Reporting and other care work writing

Part of the Learning through Work series
How many of these do you write in your job?

- Care plan notes, weight charts, fluid balance sheets, medication records
- Handover notes, communications book entries, phone messages
- Incident reports
- Signs, notices
- Emails, letters
- Rota sheets, holiday requests, time sheets, mileage claims

What other things do you write at work?

**Why so much writing?**

We do three types of writing at work:

- Record-keeping and reporting of direct care
- Messages for colleagues
- Admin for our employer

It all has one basic purpose: to **improve the quality of care**.
Learning question
What would happen at work if no one wrote anything down?

Learn more
With a colleague, list the records and reports that you write in your job. Decide with your colleague why each one is needed then see if your manager agrees.
Our records often contain personal information about the people we care for.

The law says that we must treat personal information as confidential.

It can only be shared with permission.

That is why every care organisation has a policy on confidentiality, including how to report confidential information.

Did you know?
Data Protection Act (1998) sets out strict guidelines for the collection, use and safe storage of personal information. It gives people the right to see any personal information others hold on them.

Freedom of Information Act (2001) gives people the right to see the information that organisations hold, including what is in their own records.
Understanding principles and practices relating to confidentiality is part of the Common Induction Standards (CIS 3.4).

Learn more
Ask your manager what your organisation’s policy is on confidentiality for written information.
We need to be careful to write **factually** when we are writing about people’s **behaviour**.

**What is behaviour?**

Behaviour is what a person **does** and **says**.

When we are with another person, we naturally think about four things:

1. What is this person doing/saying?
2. Why are they doing/saying that?
3. How does it affect me?
4. What do I feel about that?

Question 1 is about **behaviour**. This is what we should report – what we **see** and **hear** the person **doing** and **saying**. It definitely happened. It is **factual information**.

Question 2 is about what the person’s behaviour **means**. Unless we actually ask the person, we cannot be sure about this.
If we do ask the person, we can report what they say and make it clear that we are reporting what they told us – but that is all. If you have not asked the person, don’t try to explain their behaviour in your report.

Questions 3 and 4 are about us, not the person. How relevant do you think they are?

We write reports to help the care partners plan the person’s care.

Our feelings are important, but they do not belong in a factual report about the person. Feelings can lead to bias, e.g. writing that the person was difficult or challenging. This is unhelpful to the care partners and may be offensive to the person.

**Good to talk**

Care work is stressful. Talking to colleagues about your feelings can help relieve stress.
Care plan notes

Care plan notes are about the **person**, not about us. They explain how the care we give helps the person to live as independently as possible.

**Do not write:**

*Everything done* or *All tasks completed*

or *All care given as planned.*

Why not? Notes like that say only that the **care worker** has completed some tasks.

They give **no** useful information about the **person** at all.

**Do not write** that the person was:

*a pain* or *naughty* or *aggressive* or *unhelpful*

or *easy* or *a sweetheart* or *lovely*.

Such comments say only what the **care worker** felt about the contact.

They give **no** useful information about the **person** at all. Do you agree?
Report the right things, in enough detail

Not enough detail: Assisted to wash/dress

Enough detail: Jean washed her face. Jean said her right arm was stiff and asked me to wash her top half. She washed her bottom half. I helped her to get dressed (all items) and combed her hair.

What if there is a problem to report?

Make a note of any problems or conflicts (e.g. the person declined to take their medicine). Write what the person said and did, what you said and did – and why. Note how the matter was left.

Did you know?

Care plan notes can protect you. Imagine the person complains to their family about a ‘freezing cold’ bath you gave them. You can point to your notes showing the bath temperature was normal.
We write accident / incident reports to:

- Inform others
- Raise safety issues
- Learn from any mistakes
- Improve the quality of our service
- Check the facts if a complaint is made

What to write

- Name of those directly involved
- Date, time, place of the accident/incident
- Name of those who saw what happened
- Short, accurate, **factual** description stating what happened in the order it happened
- Any hazards present (e.g. *the floor was wet*)
- Any action taken afterwards (e.g. *nurse Jones examined Mrs Smith*)
What not to write

- Don’t explain why it happened (e.g. don’t write *she fell because the floor was wet*)
- Never blame anyone (e.g. do not say *it was the cleaner’s fault for leaving the floor wet*)

Learning question

Why should you write only what you actually saw happen?

Useful terms

**Accident** = event causing harm, loss or damage to people in care, visitors or workers.

**Incident** = anything unusual that happens to people in care, visitors or workers – including a near miss, odd behaviour and conflict.

**Near miss** = event that could have caused harm, loss or damage, but (luckily) did not.
1. What is the basic purpose of all the writing we do at work?

2. How does writing help the care partners?

3. Why is it a good idea to write reports as soon as possible?

4. Who reads what we write at work?

5. What would you say to a relative who asked to see a person’s care plan?

6. Why do the care partners want factual information?

7. What does behaviour mean?

8. How does a fact differ from an assumption?

9. How does a fact differ from a comment?

10. What is wrong with this report? Mrs Peters only ate a little b/fast.
11. What should we record in a care plan note?

12. What is wrong with just writing *All tasks completed* in a care plan note?

13. What information goes in a message?

14. What should you know about the forms and charts you complete?

15. In an accident report always say why the accident happened (if you know) - true or false?

16. Are proper sentences needed in an email?

17. What does it mean to *proof read* a letter?

18. What do risk assessments help us do?

The information you need to answer these (and many more) questions is in this booklet.*

**Bonus Q!** What does *whisky echo lima lima delta oscar november echo* spell? (See last page)

*For answer 1, see page 1. See page 2 for answer 2 and so on.*