Hartlepool & Stockton-on-Tees
SAFEGUARDING CHILDREN PARTNERSHIP

South Tees
Safeguarding Children Partnership

Tees Multi-agency Standards for Case Recording

Endorsed by the Tees Safeguarding Children Partnership's (Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton-on-Tees) (previously LSCB's):

Adopted: April 2015 (V1)

Effective from: April 2015

(**Reviewed:** January 2021)

Our commitment to equality and diversity means that these standards have been screened in relation to the use of gender-neutral language, jargon-free plain English, recognition of the needs of disabled people, promotion of the positive duty in relation to race and disability and avoidance of stereotypes.

Contents

Introduction 3
Definition of a case record 3
Purpose of case recording 3
The Standards 4
Standard 1: There is a separate case record for each service user 4
Standard 2: The content of the case record reflects professional practice 4
Standard 3: Records are legible and use plain language rather than jargon 4
Standard 4: Recording is child/young person focused 4
Standard 5: Records clearly identify the outcomes or results to be achieved for the child/young person 4
Standard 6: Recording distinguishes between fact and fiction and specifies the source of the information 5
Standard 7: There is cross referencing and signposting to other records on the child/young person 5
Standard 8: Case records shop when information has been shared 5
Standard 9: Records are up to date within 10 working days of the contact / discussion / meeting 6
Standard 10: The case record includes an updated chronology and/or summary 6
Standard 11: Records include an assessment of risk 6
Standard 12: Records demonstrate commitment to the principles of equality and valuing diversity 7
Standard 13: Records provide details about the achievement of outcomes/results as part of a review of progress and before the case is closed 7
Standard 14: Other professionals and practitioners supporting the child/young person and family are referred to in the records by name, profession/designation and agency. 7
Standard 15: Records are respectful of children, young people and their families 7
Standard 16: There is a record of children's and parents/carers' views 8
Standard 17: The case record identifies whether the child/young person is subject to a child protection plan and/or is looked after by the local authority 8
Standard 18: It is clear whether the case is active or closed 8
Standard 19: There is one record of any multi agency meetings about a child/young person or family 8
Standard 20: Case records evidence monitoring/auditing by managers 9
APPENDIX: Case Recording Audit Tool: Multi-agency Standards 10

Introduction

The standards within this document are based on a range of professional guidelines and national best practice. The development of standards for case recording which can be applied across a range of agencies providing services to children, young people and their families in the local area is intended to ensure consistent and high quality records for those who receive universal and/or targeted and specialist services. **The standards are not intended to replace single or multi agency policies and procedures.** The aim is to further support the work of practitioners and professionals to improve outcomes for children and young people by providing a set of commonly agreed statements about minimum levels of quality and performance and thereby providing a benchmark against which practice can be evaluated and measured. The development and adoption of multi agency standards for case recording will support integrated and collaborative working by ensuring consistency in recording practice across agencies.

Definition of a case record

A case record is an account, either in written or electronic format, of an agency's involvement and work with an individual child, young person or family. In most agencies, a case record will provide details of contacts with the child/young person/family, the plan and the work to be undertaken to achieve the agreed outcomes based on an assessment of need, the views of the child/young person and family members, decisions made and an evaluation of the impact of interventions.

Purpose of case recording

Case recording is one element of the service delivered to children, young people and their families and therefore an important task for practitioners regardless of the agency they work in. Whilst recording can provide evidence for planning and allocating resources at an individual and strategic level it can also:

- Help to focus the work of practitioners and professionals
- Provide a documented account of agency involvement
- Assist continuity when key agency staff are unavailable or change
- Support staff supervision and professional development
- Facilitate reflection, analysis and planning
- Provide evidence of decision making
- Support partnership with service users

Case records can also be a major source of evidence for inquiries, investigations and serious case reviews.

