

# Guidelines on Recording in Children's Residential Care



An Bord Comhairleach um Achtanna na Leanaí  
Children Acts Advisory Board

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## Foreword



These guidelines are being published by the Children Acts Advisory Board (CAAB) in association with the Health Information and Quality Authority Social Services Inspectorate. The main focus is to promote positive child care practice that will assist residential staff in both collating and recording relevant and timely information on children and young people placed in the care of the Health Service Executive. The recording in residential centres of information in the children and young person's 'care file' requires a varied set of skills allied with good overall written communication.

The *National Standards for Children's Residential Centres, 2001* state that every young person in care should have a permanent, private and secure record of his/her history and progress that contains all case file documentation and is maintained by the supervising social worker. The *Child Care (Placement of Children in Residential Care) Regulations 1995, Part IV, Article 22 (2)* specifies certain documents that should be included in the case file of the social worker.

In accordance with national standards, guidelines and legislation, children and young people should have reasonable access to their records. The process of accessing those records is less likely to be negative for the child or young person if the quality of information recorded and the method of facilitating access to those records is both readable and of a high recording standard.

The guidelines are also intended to support residential staff in their recording duties by explaining its context and purpose, and providing some guiding principles and pointers for best practice.

A handwritten signature in black ink, appearing to read 'Aidan Browne', written in a cursive style.

**Aidan Browne**  
**Chief Executive**  
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## Background

In the course of carrying out inspections of children's residential centres, the Social Services Inspectorate (SSI) observed shortcomings in policies and practice in relation to the gathering, recording and keeping of information about children and young people. These guidelines, whilst not intended to be definitive, are provided by the SSI to assist the Health Service Executive, and other providers of children's residential services, to help them address this issue by advising on good practice, legislation and international convention. They are intended to form a discussion paper, to encourage debate and action, and to promote quality in care practice. The guidelines are also intended to support staff in their recording duties by explaining its context and purpose, and providing some guiding principles and pointers for best practice.

These guidelines apply to all children subject to the provision of the Child Care Act, 1991 and the Children Act, 2001 and their subsequent amendments. The guidelines apply in settings for all children placed in statutory and non-statutory services, in foster care, residential centres, high support units, special care units and detention schools, and those who have been placed in hostels, are accessing homeless services and/or are the subject of special arrangements co-ordinated and organised by statutory bodies. These guidelines also should be applied to centres for children with disabilities living away from home. Although practice may vary, the principles of recording apply equally for a child or young person placed in a children detention school as for a child in an HSE residential centre or any other setting in which he/she is being cared for away from home.



## Why do we need ‘recording’?

Recording is an important part of the provision of care in a residential setting. It is a complex task requiring good understanding and judgement, empathy, sensitivity, and good written communication skills. It should provide an accessible well-organised account of the life of a young person in care both in terms of his/her experience of it, and in terms of the decisions and actions taken by those who provide it. Its complexity is reflected in the wide range of forms to be completed, log books to maintain and reports to file; and the requirements of the task can be seen as daunting by staff given other demands on their time and the primacy of their role in providing care and responding to children and young people with a wide range of needs.

The *National Standards for Children’s Residential Centres, 2001* state that every young person in care should have a permanent, private and secure record of his/her history and progress that contains all documentation and is maintained by the supervising social worker. This is known as the ‘case file’, and is normally held in the supervising social worker’s office. The *Child Care (Placement of Children in Residential Care) Regulations 1995, Part IV, Article 22 (2)* specifies certain documents that should be included in the case file such as: a medical report, a copy of the court order relating to the child, a birth certificate, school progress reports, a copy of the care plan, a note of every visit, a note of every review, and a note of every significant event affecting the child.

The file maintained by the residential centre is called a ‘care file’. The standards require care files to

have a copy of a birth certificate, the court order relevant to the child or a copy of parental consent to the child being in care, a written copy of the statutory care plan and note of each review, background information provided by the supervising social worker, a clear and complete record of all medical and health information from birth, and a record of all medication administered to the child. Other records required by the standards include: details of complaints and their resolution, separate records of sanctions and the use of physical restraint, evidence that care planning decisions have been acted upon, and notifications of significant events such as unauthorised absences.

Case and care files contain records concerning individuals. Whilst they are mostly in traditional printed form, they could also consist of other media such as audio recordings, reports on computer disks, or for example, videos and artwork produced within a therapeutic context. Residential centres also have other records necessary for the management and administration of day-to-day life. These include central records such as appointment diaries, message or communication books, minutes of team and residents’ group meetings, the centre’s register, and records that the standards require in a separate format, such as sanctions. Administrative records include those to do with personnel, supervision of staff, deployment of staff, budgetary management, fire safety, property and vehicle maintenance, and other ‘housekeeping’ features such as menus, food shopping, utility bills, and petty cash.



