BEYOND LIMITS
Beyond the limits of conventional support

# Record and Report Writing Policy

**The policy clarifies our duty to ensure that we maintain secure and accurate records in respect of each person who receives support. This includes reports that are written about any person who receives support.**

**February 2025**

**Review: February 2026**

## INTRODUCTION

As part of Beyond Limits registration with the Care Quality Commission (CQC) and the overall regulations, we are required to '*maintain securely, an accurate, complete and contemporaneous record in respect of each person we support*'. This includes a record of the care and treatment provided to the person and decisions taken in relation to the care and treatment provided. Records and reports that relate to a person who receives support from Beyond Limits must be of a good standard and kept confidential.

This policy provides a framework which offers guidance to all Beyond Limits employees. It has been designed to give all colleagues a clearer understanding of the types of reports we write, why we write them and how to write them in line with the regulations and best practice.

All employees will be required to write reports and keep records as part of their role.

The CQC will examine care provider records as part of an overall inspection or as part of a detailed investigation. Records such as daily notes, together with risk/safety assessments, accident reports, food and fluid and medication records will also likely be requested.

These types of records provide inspection bodies with an overview of the service and allows regulators to gain an insight into the care and support provided.

Records and reports are the communication of information, advice, or action from one person or a group of people, to another for a specific purpose. Often the ultimate function of a record is to provide a basis for decisions and action. Records are usually in the written format but can also be emails, forms, videos etc. As we move to more electronic ways of recording information, we must employ due diligence in respect of who we share these records with and protect confidentiality at all times. Importantly, all staff should ensure that:

- All care records are accurate, honest, and comprehensive
- They are familiar with the recording system used
- All records are updated with any new information in a timely way

Importantly any gaps in records can cast doubt on the integrity of the whole record. All staff should ensure that the records they produce contain all the necessary information.

## WHY IT IS IMPORTANT TO KEEP ACCURATE RECORDS

As a regulated provider, Beyond Limits will be subject to scrutiny around the accuracy and quality of the records we keep. It is very important that the records we keep are up to date, complete, accurate and legible, this is because:

- Your notes could be read out in a court of law
- Whatever you write and record you may be called on to explain the rationale behind it
- A court of law would assume that if care and support is not documented, then it has not been provided
- If records are of a poor standard, courts may see that as a reflection of the care being given
- The better your report writing and record keeping, the less likely it is that you will need to justify and explain them.

## WHAT TO DO IF YOU NEED HELP

If you have difficulty reading, writing, or using computers, you should ask for help or support. It is very important that you keep records about the support you provide for the following reasons:

- So we can identify risks quickly and put in controls to safeguard the person who receives support
- So we can identify where a person's needs have changed and update our support accordingly
- So we can identify where a person is gaining skills and reduce the support they receive accordingly
- So we can monitor the quality of support provided to people we support

- To show that you have followed the policies and procedures appropriately
- To show that you have understood your duty of care
- To show that you have followed the person's Working Policy
- So that the team work consistently and in accordance with the Working Policy
- To demonstrate that proper and considered decisions have been made about the way we support a person

REMEMBER: In a court of law, if it hasn't been written down and recorded appropriately, then it hasn't taken place.

## STANDARDS OF RECORD KEEPING

Beyond Limits expects the following hight standards of records from all of its employees:

- To be factual and in chronological order
- To be respectful and non-discriminatory. The use of offensive language, jargon or subjective statements must not form part of any records
- Records should be made as soon after an event as is possible
- All records must be dated and signed, to identify who wrote it and when
- All records must be legible, mistakes should be rectified and signed by the person responsible for the record
- The use of correctional fluid (Tippex) must not be used
- Wherever possible records should be accessible to the person being supported (in language and using terms they will understand)
- You must NEVER tear pages out from a bound book or document, even if they are blank
- DO NOT delete, erase, alter or destroy ANY record unless you have been authorised to do so

## GUIDANCE ON GOOD REPORT WRITING AND RECORD KEEPING

Everything that we record and document as part of our work should be written with the answers to the following questions in mind:

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| **WHO** | • **Are you writing for?**<br>• **Are you writing about?**<br>• **Is likely to read your reports?** |

When you write any report about a person who receives support, you need to consider 'who' you are writing for. Your colleagues, other staff members, external professionals, families, lawyers, inspectors and regulators may all have access to reports and will be looking for different information. In many instances there will be specific forms or documents to do this.

- **Person we support:** Recording a person's wishes/choices and needs. A daily record of a person's life, goals/rehabilitation targets for them.
- **Medical professionals:** Providing evidence for the use of medication/treatment decisions. Monitoring recognised behaviour/mood/levels of anxiety.
- **Commissioners:** Are allocated hours of support being used? Are targets/outcomes being met? Is the person achieving their hopes and dreams? Are they being treated with respect and dignity.
- **Family/Friends:** A true record of the individual's journey within our services. Is the family kept up to date with the support the person is receiving and in line with their wishes.
- **Organisation:** Outcome focused support plans. Evidence of learning from experience. Preparing reports for key decision makers.

