after Children - Seventy five years following the date of birth or if deceased before 18 years of age then retain for fifteen years following the child's death

- Adoption – Indefinitely

An exemplar of REC 7 can be found at **Appendix 3**.

7.9 Transfer Process Record – REC 8

This document is used to record and thereby evidence the **process** of transfer between teams, a gap noted by RQIA during their recent inspection.

The transfer initiated by the transferring team should be signed and dated by them noting the status of the case at the point of transfer i.e. Family Support, Child Protection, 'Looked After Children' or 16+ Transition.

The receiving team then needs to complete the record, indicating the date the transfer was received and the series of decisions, dates and reasons made by the receiving team, up to and including the date of allocation.

This does not replace the Closure/transfer record, REC 7 as the two documents fulfill two distinctly different purposes. REC 7 provides the summary and professional analysis required at the point of transfer, REC 8 outlines the process of transfer up to and including allocation.

Any case transferring between teams will therefore require a REC 7 and REC 8 to be completed. The exception to this is transfers from Gateway. As the UNOCINI Initial Assessment includes the requirements of REC 7, Gateway will only complete REC 8 at the point of transfer.

7.10 Case Supervision Record – REC 9

This document should be used to record any actions and decisions made about a child or family within formal supervision or during informal discussions or consultations.

It provides evidence of the decision making process and takes account of decisions made outside of review or planning meetings.

Used appropriately it should be easy for the reader to establish who made a decision and why.

It does not replace other methods of recording formal decisions such as minutes of Case Conferences, LAC Reviews or Family Support meetings.

For further information please refer to the Supervision Policy, Standards and Criteria: Regional Policy for Northern Ireland Health and Social Care Trusts; February 2008 **http://www.dhsspsni.gov.uk/supervision_policy_standards_and_criteria_regional_policy_for_northern_ireland_health_and_social_care_trusts.pdf**

8. FILE FORMAT AND CONTENTS

8.1 File format requirements

The basic requirements for the format of a file are as follows:

- All records in all sections should be filed in chronological reverse-book order
- When submitting a document for filing the social worker/ manager should indicate in which section it is to be filed
- The social worker should cross-reference accurately within the text e.g. a record such as '*I visited the family in response to a written referral from the school*' needs to be supplemented by a note specifying where this letter is to be found within the file
- All files should have the office name and timeframe applicable printed on the outside and contents section printed on the inside of the front cover
- Typed records are preferred however black ink is to be used where records are hand-written (as a minimum standard all REC 1 and REC 4's should be typed)
- Contact record to be punched on the right hand-side to facilitate reverse book filing
- Reports and minutes etc for a specific meeting should be filed together
- Looked after children and children subject to child protection will have individual files. Those in receipt of family support services will have one file opened per family. (Social Worker must ensure each child's needs is individually assessed and plans made as per UNOCINI guidance and evidenced within the family file)

8.2 Agreed File sections

For the majority of childcare teams the agreed sections are:

1. Family Information (REC 1 and the most recent UNOCINI assessment)
2. Chronology & Summary (REC 2; 7 & 8)

3. Referral and Initial Assessment (UNOCINI)
4. Recording (REC 3; 4; 5; 6 & 9)
5. Child Protection and Family Support (UNOCINI & CP& FS documents)
6. Looked After Child/ 16+ Transition (UNOCINI; LAC & 16+ Transition documents)
7. Finance
8. Legal
9. Correspondence
10. Restricted (3rd party information)

8.3 The content of Section 1 – Family Information

As well as REC 1 the most recent UNOCINI assessment should be available in this section at the front of the file as it represents the best available synopsis of the child and family's circumstances

8.4 The content of Section 2 – Chronology & Summary

The chronology of significant events record (REC 2) should be filed in section 2.
If social work involvement has ceased or transferred to a new worker or team the closure/transfer record (REC 7) should also be stored within section 2 and filed after the chronology of significant events.

If transfers have occurred, the process of transfer record (REC 8) should also be stored in section 2.

8.5 The content of Section 3 – Referral & Initial Assessment

Section 3 includes all referrals (UNOCINI) including those with a full preliminary assessment completed by the referrer. This section will also include the Initial Assessment completed by the social worker.

8.6 The content of Section 4 - Recording

Section 4 includes all contacts with or about a child recorded using contact records (REC 3); significant events records (REC 4); LAC statutory visit records (REC 5); Child Protection Visit Records (REC 6) and supervision records (REC 9)

8.7 The content of Section 5 – Child Protection & Family support

To include:

- UNOCINI Pathway Assessments
- UNOCINI review/planning documents

- Other professional assessments and reports e.g. end of year school report, Education Psychology assessment report; statement of educational needs
- Reports (Social work & other professionals) for meetings (Case Conference; Family support; Strategy; Core Group)
- Minutes of meetings (Case Conference, Family support; Strategy; Core Group)
- Joint Protocol for Investigation Forms (1 to 7)
- Requests for case conferences
- Applications to and minutes of Family Support Panels
- All parental / child contribution forms
- All child protection forms e.g. CPR 1
- Contracts with parents/ children/ others
- Child Protection Medicals
- Incident Reports

8.8 The content of Section 6 - Looked After Child/16+ Transition

To include:

- Essential Information 1 & 2
- Placement Plan 1 & 2
- UNOCINI pathway assessment and Care Plans
- Review of Arrangements and minutes
- All 16+ transitions documentation including Needs Assessment, Pathway Plans
- Statutory medicals
- Review contribution forms – parent, carer and child
- Other professional reports for reviews
- Application to and minutes of the Resource Panel
- All CLA forms
- Records & minutes of any other meetings
- Incident Reports

NB Looked After Child and 16 + transitions recording documents are currently being reviewed and streamlined with UNOCINI Assessment and Planning documents. The above list may therefore become outdated but ensure to file any revised LAC / 16+ Transition documents in section 6.

8.9 The content of Section 7 - Finance

All records relating to financial matters should be stored in section 7. This will include for example parental financial assessments; invoices; payment records; memos requesting financial resources and decisions reached.

8.10 The content of Section 8 - Legal

To include:

- Reports and plans for legal proceedings
- Court Orders
- Court directions
- Legal correspondence (not including privileged correspondence as this will be filed at section 10)
- Documents associated with the Guide to Case Management in Public Law Proceedings
- Copy of birth certificate
- Copy of adoption certificate
- Copy of Passport (Passport should be securely stored in the office safe)

8.11 The content of Section 9 - Correspondence

Section 9 should contain all correspondence, including complaints (other than to/from legal advisors) into and out of the office by letter, email, fax and memo. It should also include copies of all referrals to other agencies and services or teams within The Trust. This can also include photographs and letters to and from a parent for indirect contact.