## The Purposes and Functions of Recording in Residential Care

The purposes of recording in residential care are:  
(*The five 'A's*)

- As a permanent record of a child's life and development while in care – **archive**;
- As a tool for staff in carrying out their role – **advancing** the plan;
- To support continuity & cohesion in interventions over time – **adhering** to the plan;
- To provide evidence of progress – **achieving** the plan;
- To evidence the care provided by the centre – **accountability**.

The functions of recording are as follows:

- It charts events and incidents, positive and negative, as a systematic account of relevant activities associated with each child;
- It charts communications and interactions between the child and staff;
- It charts communications between the centre and others involved in the care of the child;
- It charts changes and patterns in behaviours;
- It charts decisions made by staff and others and the resulting interventions;
- It charts the views and agreements that underpin decisions;
- It supports and facilitates communication;
- It supports the co-ordination of multi-disciplinary interventions and partnership;
- It provides evidence of the process and procedures undertaken;
- It is an account of a carer's performance and is thereby a safeguard; and
- It provides a basis for preparing reports for reviews, case conferences and court proceedings.



## Management and Monitoring of Care Records

The *National Standards for Children's Residential Centres, 2001* require recording systems:

- to be organised and maintained to facilitate effective management and accountability;
- to support care planning;
- to maintain appropriate levels of privacy and confidentiality about young people's circumstances;
- to provide evidence that young people's views were sought and recorded;
- to be written in a style defined by the centre whereby information is clearly expressed and free from colloquialisms and stereotypes; and
- to be kept in perpetuity.

### Centre Practice:

- The centre's statement of purpose and function should include a statement that the centre actively promotes a child's or young person's right of access to records.
- Social workers making referrals to the centre should be required to identify confidential information clearly so that centre staff know that access to it is restricted. They should provide a written record of the reason for restricting access.
- The management of recording:
  - Managers provide written policy and procedural guidelines on the manner in which individual confidential records on children in centres are maintained.
  - The procedures should include guidance about the use of electronic recording systems.
  - The guidelines take due account of the need

for the record to be well-ordered and permanent.

- Guidance statements address the content, required style and linguistic standards of written entries.
- Managers provide written policy and procedural guidance on the child or young person's access to his/her records.
- Mechanisms exist for line managers to monitor standards of individual care records and the way confidentiality and security are maintained.
- There are clear arrangements for integrating information on individual files held in children's centres with case files held by social workers.
- Files are durable, and papers are partitioned in a way that is orderly and allows for ease of reference.
- Files allow for certificates, photographs and other memorabilia belonging to the child or young person to be kept safely.
- Individual records are kept in a secure cabinet in a secure part of the centre.
- Information in the individual records conforms, as far as practicable, to the requirements of the regulations.
- Information required by regulation is easily accessed, and care planning and review can be easily tracked.
- Entries to the records are respectful, non-discriminatory and non-stigmatising.
- Managers ensure that the record is written in a style and to a standard that is clearly expressed, free from unnecessary colloquialisms and gratuitous value judgements.



- Papers that are confidential and would not be open to a child or young person's access are easily identifiable.
- Staff should be aware of the contents of the centre's policy and procedural guidance.
- Staff actively encourage children and young people to read their records, to correct errors and omissions, and record personal statements including any dissent the child or young person has with decisions which affect them.
- There is evidence in the records that children and young people use and contribute to them.

There is also a requirement that managers, social workers and monitoring officers ensure that records

are maintained to a high standard. Care records should:

- be regularly monitored by managers, to assist them in appraising the quality of care practice and maintaining the centre's ethos;
- be read from time to time by supervising social workers, to confirm that the placement is suitable, safe, and continues to meet the child or young person's needs;
- be available for scrutiny by monitoring officers and inspectors;
- contain evidence that they have been read by centre managers, social workers and monitoring officers.



## Children's Access to Records

Children should:

- have reasonable access to their records;
- understand the purpose and content of their record;
- make use of their care records by reading them and making personal contributions.

The *National Standards for Children's Residential Centres 2001* states that young people have access to information about their rights under the United Nations Convention on the Rights of the Child 1989 and under the Freedom of Information Acts.