Other people may request access to records but should only do so after permission has been granted. This would normally be via a Director or Senior Service Leader and may also require consent from the person supported.

Please follow the Data Protection Policy for guidance on this.

It is also important to consider the Goal, Audience and Structure of a report or document.

- **Goal:** What is the aim of the report? What is the context of the report? What are we trying to achieve?
- **Audience:** Who has asked for the report and why? What does the audience already know about the person or situation?
- **Structure:** Is there a set format that needs to be completed? What are the main events/points that need to be covered? Should the report be written in a formal language or in the first or third person?

**Who is the report written for? Remember that the people we support, their family, staff and/or other professionals may not understand some of the terminology you us in everyday**

You should also note that people we support have a lot of information written about them and this information tends to follow them around, despite the relevance of this at times. Everything that we record, and document should be done with the "what" in mind.

| WHAT | • Do we need to record?<br>• Is the purpose of the record?<br>• Do we not need to record? |
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The following is a summary of the most common types of reports you will be expected to complete within your role at Beyond Limits. Please note, this is not an exhaustive list.

- **Daily Notes, Handover Notes, Staff Communication Records and Emails:** It can also include things like the minutes from meetings and any other correspondence around the person being supported, their support team, family, other staff and professionals
- **Health and Safety Checks:** Documentation such as fire safety checks, temperature logs, accident and incident reports and safety assessments etc.

- **Finances:** All staff will have responsibilities for finances, and you will need to document all transactions made with support money, complete weekly checks, and handle money. You may also have additional responsibilities with personal finances.
- **Medication:** If the person you support takes medication, you may have responsibilities to help them manage this. You may need to record when a person took their medication, maintain a list of their medication, audit the medication in a weekly check and record any medical appointments they may attend. You may also need to record the use of PRN (Pro Re Nata) as and when medication.
- **Monitoring charts:** For food/fluid intake, sleep, bowel movements etc. This would typically follow an assessment been completed to establish a need to monitor such things.

Each person supported has a Health and Safety, Finance and Medication Folder that contains various forms and reports you will need to complete on a regular basis. You should make sure you familiarise yourself with these. There are separate policies and procedures for each of these areas and again, you should familiarise yourself with these. The person's Working Policy will also provide you with precise details on your exact responsibilities.

**When you complete and Accident or Incident report you need to make sure you not only give clear information about what led up to event occurring, but also how you managed the situation. This can then be used by others as a learning experience to help prevent it happening again.**

When writing a report or record it is important that you always bear in mind WHY you are recording this specific information.

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| WHY | • Are we writing this report?<br>• Do we need this report?<br>• Is it important? |

Record keeping and documents are recorded to ensure that legal requirements are met and necessary standards are reached and maintained. A good record can clarify decisions, provide understanding and rationale to support plans, as well as helping to evidence what level of intervention/interaction is working and what may not be working. We need reports so that we can accurately review evidence and support choices, decisions, standards of care, education and the overall provision of care and support

**There should be a purpose to what you put in your report; it should not be a list of everything you know but it should demonstrate the factual information and evidence that you have observed including your actions or omissions and your reasoning behind them.**

Any report must contain relevant information about the person supported at any given time and the measures you have taken to respond to their needs. Evidence should be given that you have understood and honoured your duty of care and that you have taken all reasonable steps to support the person. Any actions or omissions on your part must not compromise the safety of the people we support in any way.

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| HOW | • Do we know what to record?<br>• Do we record fairly and accurately?<br>• Do we present our report? |

Any unexpected events that occur in the person's day must be recorded or any visits that the person may have from other members of the community team (e.g. GP, dietician, chiropodist etc.) or family members and a record of how the person responded to such visits should also be noted.

Reports should always be factual, consistent, accurate and a true account of what has happened. They must not be written in a subjective or judgemental style. The report should focus on what the person providing care has observed, what was done, and how the person responded.

- **Subjective** means it is based on or influenced by personal feelings, tasted or opinions rather than facts.
- **Judgmental** describes someone who forms opinions without reason, usually harsh or critical ones, about people.
- **Objective** means it is not influenced by personal feelings or opinions in considering and representing facts.
- **Do not include abbreviations and jargon.** Professional language should be simple and direct. Check the language you use will be clearly understood by those who are reading it (i.e. other support staff, staff for whom English is a second language, inspectors, or other people outside of the organisation)
- **Do not use meaningless phrases like "slept well" or "had a good day".** Better to say, *"Mr Smith slept for 8 hours, getting out of bed only once to use the toilet"* or *"Mr Smith spent a quiet day not wishing to interact with others, but enjoyed a visit from his friend who called this afternoon"*. This is being **objective** stating exactly what happened rather than being **subjective** by saying why you believe someone slept well or what he or she did during the day to make you believe it was enjoyable for them.
- **Do not make offensive, subjective statements,** such as "sweet old lady, pleasantly confused".
- **Do not predict outcomes or make a diagnosis when recording,** this may be inaccurate or misleading to other members of the team.
- **Rather than label someone confused, it is better to describe the actions** the person is doing which leads you to believe they are confused.