Any emails, letters, memos or faxes should be placed on file within section 9 and cross-referenced to either a contact record (REC 3) or a significant record (REC 4) whichever is most appropriate.

8.12 The content of Section 10 - Restricted (3rd party information)

Section 10 contains all restricted information including privileged legal correspondence, records of legal consultations, serious adverse incident reports and any audit record, report or findings. Information transferred from Access NI forms or records of legal consultation. Any staff member who is unsure about what should be considered as restricted should discuss this with their line manager.

8.13 Gateway: Storing client information

Gateway is a recently developed service across all five Health and Social Care Trusts. It is the 'front door' to children's social work service and is the first point of contact for the public and professionals when they wish to share a concern about a child not already known to social services. Gateway completes Initial Assessments within a maximum period of 10 days and either closes or transfers within this timeframe. (Unless 'child protection' in which case transfer occurs at the Initial Case Conference).

As a result there is no expectation for Gateway to hold 'files' containing 'sections' as described above. In the majority of cases there is such little information to file it is viewed as an unnecessary administrative burden to comply with this requirement. Nor is there an expectation that Gateway will complete a family and professional information record (REC 1) or closure/transfer record (REC 7). The UNOCINI Initial Assessment is a snap-shot assessment which meets all the requirements of REC 1 and 7 in a readily accessible stand alone document.

Gateway is involved for such a short time it is unlikely to have information to store beyond the referral, initial assessment and transfer process record (REC 8). There may be however, 10 days worth of other recording documents e.g. case supervision records. Gateway will therefore not have 'files' including sections as is traditionally understood. It has been agreed however that when information is stored (paper version) it will be done so in the following order as it exists in a particular case:

1. Transfer Process Record (REC 8)
2. Chronology of Significant events record (REC2)
3. UNOCINI Referral
4. UNOCINI Initial Assessment
5. Recording – (REC 3, 4, 5, 6, 9)
6. Child Protection and Family Support
7. Looked After Child/ 16+ Transition
8. Finance
9. Legal
10. Correspondence
11. Restricted (3rd party information)

It is recognized that some Gateway offices are currently 'paper free' or 'paper light' as all client information is securely stored on a database. There is no requirement for these offices to print a paper version for storage purposes. It is understood that should a professional and/or client require a paper version, this can be printed upon request.

The above will become out-dated in the near future as the Information System developments with particular reference to Gateway will negate the need for any paper records of client information to be held. This Policy will be revised when the Information System to support UNOCINI is developed and implemented throughout all five Trusts.

9. ADMINISTRATION OF FILES – RESPONSIBILITIES

This section defines the specific responsibilities of all parties to ensure a consistent approach to opening and closing a file; transferring cases; maintaining the filing system and filing documents.

9.1 Opening Files

Once a decision by the Team Leader has been reached to create a file, administrative staff will:

- Open a child or family file – looked after children and children subject to child protection will have individual files. Those in receipt of family support services will have one file opened per family. (Social Worker must ensure each child's needs is individually assessed and plans made as per UNOCINI guidance and evidenced within the family file)
- Access any existing (Historical) files and ensure these are brought together with the new file for the social workers attention.
- Give the file a SOSCARE number and record the Health and Care Number (HCN)
- Insert the designated sections
- Note different surnames on SOSCARE and the files ensuring to cross-reference on SOSCARE and other files (including any other electronic system in use by a team/Trust)
- Note on the new file the number and location of any existing files
- Attach to the outside of the front cover the designated pro forma and complete sections marked with an asterisk*****:
    - Name*****
    - File Ref No*****
    - Date of first entry in file*****
    - Date of last entry in file:
    - Volume No.* _____
    - Retention period as defined in *Good Management Good Records* (DHSS&PS 2004).

9.2 Closing Files

Where a case has been identified for closure the Social Worker will:

- Complete a case closure/transfer form (REC 7); attach to the completed file and forward to the manager

The manager will:

- Make a decision to close a case and to sign this off
- Satisfy him/herself that all recording is complete and correctly filed prior to closure
- Complete relevant section on REC 7 including the file destruction date as per *Good Management; Good Records* (DHSS&PS 2004). (See 7.8 for further details regarding the disposal schedule for children/family files)
- Forward the file to administrative staff
- Ensure that SOSCARE is updated

The Administrative staff will:

- Complete the outside of the front cover the designated pro forma and complete sections marked with an asterisk*****:
    - Name
    - File Ref No
    - Date of first entry in file
    - Date of last entry in file:*
    - Volume No. _____
    - Retention period as defined in *Good Management Good Records* (DHSS&PS 2004)*. (See 7.8 for further details regarding the disposal schedule for children/family files)
- File in the appropriate closed records filing system

9.3 Transfer Cases

The arrangements and responsibilities in relation to transfers between Trusts for children subject to Child Protection are outlined in detail in Chapter 7 of the Regional Child Protection Policy & Procedures and must be fully complied with.

The information that is shared at an early stage in the notification/transferring process for **all** children (Child protection & Family Support) moving between Trusts (as a minimum) needs to be the most up to date UNOCINI Assessment (report to Case Conference or Family Support Meeting); Minutes of the most recent Case Conference or Family Support meeting; Child Protection or Family Support Plan and relevant family history details (if not readily available in UNOCINI Assessment). The reason for Social Work involvement including the reason for registration (if Child Protection) should also be provided to the receiving Trust within 5 working days.

The **final** step in the transfer process is the safe transfer (hand-delivered) of all the original social work files to the receiving Trust. **Copy files will not be made, transferred or held by either the receiving or originating Trust. The original file will move with the client.**

A record of the transfer will be made using REC 8. The transfer initiated by the originating Trust should be signed and dated noting the status of the case at the point of transfer e.g. Family Support and the number of files transferring.

The receiving Trust then needs to complete the record, indicating the date the transfer was received including the number of files received. As the files will be hand-delivered, the date of transfer and receipt of transfer recorded on REC 8 by both the originating Trust and the receiving Trust should be the same.

The original REC 8 will be held by the receiving Trust and a copy of REC 8 will be held by the originating Trust. REC 8 will serve to confirm the receiving Trusts receipt of files.

The originating trust will place a record on SOSCARE and any other electronic system that the files have transferred; providing details of the new location and the name of the manager in receipt of the files.