To be read in conjunction with **The Rough Guide to Recording and Report Writing** available on the Tee Safeguarding Children Procedures website at:
https://www.teescpp.org.uk/practice-tools/rough-guides-for-practitioners/

The Standards

Standard 1: There is a separate case record for each service user

What this standard means in practice
A child/young person may "go missing" from the agency record where files are kept on families rather than on individual children. Where each child does not have a separate file, or a separate section in the file, there is a risk that the needs of one child or other family member may dominate the record, resulting in the needs and views of others being overlooked. It will also prove very difficult to monitor outcomes/results for individual child/young person.

Standard 2: The content of the case record reflects professional practice

What this standard means in practice
Case records are a means by which practitioners can justify, explain and be accountable for their actions. The content of case records should be sufficient to give an account of all significant aspects of work undertaken, why, regular review of progress of the work undertaken and what the outcomes or results are. In some agencies this will mean that a record is made of each contact with the child/young person and/or family, the purpose of each contact and any actions taken.

Standard 3: Records are legible and use plain language rather than jargon

What this standard means in practice
To avoid misinterpretation by managers or others who access the case record, or the overlooking of important information, all case recording should be easily readable by being written clearly in black ink or recorded electronically. With some safeguarding provisions, service users have the right to see information recorded about them and so the use of professional jargon[1], acronyms and uncommon abbreviations should be avoided to ensure records, and therefore the account of decisions made and actions taken, can be easily understood.

Standard 4: Recording is child/young person focused

What this standard means in practice
Often practitioners are working with parents and carers who may be facing a wide variety of problems. In many cases the route to improving a child's outcomes is by supporting and helping the parents. However, it is important that practitioners maintain a child focus and give children a voice which should be clearly evidenced in the records. Parents/carers' needs should never dominate the child's record at the expense of the child.

Standard 5: Records clearly identify the outcomes or results to be achieved for the child/young person

What this means in practice
Practitioners and professionals providing services to individual children or families need to start with the outcomes or results the intervention is aiming to achieve for that child and his/her family. This will be based on an assessment of need. Once the outcomes or results to be achieved have been agreed, a clear plan of action, with specified timescales, to ensure they are achieved will be developed in partnership with the child and family and may involve other services and agencies.

---

1 This does not include medical terminology although the use of unnecessary medical jargon will better ensure service users' understanding when accessing their own, or in some circumstances, their children's records

Without a focus on results and outcomes, and a record of the actions identified to best achieve those results, practitioners' work with children and their families will be unfocused and reviewing progress difficult.

Standard 6: Recording distinguishes between fact and fiction and specifies the source of the information

What this means in practice
Practitioners may gather or receive information from a range of sources when providing a service to a child or young person and make observations themselves. It is really important for the source of the information to be specified. This will ensure that anyone reading the record will understand the context of the information e.g parent self-reporting. It must be recorded whether information gathered are facts, information or opinion e.g a teacher may say a child has an ASD diagnosis however when this is explored the teacher has received this information from the parent and the parent has misinterpreted the information received from a professional. If the record is not clear where the source of the information came from information can become fact without being substantiated.

Failing to differentiate between fact and opinion in recording can result in the significance of some information being overlooked, or opinions becoming accepted as facts and unduly influencing the management of the case. The following helps to explain facts vs opinions:

FACT: A fact is what has been seen, heard or done by the writer. Such facts should be recorded contemporaneously if possible.

ASSUMPTION: A statement about the unknown based on a known. It is vital for professionals to seek and record facts, and not to make assumptions and inferences unless they are based on facts (professionals need to be clear when writing the record that they have made an assumption).

OPINION: The practitioner will form an opinion based on a fact.

The reasons for actions and decisions should be clearly recorded so that they are available to the services user and agency.

Standard 7: There is cross referencing and signposting to other records on the child/young person

What this means in practice
In some agencies not all information about a child/young person can be kept on one file. In many cases this would render the file unmanageable in terms of the size of the record. For some agencies a child's record might be a collection of a number of component files or records held in different parts of the agency. To ensure that important information is not overlooked, there should be a record of all the different components of the case file on the main record, and their location, to ensure that important parts of a child's records do not go missing and to effectively signpost anyone accessing the records.