The SSI has published separate guidelines on children's access to records which is available on the SSI section of the Health Information and Quality Authority (HIQA) website: [www.hiqa.ie](http://www.hiqa.ie)

Apart from having the right to it, children require access to information in order to understand why they are in care, to meaningfully participate in decisions affecting their lives, and to know what services are available to them. Since children have a right to understand their records it is important that they are made intelligible to them as far as possible. This has implications for the way in which records are written.

The facilitation of access to records should take into account the age and understanding of the child or young person. Sometimes this reason is used for facilitation not to take place, when in fact staff are concerned that children or young people could become upset by aspects of their history discovered through access to their records. This could certainly be true if the information accessed has been unknown to them, but it does not take away from them their right to know. How they are told about sensitive issues is a matter for careful planning and discussion over time with them rather than a moment of revelation when records are made accessible. Access to their files and daily log books on a daily or weekly basis as the records are being produced reduces the probability of children and young people becoming upset by information that has been kept from them. In providing access to information that was previously restricted staff should take into account the potential emotional impact of the information and ensure that suitable support is available. The right and its promotion should be the default position of the centre rather than attitudes or practices that provide reasons for unnecessarily restricting access or failing to facilitate it.



## The Legislative Background

The Freedom of Information Acts and Data Protection Acts constitute a legislative structure that provides some of the rules governing the recording, protecting and making accessible of personal information. The two major principles enshrined in the relevant legislation are that individuals have a statutory right to personal information about them that is held by public bodies, and that those who gather personal information have a duty to maintain accurate up-to-date records and protect the privacy of individuals, within limits defined by law.

### **Freedom of Information Acts 1997 & 2003**

These Acts describe the statutory rights of people to access to information kept by public bodies:

- Individuals and groups have a right to know the basis on which public bodies have made any decisions affecting them.
- Every person has a right to access personal records kept by public bodies. There is a presumption, under the Act, that people are entitled to know what is written about them.
- People are entitled to seek to have any public records held on them corrected, if these prove to be inaccurate or misleading.
- Every person has a right to obtain general information held by public bodies about their structure and organisation, what services they provide to the public, what types of records they keep, and what arrangements they have made to facilitate access to these and other information held.
- Public bodies are obliged to publish details of procedures, guidelines and practices that inform the decisions they make which may affect the entitlements of people using its services.
- There is a right of appeal to the independent Office of the Information Commissioner against refusal to provide information.

These statutory rights are qualified by the need to maintain “third party” rights to privacy and public interest immunity. In practice, in social care settings, a ‘third party’ is generally considered to be another individual referred to in a record or report. Guidance about third party requests for information can be found on the FOI website. The Act was amended in respect of some government information in 2003.

The following websites provide the full text of the Acts, as well as explanatory guides and answers to frequently asked questions in relation to the Acts: [www.foi.gov.ie](http://www.foi.gov.ie), [www.oic.gov.ie](http://www.oic.gov.ie)

### **The Data Protection Acts 1988 & 2003**

These Acts refer to the right of an individual to privacy in relation to personal data held about them and the duty of those who maintain personal information to protect its confidentiality.

1. The Acts apply regardless of the storage medium, whether the data is stored on your computer, on a laptop, on a floppy disk or in a manual filing system.
2. In the case of any court or judicial proceedings, the obligation to surrender records would supersede both the Freedom of Information and the Data Protection Acts.
3. Individuals can be identified by means other than just their name. In many cases their date of birth and location can be enough to identify them.
4. It is possible that the centre may be asked to provide an audit of personal information; therefore its records should show an audit trail of its information.
5. Individuals providing information, such as parents, should be made aware of the purposes for which information may be used, including any secondary uses.

The website of the Office of the Data Commissioner provides the full text to the Data Protection Acts as well as explanatory guides and sample scenarios: [www.dataprotection.ie](http://www.dataprotection.ie)



## Points for Practice

- Everything written in a child care record should be publicly defensible, - to the child, to parents, to those authorised to examine records, to other professionals with a bona fide interest in the case, and on some occasions to the courts.
- The highest levels of respect for the child, his/her parents and family should be evident in all records.
- Brief, frequent records that gradually build up a picture are preferable to lengthy but intermittent reports, (although sometimes the latter might be required).
- Headlining a report with a word or a phrase: 'Unauthorised Absence', 'Cancelled Access Visit', 'Health Concern', 'Reaction to Telephone Call', 'Visit from Siblings', 'Physical Restraint'.
- Intelligibility: Clear language, concise description, avoidance of value judgements, clear identification of the facts in the report.
- Separation of judgement from facts: It is reasonable to record an opinion or judgement so long as it is clearly identified as one, and is relevant to the matter being reported. Like all judgements it should have a clear link to evidence. A new paragraph starting: "It is my view that..." or "One explanation of today's events could be that..." would clearly signal a move from a record of facts to a record of opinion or judgement.