9.4 Maintaining the Filing System

- All paper-based files should be maintained in a secure lockable filing cabinet
- All electronic files should have appropriate security access levels
- When a file is removed from the cabinet a tracer must be completed to indicate who has taken it and its location (unless this is done via electronic bar codes)
- The tracer must be updated on the file's return (unless this is done via electronic bar codes)
- Filing cabinets should be routinely checked to ensure e.g. files are present; tracers completed and closed files removed
- There will be a need for regular monitoring of security access levels in relation to the range of files stored electronically
- When a file reaches an unmanageable thickness (but the case remains open) a continuation file should be opened and key documents should be transferred to it e.g. Court Orders, child's information (copy of birth certificates, passport etc.), chronology of significant events (REC 2), family and professional information record (REC 1). Social Workers, their managers and administrative support should together monitor the size of files and take action when required.

9.5 Filing Documents

The Social Worker will:

- Ensure all documents are signed (or typed full name) and dated prior to filing
- Ensure that all documents can be readily identified by administrative staff i.e. name SOSCARE and Health & Care Number
- Forward documents promptly to administrative staff
- Ensure duplicate copies are not filed within the one file – but rather shredded

The Administrative Staff will:

- File information for LAC and Child Protection files within one working month and Family Support within six weeks of receipt
- File information in a particular file sooner than stated above at the request of the Social Work Manager
- File in chronological reverse book order

9.6 Quality Assurance/ Audit

It is important that a systematic and planned approach to the management of records is in place within all Trusts. This should ensure that from the moment a record is created until its ultimate disposal, the Trust can control both the quality and the quantity of information it generates; can maintain that information in a manner that effectively serves its needs and those of its stakeholders; and can dispose of the information appropriately when it is no longer required.

There are three different levels of quality assurance:

1. Social workers should self-audit their own recording.

2. First-line managers should audit and monitor the quality of recording undertaken by staff in the team. . The outcome of all audits should be discussed with the staff member during Supervision to:
   - ✓ Identify adherence to the recording standards
   - ✓ Identify strengths and weaknesses (and how the latter are to be remedied)
   - ✓ Identify the social worker's training/ development needs
   - ✓ Sign (or typed full name) and date the records

   First Line Managers also have responsibility to sign off records (or typed full name), assessments, and reports etc. completed by Social Workers.

3. Senior managers are also responsible for auditing. . Whereas self audits and first-line manager monitoring are essentially *operational* in purpose the senior manager audits are equally strategic.

Regionally agreed auditing tools are currently being developed to achieve consistency in audits undertaken at all levels within Trusts. It is anticipated that the audit tools, once available, will be accompanied by a regional statement regarding the frequency of such audits and the processes to be undertaken within Trusts to ensure key findings are disseminated to key staff in order to improve performance.

10. RECORDING STANDARDS AND CRITERIA

The following standards define what needs to be in place in order for Trusts to ensure a consistent approach to recording at all levels throughout Northern Ireland.

A number of criteria are provided under each standard to assist in determining if a stand*ard has been* met or not.

Standard 1

Files are created, maintained and closed in such a way as to make information readily accessible and retrievable.

Criteria:

- Files are structured in adherence to the recording policy
- All entries are filed in chronological and reverse-book order
- All entries are either typed or black ink is used if hand-written (REC 1 & REC 4 should be typed as a minimum standard)
- Files are opened in adherence to policy
- Files are closed in adherence to policy
- Files are maintained in adherence to policy
- Filing of documents is undertaken in adherence to policy
- Files are stored in adherence to policy

Standard 2

Files contain the correct documentation.

Criteria:

- The content of files is as stipulated in the recording policy
- To enable key information to be readily understood recording is completed using the agreed recording documents (REC 1-9, **Appendix 2**) where appropriate

Standard 3

Files provide evidence of planned and purposeful work with children and families.

Criteria:

- There is evidence of UNOCINI Assessment
- There is evidence that information obtained has been analysed and that the analysis has influenced the plan
- Professional judgement and knowledge is evidenced which may include research, obtaining specialist views, or using own expertise. There is a multi-agency plan (based on UNOCINI) in existence in respect of each child subject to family support or child protection processes
- The social worker develops an individual plan specifying the aims of each input and progress against these aims
- The desirable outcomes (for children) of interventions are defined and monitored within the plan
- Plans are formally reviewed and updated as appropriate in supervision with amendments to plans recorded in the file

Standard 4

Recording is conducted promptly

Criteria:

- All records are dated and signed (or typed full name) and the section of the file the record is to be filed under to be noted, prior to submission to the administrator for filing
- Records relating to child protection investigations are recorded immediately (within 24 hours)
- Records of significant events (REC 4) are completed within one working week
- Records of the visit to a 'Looked after' child or to a child on the child protection register (REC 5 & 6) to be completed within one working week
- Records of daily contacts (REC 3) within one working month
- Assessments are conducted and recorded within stipulated timeframes

Standard 5

Recording is consistent with relevant legislation and is duly respectful of service users.

Criteria:

- Records clearly distinguish between fact, opinion, judgement and hypothesis
- Records should contain evidence of service user contribution
- Records are written in such a manner as they can be readily understood by the service user – e.g. jargon is avoided, acronyms are explained, job titles are stated etc
- Records demonstrate that statutory requirements have been met
- Service users' views are recorded, especially where these differ from the social worker's views
- Records comply with the requirements of Data Protection/ Human Rights/ Freedom of Information legislation
- However, concerns about the above legislation do **not** prevent the social worker from analysing material and expressing opinions
- Service users are informed of their rights to access information held about them
- Service user details are accurately recorded e.g. spellings of names, ethnicity

Standard 6

Recording is child-centred.

Criteria:

- Records indicate that children have been seen and spoken to (where appropriate, on their own)
- Where it has not been possible to see and speak to children on their own, recording clearly states why this is so, that this fact has been shared with management and what steps are to be taken to address this

- Records demonstrate that efforts have been made to obtain and record the wishes and feelings of all children, including their hopes and fears (including e.g. disabled children with communication difficulties and for whom English is not their first language)
- The impact of parental functioning and behavior on the child's development and well-being is assessed
- Records describe children's *experiences* i.e. they paint a picture of what life may be like from a child's perspective

Standard 7

Child protection records contain specific relevant information.

Criteria:

- There is an accurate detailed record of any injuries, signs and indicators and parental behaviours which give rise to concern
- There is an accurate record of explanations offered by children, parents and others who may hold relevant information.
- Immediate risk to children is evaluated and immediate protective action considered
- Longer-term risk to children is evaluated with the plan describing how this is to be countered
- Consultations with managers around child protection matters, and decisions which ensue from these are recorded
- Reports are prepared in advance and provided to the chairperson at least two working days before the Initial and Review Case Conference. The Reports will be shared in full with children (if appropriate) and parents/carers one working day before the Initial Case Conference and three days before the Review Case Conference (as per Area Child Protection; Policy and Procedures and UNOCINI Guidance)
- Relevant assessment/UNOCINI forms should be clearly completed and filed

Standard 8

Records demonstrate a commitment to multi-agency practice.