Standard 8: Case records shop when information has been shared

What this means in practice
Inquiries and investigations repeatedly highlight the failure of agencies to effectively share information about children and young people. Conversely, sharing too much information is rarely raised as an issue in cases where services have failed to safeguard children. Practitioners should routinely record which information has been shared, with whom, when and how including with young people and their families.

Standard 9: Records are up to date within 10 working days of the contact / discussion / meeting[2]

What this means in practice
Maintaining up to date records is part of the service provided to children and families and therefore an essential task for staff. Timely record keeping helps to ensure robust agency decision making, particularly in the absence of key practitioners and professionals, and the importance of keeping up to-date records has been highlighted in the findings of many inspection and inquiry reports. Recording should not be allowed to accumulate and managers should ensure sufficient time is available to enable practitioners to complete recording in a planned way. Reliance on memory and failure to record within reasonable timescales may result in key information being forgotten and missed from the record. For some practitioners there will be a requirement to comply with shorter, agency specific recording timescales.

Standard 10: The case record includes an updated chronology and/or summary

What this means in practice
A chronology lists in date order all the major changes and significant events in a child or young person's life and is a useful tool to gain an overview of events in respect of an individual child. The chronology should be a record of factual information and starting a chronology could involve the child and family and will provide an opportunity to check out the accuracy of information. A chronology draws on various sources of information such as previous agency records, information from other agencies and information from the child or young person and his or her family. The chronology should not replicate detailed case recording but is more a timeline of significant events and major changes. Maintaining a chronology in a child's records can support agency decision making by highlighting how particular events have impacted on a child or young person.

A **case summary** provides a summary of events, changes and work undertaken by key practitioners over a specified period of time. Completing or sharing a summary with a family offers an opportunity to reflect on progress over the period covered by the summary and to discuss achievements as well as any difficulties or challenges being experienced. Writing a case summary provides practitioners with an opportunity to reflect on the effectiveness of interventions and to review progress towards the planned results or outcomes. It is also useful when cases are transferred between practitioners. Completing regular case summaries can support staff supervision processes, include information from and the perspectives of other practitioners working with the child and family, help to ensure continuity when cases are transferred and are an important source of information for colleagues and supervisors in the absence of the case holder.

Standard 11: Records include an assessment of risk

What this means in practice
There are a number of risks associated with all aspects of providing services to children and young people. All agencies working with children, young people and families have a responsibility to take all reasonable measures to ensure that any significant harm to children's wellbeing is minimised. Practitioners are responsible for identifying risks to the children and young people they are working with, and any risks to themselves, and they should ensure that these are recorded with any decisions made about their management. Where there are concerns about significant harm to a child's wellbeing, a record should be made of those concerns and appropriate actions taken in line with local procedures and protocols.

---

2 This is a minimum standard for all recording. Some agencies may require practitioners to comply with shorter timescales

Standard 12: Records demonstrate commitment to the principles of equality and valuing diversity

What this means in practice
Delivering the appropriate services to support children, young people and their families to contribute to improving outcomes needs to be based on a commitment to equalities and valuing diversity. Records should include accurate information about:

- Gender
- Nationality, race and culture
- Language(s) spoken in the home
- Religion and current practice
- Disability and/or health conditions

Recording should evidence a commitment to anti discriminatory practice and demonstrate that practitioners are working with diversity sensitively and in a non-judgemental way to identify the particular issues for children and young people.

Standard 13: Records provide details about the achievement of outcomes/results as part of a review of progress and before the case is closed

What this means in practice
Every practitioner working in every agency needs to focus on improving outcomes and making a difference to those children, young people and families who receive services and interventions. The process of evaluating the impact of services and interventions on outcomes needs to start when the planning of the service or intervention starts. Evaluation should be built around a well-informed needs assessment and a rationale for why particular actions will produce the sorts of changes that will meet those needs. It then needs to be supported by the collection of information to enable progress to be regularly monitored and the achievement of outcomes to be evidenced. Records should therefore provide evidence of evaluation of what has changed for a child/young person as a result of interventions and therefore evidence of the effectiveness of agency involvement. Case closure should only be approved by supervisors and managers if an evaluation of outcomes achieved has been undertaken and recorded.