**Accessibility** should be a key feature of the recording system and the following can help:

*In general:*

- The purpose of keeping records should be clear.
- Content:
  - should be focused on the child's needs;
  - should give an indication about how the child and staff interact;
  - should represent the child's views and experience of care;
  - should show how problems have been tackled.
- The structure of files should feature:
  - Clear indexing and partitioning of files;
  - Chronological consistency;
  - Cross-referencing in order to avoid duplication.

*In particular:*

- The purpose of making each individual record should be clear.
- Setting a context: Date, time, members of staff on duty, child or young person's name, others involved. The roles of the people concerned should be clear.

An efficient cross-referencing system enables staff to write an account of an event concisely once and simply refer to it in other documents so that accessibility is facilitated at a future date. An example would be completing a notification form in order to inform a social worker of an unauthorised absence. The notification form would contain all the relevant detail including a list of the people notified in accordance with the standard. The child or young person's log book entry for that day would have a brief note indicating that an unauthorised absence took place and that details could be found in the completed notification form. There would be one account of the event, and unnecessary duplication would be avoided.

The guidelines to staff provided by the centre manager should include instruction about referring to other children or young people in an individual



child or young person's report. Where more than one child or young person has been involved in an incident it is necessary to report on their interaction, and reference to other parties cannot be avoided. It is sometimes argued that this raises questions regarding confidentiality and the right of children and young people referred to in reports to have access to them. It would make sense to use the names of all individuals involved rather than

mask their identity by use of initials. The basis for this is the fact that by being involved they already know the identities of those they have interacted with and an account of the incident will reflect this. As an additional safeguard the same account should be used to describe the incident in each child or young person's record, and where appropriate, each person involved should see the final record.



## Planning for Children and Young People

Care plans should be written so that the issues under consideration and the views of all relevant parties, along with the decisions which follow from them and agreements about them, are clearly recorded and defined.

They should be signed with a clear signature (rather than initialled), and dated so that the agreements

and decisions can be owned by all the relevant parties.

Written care plans and care plan reviews should show the factors that influenced decisions, and indicate whether they were inclusive of all relevant parties. They should provide a means of tracking the care 'career path' of an individual child or young person.

## Writing a Daily Log, a Report for a Review, a Conference or for Court

- All such written reports are expected to be informative, accurate and concise. The account should be based on facts, and these facts should be presented in an accurate manner.
- The writer must be concise and clear in what he/she sets out to convey and must be able to support, with accurate evidence, what has been documented.
- Entries in log books should be legible, concise and focused on outcomes for the child or young person.
- Record as soon as is reasonably practicable after a significant event or shift as accuracy is diminished after a period of time. Keep in mind that your immediate priority is to look after the children and young people in your care.
- By signing your report or entry you take professional responsibility for it.
- Reports and entries in log books should be contemporary, complete, relevant, signed and dated.



## ‘Rules of Thumb’ for Report Writing

1. Know the purpose of your report.
2. Lay out the information appropriately.
3. Write your report in a style that is easy to read:
  - Ensure that your report is professional.
  - Ensure that your report is informative.
  - Ensure that your report is concise and to the point.
  - Ensure that your report is focused and clear.
  - Ensure that your report is balanced and fair.
  - Ensure that spellings, punctuation and grammar are correct.
  - Include dates and, where appropriate, times of relevant events and incidents.
4. Avoid ambiguity.
5. Ensure that you distinguish fact from opinion clearly.
6. Your opinion should be professional, value-free and supported by evidence.
7. Sign and date everything you write and state your position or title.

## General Points to Remember

- Recording is an intrinsic part of the professional role of staff in residential settings.
- Recording is the key element to good child care practice. Children and young people in care are entitled to a high quality of administration and accountability in terms of how personal information about them is gathered, kept and used.
- All records should be legible; and short, simple sentences in a style that is easy to read are best.
- Reports should be complete. If for some reason the report is not completed on the day in question this should be indicated in the report.
- Where appropriate, and more rather than less frequently, children and young people should be supported by key members of staff to read their records – both log books and files. It is hoped that they gain useful insight from reading these accounts of their lives. This can best be achieved when the records are written with sensitivity from a position of respect and unconditional positive regard and include the positive aspects of their circumstances and behaviour as well as the difficulties in their lives.