As part of its commitment to multi-agency practice, the Health and Social Care Trust standards, procedures and protocols should be shared with partner disciplines to assist their understanding of how the HSCT seeks to ensure highest standards of service.

Criteria:

- All staff should be aware of the pending Regional Information Sharing Agreement.
- The rationale for sharing information with another agency is made explicit
- The rationale for referring a child and/or family to another agency is made explicit in writing – along with the contribution to children's outcomes such an intervention might make
- Consideration is given to drawing on the specialist expertise of other disciplines and agencies
- Where specialist assessments are commissioned, the findings of these are considered and integrated into plans

- Records demonstrate a mutual understanding (intra- and inter-agency) of the nature of shared information and agreed actions
- All appropriate agencies make a positive contribution to e.g. making referrals, child protection conferences, LAC reviews, core groups and (especially) to the making and implementation of multi-agency plans

Standard 9

Records demonstrate professional accountability.

Criteria:

- Records are concise and written in clear, grammatically-correct English
- All records are signed (or typed full name) and dated (except in circumstances when documents are electronically transferred)
- Supervision records are created and filed as stipulated in the supervision policy and standards
- Formal reports (for meetings and conferences) are drafted, proof read and produced by the social worker in advance of the forum and signed by both the social worker and supervisor
- Records demonstrate analysis of information and outcomes of work plans
- Any physical or verbal threats or intimidating behaviour experienced by the worker should be recorded as an incident using significant event record (REC 4) and referenced on REC 1 & 2. There will also be a requirement for the worker to complete a Trust Incident form and to provide this to management. It is not expected that this record will be retained on the child's file

Standard 10

Recording demonstrates a commitment to diversity in all aspects of work (i.e. that all children and families are entitled to the same quality of service irrespective of ethnicity, religion, language, gender, age, disability or sexual orientation).

Criteria:

- All assessments, plans and interventions address the implications of the child's ethnicity etc (see list above)
- The potential vulnerabilities of specific children e.g. physical/sensory disability, young carers, children at risk of grooming, children in homes where domestic violence/substance misuse is a feature etc, are identified and addressed. Discrimination that children may experience is acknowledged and, in so far as this is possible, addressed by service provision
- There is effective communication with all children (including e.g. disabled children with communication difficulties and for whom English is not their first language)
- All children receive an appropriate level of protection
- Children and families receive appropriate services irrespective of ethnicity etc (see list above)

Standard 11

The quality of recording is assured by social workers and management.

Criteria:

- The social worker assures the quality of his/her own recording by auditing their own recording at a frequency agreed using the regionally agreed audit tool currently being developed
- The first line manager samples files of each supervisee at a frequency agreed using the regionally agreed audit tool currently being developed against the recording standards:
    - ✓ Identifying adherence to the recording standards
    - ✓ Identifying strengths and weaknesses (and how the latter are to be remedied)
    - ✓ Identifying the social worker's training/ development needs
    - ✓ Signing (or typed full name) and dating the records
- Senior managers audit a small sample of case files and supervision records as per agreement and using the regionally agreed audit tool.

APPENDIX ONE

LEGAL REQUIREMENTS

Public Records Act (Northern Ireland) 1923

Document available at:

http://www.legislation.gov.uk/RevisedStatutes/Acts/apni/1923/capni_19230020_en_1

It is essential that HPSS staff understand that all HPSS records are classed as public records under the Public Records Act (Northern Ireland) 1923. Therefore Chief Executives and Senior Managers are personally accountable for records management within their own organisations.

Freedom of Information Act 2000

Document available at: http://www.opsi.gov.uk/acts/acts2000/ukpga_20000036_en_1

The Freedom of Information Act 2000 creates a statutory right of access by the public to all records held by public bodies (exceptions apply).

Data Protection Act 1998

Document available at: http://www.opsi.gov.uk/acts/acts1998/ukpga_19980029_en_1

All HPSS organisations have a statutory duty under the Data Protection Act to protect the personal data they hold, in relation to records management. All HPSS organisations must ensure that they have a system to:

- Maintain the accuracy of records held
- Protect the security of personal data
- Control access to personal data
- Make arrangements for secure disposal once the record is no longer required. However all HPSS organisations must ensure that they comply with legislative requirements in terms of safe/secure storage of records/files for specified timescales and only dispose of records in keeping with legislation governing disposal/destruction.

The Data Protection Act covers computerised records as well as manual/ paper records. The Data Protection Act outlines 8 basic data protection principles to be followed by anyone ``processing`` data.

`` Good Management, Good Records ``DHSSPS 2002

Document available at:

http://www.dhsspsni.gov.uk/dhs-goodmanagement.pdf

Good management and good records states:

``Records management is most effective when it commands commitment from senior managers and all HPSS staff regard it as a professional activity requiring specific expertise and good practice ``

This document highlights the importance of an effective records management service to ensure information is properly managed and available whenever and wherever there is justifiable request for it.

APPENDIX TWO

RECORDING DOCUMENTS

REC 1 – Family and professional information record

REC 2 – Chronology of significant events record

REC 3 – Contact record

REC 4 – Significant event record

REC 5 – LAC statutory visit record

REC 6 – Child protection visit record

REC 7 – Closure/transfer record

REC 8 – Transfer process record

REC 9 - Case supervision record

FAMILY AND PROFESSIONAL INFORMATION RECORD Volume Number _____					
Client Details:					
Surname		**Alternative last name**		**Forename**	
DOB		**SOSCARE No:**		**H & C No:**	
Ethnicity		**First Language Spoken**		**Person(s) with parental responsibility**	
Current Address		**Telephone Number**		**Previous Address**	

Others In Household:					
Name	**DOB**	**Relationship**	**Address & Telephone**	**SOSCARE number**	**H & C No:**

Relevant Others (Family relatives & friends living outside household):					
Name	**DOB**	**Relationship**	**Address & Telephone**	**SOSCARE number**	**H & C No:**

Current Professionals Involved (e.g. H.V. Schools):			
Name	**Role with child/family**	**Address**	**Telephone number**

Is the child(ren)'s name(s) on the Child Protection Register:			YES/NO
Category of Registration			
Date registered:		**Date de-registered:**	
Is the child(ren) Looked After:			YES/NO
Date became Looked After:		**Date returned home:**	
Current Legal Status:			
Reason for current Social Work Involvement:			
What are the know risk factors for staff?			