Standard 14: Other professionals and practitioners supporting the child/young person and family are referred to in the records by name, profession/designation and agency.

What this means in practice
For many children their needs cannot be met by one agency and this will be reflected in the range of services supporting them and their families. Where records refer to other professionals and practitioners involved with a child/young person, these should include name, profession or designation and agency with relevant contact details. This will provide a full picture of those supporting a child and enable easier and quicker contact.

Standard 15: Records are respectful of children, young people and their families

What this means in practice
For the practitioner the case record will be just one of a number of similar records they keep as part of their duties in the agency. For the service user it is their record. Although the practitioner makes the records, they are made about, for, and ideally with the service user. The case record does not simply provide a documented account of the agency's involvement with an individual service user.

For many young people, particularly those looked after, the case record may be the main source of information about significant events, decisions and people in their lives. It is not simply what is recorded, but the way in which the record is maintained that provides a reflection of the agency and practitioner's attitude towards service users. Care should be taken to ensure that:

Names are spelled correctly and consistently throughout the record

- Dates of birth are recorded accurately
- Unsubstantiated opinions are avoided
- Oppressive and discriminatory statements are avoided
- The general presentation of the case file/record is of an acceptable standard

Standard 16: There is a record of children's and parents/carers' views

What this means in practice

Children and their parents/carers have a right to participate in decisions which affect them, to have their views recorded and in their own words. Where different tools have been used to help children express their views, such as drawing or games, their use should be explained in the record. Letters and notes from children can form a legitimate part of the case record and can also be used to evidence progress towards, or achievement of, planned results and outcomes.

Standard 17: The case record identifies whether the child/young person is subject to a child protection plan and/or is looked after by the local authority

What this means in practice

Children who are subject to child protection plans and/or who are looked after by the local authority are particularly vulnerable to poorer outcomes than other children. Where agencies are providing services as part of a multi-agency protection plan for a child/young person or a looked after child, the case record should clearly identify this to ensure appropriate responses and decision making in the absence of key staff.

Standard 18: It is clear whether the case is active or closed

What this means in practice

Delays in responding appropriately to children and young people can be avoided if records easily evidence whether the case is active, and therefore a child/young person is currently receiving a service or intervention from the agency, or closed and the intervention has ceased.

Standard 19: There is one record of any multi agency meetings about a child/young person or family

What this means in practice

A key aim of multi-agency working is to ensure that agencies work collaboratively to more effectively meet children's needs and improve outcomes. Increasingly, decisions about individual children and young people are taking place in multi-agency and multi-disciplinary meetings or through multi agency discussions which include children and their parents/carers. One record of such a meeting/discussion should be produced which can then be copied to all attendees including the young person and family. In this way, there is a clear and consistent record of decisions made and actions agreed which can be included in each agency's records.

Standard 20: Case records evidence monitoring/auditing by managers

What this means in practice

Case records are the key source of evidence for the decisions made by both practitioners and agencies. As such they have become increasingly important measures of accountability and organisational and personal effectiveness. Managers should accord recording a high priority and undertake regular monitoring and auditing of case records (See Appendix for an audit tool) to ensure practice is consistently of a sufficiently high standard across the agency or service. A record of such quality assurance activity should be maintained on the file. Managers also contribute to records through recording or approving decisions and recording supervision discussions.

APPENDIX: Case Recording Audit Tool: Multi-agency Standards

AGENCY:		**CASE FILE REF NO/INITIALS:**	
AUDITED BY:		**DESIGNATION:**	
DATE:			

QUALITY STANDARD	**GUIDANCE NOTES**	**EVIDENCED Y/N**	**ACTION REQUIRED**	**ACTION COMPLETED (DATE AND INITIALS)**
1. There is a separate case record for each service user	The child/young person has their own file or, exceptionally, a separate section in a family file.			
2. The content of the case record reflects professional practice	Records give an overall account of the work undertaken, why it was undertaken, review of progress towards achieving improved and the outcomes.			
3. Records are legible and use plain language rather than jargon	Records are clearly written in black ink, typed or recorded electronically. Use of professional jargon is avoided and language is kept simple.			
4. Recording is child/young person focused	The file tells the story of the child and not the story of services or parents.			
5. Records clearly identify the outcomes or results to be achieved for the child/young person	Recording clearly identifies and is consistently focused on the outcomes or results to be achieved with specified timescales.			