Signed: **Date completed:** **Position:**

CHRONOLOGY OF SIGNIFICANT EVENTS RECORD			
Client Name :		**SOSCARE No :**	**H & C No:**
Date of Significant Event	**Nature of Event /Interview**	**Identify where detailed recording of Significant Event can be located**	**Signature and Date**

CONTACT RECORD		
Client Name:	**SOSCARE No:**	**H & C No:**
Date Reported :	**Time Reported :**	
Type of contact :	**Initiated by:**	
Date of contact :	**Nature of Event / Interview :**	
Who was involved :		
Purpose:		
Key issues discussed :		
Action required or taken :		
Restricted : Yes/No* delete as appropriate		

Signed: **Date:**

*** Type** **M - Meeting** **DC – Direct work with child** **TC – Telephone Call** **O -Other**
HV – Home Visit **L - Letter** **MB – Message Book**
E – Email **OD - Office Duty** **OI – Office Interview**

Health and Social Care

REC 3 (II)

CONTACT RECORD		
Client Name:	**SOSCARE No:**	**H & C No:**
Date Reported :	**Time Reported :**	
Type of contact :	**Initiated by:**	
Date of contact :	**Nature of Event / Interview :**	
Who was involved :		
Purpose:		
Key issues discussed :		
Action required or taken :		
Restricted : Yes/No* delete as appropriate		

Signed: **Date:**

Date Reported :	**Time Reported :**
Type of contact :	**Initiated by:**
Date of contact :	**Nature of Event / Interview :**
Who was involved :	
Purpose:	
Key issues discussed :	
Action required or taken :	
Restricted : Yes/No* delete as appropriate	

Signed: **Date:**

* Type	M - Meeting	DC – Direct work with child	TC – Telephone Call	O -Other
	HV – Home Visit	L - Letter	MB – Message Book	
	E – Email	OD - Office Duty	OI – Office Interview	
	E – Email	OD - Office Duty	OI – Office Interview	

CONTACT RECORD		
Client Name:	**SOSCARE No:**	**H & C No:**
Date Reported :	**Time Reported :**	
Type of contact :	**Initiated by:**	
Date of contact :	**Nature of Event / Interview :**	
Who was involved :		
Purpose:		
Key issues discussed :		
Action required or taken :		
Restricted : Yes/No* delete as appropriate		

Signed: **Date:**

Date Reported :	**Time Reported :**
Type of contact :	**Initiated by:**
Date of contact :	**Nature of Event / Interview :**
Who was involved :	
Purpose:	
Key issues discussed :	
Action required or taken :	
Restricted : Yes/No* delete as appropriate	

Signed: **Date:**

Date Reported :	**Time Reported :**
Type of contact :	**Initiated by:**
Date of contact :	**Nature of Event / Interview :**
Who was involved :	
Purpose:	
Key issues discussed :	
Action required or taken :	
Restricted : Yes/No* delete as appropriate	

Signed: **Date:**

*** Type** **M - Meeting** **DC – Direct work with child** **TC – Telephone Call** **O -Other**
HV – Home Visit **L - Letter** **MB – Message Book**
E – Email **OD - Office Duty** **OI – Office Interview**

SIGNIFICANT EVENT RECORD		
Client Name :	**SOSCARE No :**	**H & C No:**
Date Reported :	**Time Reported:**	
Type of contact* (e.g. Home Visit)	**Initiated by:**	
Date of Significant Event :	**Nature of Event / Interview :**	
Who was involved :		
Purpose :		
Detail of Event / Interview :		
Analysis:		
Action taken or required :		
Restricted : Yes/No* delete as appropriate		

Signed: **Date:**

*** Type** **M - Meeting** **DC – Direct work with child** **TC – Telephone Call** **O - Other**

HV – Home Visit **L - Letter** **MB – Message Book**

E – Email **OD - Office Duty** **OI – Office Interview**

LAC STATUTORY VISIT RECORD		
Client name:	**SOSCARE no:**	**H & C No:**
Date of this visit:	**Date of last visit:**	
Location:		
Persons present:		
Does this visit meet the statutory requirement: : Yes/No* delete as appropriate **If NO, give reason:**		
Was the child seen alone: : Yes/No* delete as appropriate **Describe interaction. If not seen alone outline reason.**		
Details of visit		
CHILD: Comment on and assess the child's progress (include child's views, wishes and feelings) regarding the following: Contact, Family, Placement, Health, Education/training/emloyment, Care Plan.		
CARER: Please note any issues discussed changes in household/facility since last visit, Social Worker's assessment of placement and if it continues to meet the child's needs.		
Has any complaint been made since last statutory visit : Yes/No* delete as appropriate **If YES, when, by whom and action taken:**		
Issues affecting care plan		
Issues/action to be taken by next visit		

Signed Social Worker: **Date:**

Team Leader's Comments

Does this visit meet the statutory requirement : Yes/No* delete as appropriate **If NO, give reason and action to be taken:**

Signed Team Leader: **Date:**

CHILD PROTECTION VISIT RECORD		
Client name:	**SOSCARE no:**	**H & C no:**
Date of this visit:	**Date of last visit:**	
Location:		
Persons present:		
Was the child seen alone: Yes/No* delete as appropriate **Describe interaction. If not seen alone outline reason.**		
Details of visit		
CHILD: Comment on and assess the child's progress as it relates to the child protection plan (include child's views, wishes and feelings)		
PARENT/CARER: Please note any issues discussed, changes in household since last visit and your assessment of the visit as it relates to the child protection plan		
Issues affecting child protection plan		

Action to be taken

Issues/action to be taken by next visit

Signed Social Worker: **Date:**

CLOSURE / TRANSFER RECORD* delete as appropriate			
Client name:		**SOSCARE no:**	**H & C no:**
Summary of Involvement:			
Aims Achieved:			
Aims Not Achieved:			
Reason(s) for Closure/Transfer:* delete as appropriate			
Client Informed of Closure/transfer?	**Yes/No*** delete as appropriate	**Agreeable to Closure/transfer?**	**Yes/No*** delete as appropriate
Agency/Worker Referred or Transferred to:			
Closure/transfer letters sent to:			

Signed Social Worker: **Date:**

Team Leader's Comments:	
Date SOSCARE updated:	

File Destruction Date:

Signed Team Leader: **Date:**

TRANSFER PROCESS RECORD					
Client Name:		**SOSCARE No:**		**H & C no:**	
Transferring Team Name & Location:		**Date of Transfer:**		**Number of files transferred:**	
Category: (indicate with an X)	**Family Support**	**Child Protection**	**Looked After Children**		**16+ Transition**

Signed Transferring Team Leader/Designated Officer: **Date:**

Receiving Team Name & Location:	**Date Transfer received:**	**Number of files received:**

Signed Receiving Team Leader/Delegated Officer: **Date:**

Action by Receiving Team Leader/Delegated Officer		
Date Placed on waiting list:	**Reason:**	
Dates the decision to remain on waiting list was reviewed by Team Leader/Delegated Officer and reason:		
Allocated to & Date:		

Team Leader Signature: **Date:**

CASE SUPERVISION RECORD		
Client Name :	**SOSCARE No :**	**H & C No:**
Date of Discussion:	**Persons involved:**	
Discussion:		
Decisions and actions agreed:		

Signed Supervisor: **Date:**

Signed Supervisee: **Date:**

APPENDIX THREE

EXEMPLARS OF RECORDING DOCUMENTS (REC 1-9)

Case Summary:

Anna, the 14 year old daughter of the Bradley family has alleged that her father (Paul Bradley) inappropriately touched her on a number of occassions in the past 6 months. This led to a breakdown in family relationships prompting her to move out and is currently living in a kinship placement with her maternal aunt, Mrs Black. A Child Protection Case Conference placed the 2 younger children (Emma, aged 12 and Gillian, aged 10) on the Child Protection Register with the provision that Mr Bradley leave home whilst assessment work was undertaken:

- Dad attends Hearn House for assessment
- The children attend the family centre for safety work
- Mum's protectiveness to be assessed
- Dad to have contact 3 days a week with the two younger siblings supervised by Mum and monitored by Social Services – a 'safe caring contract' in place
- Social Worker to assist Anna and mum to 'rebuild' relationship – develop contact

FAMILY AND PROFESSIONAL INFORMATION RECORD

Volume number **1**

Client Details:

Surname	Bradley	**Alternative last name**	N/A	**Forename**	Anna
D.O.B.	1/1/96	**SOSCARE no:**	123456	**H & C No:**	**789**
Ethnicity	White	**First Language Spoken**	English	**Person(s) with parental responsibility**	Parents: Mr. and Mrs. Bradley
Current address	C/o Mrs. Black, maternal aunt: 41 Lisburn Road Belfast BT9 2BA	**Telephone number**	028 90333333	**Previous address**	Family Home,333 Cyprus Avenue Antrim, BT40 3QA

Others In Household:

Name	DOB	Relationship	Address & Telephone	SOSCARE number	H & C No:
Mrs Stephanie Black Mr Philip Black	1/1/50 1/1/60	Maternal Aunt (kinship) Maternal Uncle (kinship)	41 Lisburn Road Belfast, BT92BA	N/A N/A	000 111

Relevant Others (Family relatives & friends living outside household):

Name	DOB	Relationship	Address & Telephone	SOSCARE no	H & C No:
Mrs Mary Bradley	1/1/49	Mother	333 Cyprus Avenue	123457	222
Emma Bradley	1/1/98	Sister	As above	123458	333
Gilian Bradley	1/1/10	Sister	As above	123459	444
Mr Paul Bradley	1/1/48	Father	As above	123410	555

Current Professionals Involved (e.g. H.V. Schools):

Name	Role with child/family	Address	Telephone number
Mr Evans	Designated Teacher	Antrim High School	028 9422222
Mrs Smyth	Health Visitor	Antrim Health Centre	0289455555
Mr Thompson	Link Worker to Kinship Carers	Family Placement Team Antrim	028 9466666

Is the child(ren)'s name(s) on the Child Protection Register:			NO
Category of Registration	Confirmed Sexual Abuse		
Date registered:		**Date de-registered:**	
Is the child(ren) Looked After:			YES
Date Became Looked After	1 August 2009	**Date returned home:**	N/A
Current Legal Status:	Article 21 – Voluntary accommodated		

Reason for current Social Work Involvement:

Anna alleged her father inappropriately touched her on a number of occasions. She is now in a kinship placement with her maternal aunt and uncle. Her younger siblings remain at home with mum and are on the child protection register. Dad is currently out of the home pending assessment.

What are the know risk factors for staff? None know.

Signed: Tracy Robinson **Date completed:** 20/8/09 **Position:** Social Worker

REC 2

CHRONOLOGY OF SIGNIFICANT EVENTS RECORD			
Client Name :	Anna Bradley	**SOSCARE No :** 123456	**H & C No:** 789,222,333,444
Date of Significant Event	**Nature of Event /Interview**	**Identify where detailed recording of Significant Event can be located**	**Signature and Date**
1st December 2009	Allegation that Mr Bradley is staying overnight in family home contrary to child protection plan	Significant Event Record, Section 4; Recording, File 1	Tracy Robinson 2/12/09
6th December 2009	LAC Review – Anna to remain in care pending ongoing assessments	LAC Report and Minutes, Section 6; LAC, File 1	Tracy Robinson, 10/12/09
14th December 2009	Review CPCC – Anna's sisters names are retained on the CPR 'potential sexual abuse'	Case Conference Report & Minutes, Emma & Gillian' files, Section 5; Child Protection and Family Support, File 1	Tracy Robinson, 16/12/09
4th January 2010	Anna suspended from school for 2 weeks - fighting	Significant Event record, Section 4, Recording, File 1	Tracy Robinson, 4/1/10

Health and Social Care

REC 3 (II)

CONTACT RECORD		
Client Name: Bradley Family	**SOSCARE No:** 123456,7,8,9	**H & C No:** 789,222,333,444
Date Reported : 1/12/09	**Time Reported :** 11am	
Type of contact : T/C	**Initiated by:** Anonymous	
Date of Contact: 29th and 30th November 2009	**Nature of Event / Interview:** Allegation that Paul Bradley is staying overnight in the family home contrary to child protection plan.	
Who was involved : Anonymous female caller to Social Worker, Tracy Robinson		
Purpose : To share concerns with Social Services		
Key issues discussed : Caller is aware that Paul Bradley had been asked to leave the house by Social Services and that he should not be there. She reports Mr Bradley has been staying overnight in the family home when the children are present, dates provided Friday and Saturday night 29th and 30th November. The caller refused to meet with me or to give any further details. Thanked her for calling and asked if she would call back again if she had further concerns/information to report		
Action required or taken : Mrs Bradley, Emma and Gillian to be interviewed - Significant Event Record 1/12/09 Mr Bradley to be interviewed – Significant Event Record 1/12/10 Emma interviewed – Significant Event record – 2/1/10		
Restricted : NO		

Signed: Tracy Robinson **Date:** 1/12/09

Date Reported :	**Time Reported :**
Type of contact:	**Initiated by :**
Date of Contact :	**Nature of Event / Interview :**
Who was involved :	
Purpose :	
Key issues discussed :	
Action required or taken :	
Restricted : Yes/No* delete as appropriate	

Signed: **Date:**

*** Type** **M - Meeting** **DC – Direct work with child** **TC – Telephone Call** **O - Other**
HV – Home Visit **L - Letter** **MB – Message Book**
E – Email **OD - Office Duty** **OI – Office Interview**