QUALITY STANDARD	GUIDANCE NOTES	EVIDENCED Y/N	ACTION REQUIRED	ACTION COMPLETED (DATE AND INITIALS)
6. Recording distinguishes between fact and opinion	There is a clear line drawn between fact and opinion. Where opinion is recorded, reference is made to the evidence that leads to this view.			
7. There is cross referencing and signposting to other records on the child/young person	The file contains of record of other files held on the child/young person within the organisation and their location.			
8. Case records show when information has been shared.	There is a record of when, with whom and how information has been shared including with children and their families. This can be further evidenced by recipients' signatures.			
9. Records are up to date within 10 working days of the contact / discussion / meeting	This is a minimum standard for all recording. The agency may require practitioners to comply with shorter timescales.			
10. The case record includes an updated chronology and/or summary	There is a chronology of major and significant events in the child's life including achievement of outcomes. This should reflect multi-agency involvement. The file should evidence completion of regular case summaries which reflect on progress, achievements and challenges during the period.			
11. Records include an assessment of risk	The file should include assessment of risk to the child/young person and to practitioners. There should be a record of how these risks will be managed with regular reviews.			

QUALITY STANDARD	GUIDANCE NOTES	EVIDENCED Y/N	ACTION REQUIRED	ACTION COMPLETED (DATE AND INITIALS)
12. Records demonstrate commitment to the principles of equality and valuing diversity	The case file should accurate information about gender, nationality, race, culture, language, religion, disability and health conditions. Recording should provide evidence that the practitioner is working with diversity sensitively and none judgementally.			
13. Records provide details about the achievement of outcomes/results against the ECM outcomes as part of a review of progress and before the case is closed	The file provides evidence of the evaluation of the impact of services and interventions and what has changed for the child/young person. There should be clear referencing to the 5 ECM outcomes. This should be the focus for every review of the case. The case should not be closed without a record of such an evaluation.			
14. Other professionals and practitioners supporting the child/young person and family are referred to in the records by name, profession/ designation and agency	The file should give a full picture of each agency working with the child to achieve improved outcomes collaboratively. The respective practitioner contact details are clearly recorded.			
15. Records are respectful of children, young people and their families	The file should be securely bound and well presented. Names should be spelled consistently, dates of birth recorded accurately throughout the file. There should be an avoidance of oppressive and discriminatory statements and			

QUALITY STANDARD	GUIDANCE NOTES	EVIDENCED Y/N	ACTION REQUIRED	ACTION COMPLETED (DATE AND INITIALS)
	unsubstantiated opinions. Recording is understandable and the file is accessible to the child/young person.			
16. There is a record of children's and parents/carer' views	Children's views should be clearly evidenced in the file in their own words. Where different tools have been used to help them express their views, their use should be explained. Children's own recording is included. Parents' and carers' views are clearly evident throughout the file.			
17. The case record identifies whether the child/young person is subject to child protection registration and/or is looked after by the local authority	It is immediately evident from the file whether the child is on the CP register or looked after.			
18. It is clear whether the case is active or closed	It is clear from the file whether the child is currently receiving a service or intervention from the agency or the case has been closed, the intervention has ceased and the date it ceased.			
19. There is one record of any multi-agency meetings about a child/young person or family	The file should provide evidence of collaborative working through records of multi-agency meetings and discussions. It is clear that there is only one record of such meetings which have been shared with each involved agency.			

QUALITY STANDARD	GUIDANCE NOTES	EVIDENCED Y/N	ACTION REQUIRED	ACTION COMPLETED (DATE AND INITIALS)
20. Case records evidence monitoring / auditing by managers	It is clear that managers are monitoring and auditing the file and recording, and improvement actions have been identified and acted upon.			