HSC Health and Social Care

REC 4

SIGNIFICANT EVENT RECORD

Client Name : Bradley Family	**SOSCARE No :** 123456,7,8,9	**H & C No:** 789,222,333,444
Date Reported : 1/12/09	**Time Reported:** 4pm	
Type of contact* (e.g. Home Visit) H/V	**Initiated by:** Social Worker	
Date of Significant Event : 29th and 30th November	**Nature of Event / Interview :** Allegation that Mr Bradley has been staying overnight in family home contrary to CP Plan	

Who was involved : Tracy Robinson, Social Worker; Mrs Bradley; Emma and Gillian

Purpose : To discuss allegation with Mrs Bradley, Emma and Gillian (on their own)

Detail of Event / Interview :

Informed Mrs Bradley and subsequently Emma and Gillian of the anonymous allegation regarding Mr Paul Bradley staying overnight, specifically on 29th and 30th November. Reminded her of the 'safe caring contract' and the CP Plan.

Mary Bradley admitted that her husband had stayed but she was sick and he stayed in order to look after her and to make meals etc. She advised this was the first time it had happened and that he was never alone with the children. Advised Mary of the risk she was exposing her children to and the potential consequences of their actions. Discussed at length the potential consequences:

i. The case conference would be re-convened
ii. That risks to the children would be re-assessed
iii. That if the risks were assessed as being significant than the children's continued placement at home would be re-considered

Mary cried throughout the interview. She stated that it would not occur again and that she would fully comply with the 'safe caring contract'. I informed her that I would also speak with her husband and outline the consequences. I asked her permission to speak with the children.

I spoke with Emma and Gillian alone. They are aware their dad is not meant to do this following the allegations Anna made. Both claimed that he had never done anything to hurt them and that they missed him at home. Emma thinks Anna is lying. Emma and Gillian confirmed that their mother ensured they were not on their own with their father.

Acknowledged their feelings re: missing their father but advised the children of the importance of keeping to agreements with SS.

Analysis:

In my professional opinion I believe that:

- Mr and Mrs Bradley have not adhered to the CP Plan and I therefore question their ability to do so in the future.
- Mrs Bradley did not volunteer the information – I believe this questions her willingness and capacity to adhere to the Plan in future.
- I believe Mrs Bradley is now very clear re: consequences of breeching CP Plan
- I believe Mrs Bradley did ensure the children were not left alone with their father
- I remain unconvinced that Mr & Mrs Bradley will cooperate fully with the CP and the children are likely to be placed in a situation of potential risk in the future.

Action taken or required :

On the basis of the above it is my professional opinion that the following action is necessary:

- Arrange urgent visit to Mr Bradley and Anna
- Inform Core Group members and convene Core Group meeting
- Mrs Grey, manager advised following visit – Mrs Grey to inform Case Conference Chair

Restricted : NO

Signed: Tracy Robinson **Date:** 1/12/09

*** Type** **M - Meeting** **DC – Direct work with child** **TC – Telephone Call** **O - Other**
HV – Home Visit **L - Letter** **MB – Message Book**
E - Email **OD - Office Duty** **OI – Office Interview**

Health and Social Care

REC 5

LAC STATUTORY VISIT RECORD

Client name: Anna Bradley	**SOSCARE no:** 123456	**H & C No:** 789
Date of this visit: 13th November 2009	**Date of last visit:** 18th October 2009	

Location: Placement address – Mr and Mrs Black's home

Persons present: Anna Bradley, Mrs Black, kinship carer and maternal aunt; Tracy Robinson, SW

Does this visit meet the statutory requirement: YES

Was the child seen alone: Describe interaction. If not seen alone outline reason.

Yes. Anna was very communicative throughout the visit and appeared settled and relaxed.

Details of visit:

CHILD: Comment on and assess the child's progress (include child's views, wishes and feelings) regarding the following: Contact, Family, Placement, Health, Education/training/employment, Care Plan.

Placement:

- Anna still enjoys her placement & is happy to be with her aunt & uncle – she is well settled.

Family/Contact:

- Anna still wants to be at home if relationships were to improve and her safety secured but is realistic about the timescales involved.
- She continues to be upset about Emma & Gillian's anger towards her and although she understands it she misses the closeness they had.
- Anna feels she is getting on much better with her mother and she thinks her mum is trying hard.
- She is content with the flexible contact arrangements she has with her mum and sisters and does not want any changes.
- Anna still does not want to have any contact with her dad although she thinks she might text him – Anna knows any contact should be discussed and agreed with me.

Health:

- Anna had her booster injection in school this month but is otherwise well

Education:

- Problems still continue at school – she likes the work but gets frustrated and can be aggressive
- Anna continues to see her school counsellor and finds this supportive

Care Plan:

- Anna feels she is benefiting from the family centre service and is keen for this to continue
- Care Plan remains appropriate – no change required

CARER: Please note any issues discussed changes in household/facility since last visit, Social Worker's assessment of placement and if it continues to meet the child's needs?

Mrs Black:

- Is aware of care plan & timescales
- Remains committed to caring for Emma for as long as necessary including permanently if required
- Reports to be benefiting from the support of her link worker and has no particular issues to resolve or query
- Reports to struggle at times to 'say the right thing' to Emma when she gets upset about her circumstances
- Continues to struggle with her sisters decision to remain in a relationship with Mr Bradley
- Is mindful to keep negative thoughts about family members and the situation from Anna

SW Assessment:

- Placement continues to meet Emma's needs appropriately
- No change to Care Plan required

Has any complaint been made since last statutory visit If YES, when, by whom and action taken:

N0

Issues affecting care plan

None – Care Plan remains appropriate and valid.

Emma is considering some level of indirect contact with her father possibly via text messaging. Emma is aware this needs to be discussed and agreed with social services – May have implications for Care Plan

Issues/action to be taken by next visit

None

Signed Social Worker: Tracy Robinson **Date:** 18/11/09

Team Leader's Comments

Emma's needs continue to be met and Care Plan remains appropriate. Services as per Care Plan to continue.

Does this visit meet the statutory requirement If NO, give reason and action to be taken:

Yes

Signed Team Leader: Lorraine Grey **Date:** 26/11/09

Health and Social Care

REC 6

CHILD PROTECTION VISIT RECORD		
Client name: Emma Bradley	**SOSCARE no:**123458	**H & C no:** 333
Date of this visit: 4/1/10	**Date of last visit:** 27/12/09	
Location: Family Home		
Persons present: Mrs. Bradley, Emma, Gillian and Social Worker, Tracy Robinson		
Was the child seen alone: Yes/No* delete as appropriate **Describe interaction. If not seen alone outline reason.** Yes		
Details of visit		
CHILD: Comment on and assess the child's progress as it relates to the child protection plan (include child's views, wishes and feelings) Emma was in good, chatty form. She had a great time over Christmas and the New Year with her friends though acknowledged that the absence of her father was difficult to cope with. Anna visited the family home a lot over the holiday period which Emma enjoyed although still feels it is 'weird' that Anna doesn't stay. Emma is beginning to understand the concerns professionals have about her safety & well-being and the importance of compliance with the Child Protection Plan. On this basis Emma is keen to progress the protection work at the family centre but would rather not attend. She wants her family back together but understands Anna needs to feel safe. She herself does not feel in any danger from her father.		
PARENT/CARER: Please note any issues discussed, changes in household since last visit and your assessment of the visit as it relates to the child protection plan Mrs. Bradley noted that she had a very difficult Christmas and New Year – she missed her husband and reported the difficulties she had in the practicalities of Christmas and how 'worn out' she feels as a single parent. Despite this she remains hopeful for the future primarily because of an improvement in her relationship with Anna. Mrs. Bradley is keen to have the family together but remains adamant that Mr. Bradley will not return home if the girls' future would be jeopardized. Mrs. Bradley states that as well as professionals, she too needs to be assured of their safety – she is beginning to think about conversations/occasions in the past in light of Anna's allegations and is working through these with her social worker at the family centre.		
Issues affecting child protection plan None at present. The Child Protection Plan is being fully implemented at present with no issues arising.		

Action to be taken

Issues/action to be taken by next visit
None – Child Protection Plan remains focus of intervention, nothing further to be done/addressed

Signed Social Worker: Tracy Robinson **Date:** 8/01/10

TRANSFER RECORD

Client name: Anna Bradley	**SOSCARE no: 123456**	**H & C no:** 789

Summary of Involvement: S/S involvement began in August 2009 when Anna, aged 14, alleged her father sexually assaulted her. Due to this and subsequent family relationship difficulties, Anna immediately moved to the care of her maternal aunt and uncle as a kinship placement. Her 2 sisters remain at home with their mother and names placed on the Child Protection Register. Mr Bradley remains out of the family home as per CP Plan.

Anna is 'Voluntarily Accommodated' and as a looked after child, has been reviewed as per statutory requirements.

A schedule of assessments are complete/in progress:

- Assessment of risk posed by Mr Bradley - In progress
- Protective Parenting Assessment of Mrs Bradley - Complete
- Safety work with Anna and sisters - Complete
- Recovery work with Anna – In progress

Mrs Bradley has completed the protective parenting assessment work which had a positive outcome. This work will need revisited at the conclusion of the assessment of Mr Bradley. Anna has increased her contact at home and relationship difficulties between her, her mother and siblings have improved. She has no contact with her father and does not want to consider contact at this time

Anna's sister's names remain on the Child Protection Register; the next Review is scheduled for 15th February.

Anna has enjoyed a very stable kinship placement with her maternal aunt & uncle which remains available to her if a permanent placement is required

Aims Achieved:

- The Protective Parenting Assessment of Mrs Bradley had a positive outcome – viewed as protective
- The girls have a general understanding of 'keeping safe'
- Anna is benefiting from recovery work which is ongoing
- Appropriate placement secured and supported

Aims Not Achieved:

- Assessment of risk posed by Mr Bradley - In progress
- Recovery work with Anna – In progress
- Review of protective parenting assessment by Mrs Bradley at the conclusion of the assessment of Mr Bradley

Reason(s) for Transfer:

Anna's needs will be best met by the specialist services provided by the LAC Team

Client Informed of transfer?	YES	**Agreeable to transfer?**	YES
Agency/Worker Referred or Transferred to:		Miss Leathem, LAC Team, Antrim	
Transfer letters sent to:		Mrs Smyth, Health Visitor, Antrim Health Centre Mr Evans, Designated Teacher, Antrim High School	

Signed Social Worker: Tracy Robinson **Date:** 12th January 2010

Team Leader's Comments: Appropriate for transfer to LAC Team, Antrim – see minutes of transfer meeting (8/01/10)	
Date SOSCARE updated:	14th January 2010

File Destruction Date: N/A

Signed Team Leader: Lorraine Grey **Date:** 14th January 2010

TRANSFER PROCESS RECORD				
Client Name: Anna Bradley		**SOSCARE No:** 123456		**H & C no:** 789
Transferring Team Name & Location: Antrim Family Support & Intervention Team		**Date of Transfer:** 14th January 2010		**No of files transferred:** 3
Category: **(indicate with an X)**	**Family Support**	**Child Protection**	**Looked After Children**	**16+ Transition**
			X	

Signed Transferring Team Leader/Designated Officer: Lorraine Grey **Date:** 14/01/10

Receiving Team Name & Location: Antrim LAC Team, Antrim	**Date Transfer received:** 14th January 2010	**No of files received:** 3

Signed Receiving Team Leader/Delegated Officer: Miss McBride **Date:** 14/01/10

Action by Receiving Team Leader/Delegated Officer		
Date Placed on waiting list: N/A	**Reason:** N/A	
Dates the decision to remain on waiting list was reviewed by Team Leader/Delegated Officer and reason:		
N/A		
Allocated to & Date: Miss Leathem, 14/10/10		

Team Leader Signature: Miss McBride **Date:** 14/01/10

CASE SUPERVISION RECORD		
Client Name : Anna Bradley	**SOSCARE No :** 123456	**H & C no:** 789
Date of Discussion: 1/12/09	**Persons involved:** Social Worker Tracy Robinson and Mrs Grey, Team Leader	

Discussion:

Mrs Grey provided with an overview of the anonymous allegation regarding Mr Bradley staying the weekend in the family, contrary to 'Safe Caring Contract' and Child Protection Plan.

A detailed account was given of the subsequent interviews with Mrs Bradley, Emma and Gillian.

Decisions and actions agreed:

- SW to proceed with planned interviews with Mr Bradley and Anna in her placement
- SW to inform Core Group members and arrange Core Group Meeting to be chaired by manager, Mrs Grey
- Mrs Grey to inform Case Conference chair
- Mrs Robinson to update Mrs Grey following interviews with Mr Bradley and Anna

Signed Supervisor: Lorraine Grey **Date:** 1st December 2009

Signed Supervisee: Tracy Robinson **Date:** 1st December 2009

Equality

This policy/proposal has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998, and it was found that there were no negative impacts on any grouping.

Human Rights

This policy has been considered under the terms of the Humans Rights Act 1998 and was deemed compatible with the European Convention Rights contained within the Act.