Quality of records and communications with all external parties/stakeholders is a direct measure of the service we provide.

- Failure to record accurate information can have serious consequences. We need to ensure that the people we support are treated effectively and appropriately
- It can provide an objective record of the care the person received that can be used in court or in the event of a complaint
- It can provide a record for the person of their time in the service
- It can contribute to the development, implementation, and review of the plan for the person
- A good record can identify and support staff to respond to a person's needs
- It can help to recognise and establish patterns in the person's life and/or behaviour
- It can support the provision of consistent, high-quality care

- It can demonstrate that the service meets regulatory requirements.

Although for professional reports it may be necessary to use technical language, the extent to which we do this will depend on the audience. Slang and colloquial terms should always be avoided, unless it is a direct quote from an individual which is clearly indicated. Acronyms should always be spelt out in full the first time they are used in a report. For example: Care Quality Commission (CQC).

**A professional report should give the reader EASY access to a logical evidence-based account of the issue in question. Start with the facts, which can then be analysed to form any recommendations. This order helps to make things within the report flow naturally.**

All reports and documents are reviewed as part of our audit process. As a minimum standard an audit of the service is carried out every quarter (4 audits per year) although random spot checks may happen at any time. This process supports the organisation to identify areas for any training that may be required and also evidences our compliance with regulatory standards.

## DATA RETENTION

We are legally required to keep certain records for a certain period of time:

- Risk assessments: **Archive only when a new assessment replaces it**
- Record of purchase of medical devices and medical equipment: **18 months**
- Operational policies and procedures (current and previous version): **3 years**
- Incident, events, or occurrences reported to CQC: **3 years**
- Logbook of housing related maintenance requests: **3 years**
- Maintenance of equipment: **3 years**
- Electrical testing: **3 years**
- Fire safety: **3 years**

- Medical gas safety, storage, and transport: **3 years**
- Water safety: **3 years**
- Staff employment: **3 years after last entry**
- Duty rotas: **4 years after the year they relate to**
- Purchase of medical devices and equipment: **11 years**
- Final annual accounts: **30 years**

## REPORTABLE INCIDENTS

Certain **incidents** are reportable to CQC and must be done so within **24hours** of the incident occurring. There is an electronic form which must be completed.
https://www.cqc.org.uk/guidance-providers/notifications/notification-finder

Incidents must be reported immediately to your line manager. It is the responsibility of the Registered Manager or Director to complete and send a CQC notification via the portal (keeping a copy in the file of the person we support it relates to).

These incidents are:

- Serious injuries to a person we support resulting in an impairment of the sensory, motor, or intellectual functions which is not likely to be temporary (head, sight, or hearing injuries)
- Serious changes to the structure of a person we supports' body (breaks to bones, trauma to the body)
- A person we support experiencing serious prolonged pain or psychological harm (a break-down, on-going pain)
- The shortening of life expectancy of a person we support (identification of serious illness)
- Incidents that have required treatment to prevent death
- Injuries that if not treated may result in one of the above
- Applications to deprive a person we support of their liberty
- Incidents reported to or investigated by the police including a person going missing, assault or malicious damage, theft of property or money belonging to a person we support.

- Allegations of abuse
- Events that appear or threaten to prevent Beyond Limits continuing to be able to carry out their regulated activities including insufficient number of suitably qualified and skilled staff
- An interruption of the supply of electricity, gas, water, or sewage to the premises of the organisation lasting for a continuous period more than 24 hours
- Physical damage to the organisational premises which is likely to have a detrimental effect on the provision of services to the people we support
- Failure of fire alarms or other safety devices owned or used by Beyond Limits where this might have an effect of the support of a person lasting for a continuous period more than 24 hours.

The death of a person we support must be reported to CQC and must be done within 24 hours of the death occurring. It is the responsibility of the Registered Manager and/or a Director to complete and send a notification to CQC. (A copy of this notification must be kept in the file of the person who has died).

## NOTIFICATION TO CARE QUALITY COMMISSION OF CHANGES

Changes to the management and people in day-to-day charge of Beyond Limits business must be reported to CQC.

- If the registered manager is likely to be absent from work for more than 28days continuously notice must be given to CQC unless it is an emergency change then it must be within **5 working days.** The notification must include the expected length of absence, the reason, arrangement to cover their role, name and address and qualifications of the person who will be covering the absence, any proposed date for reappointment if it is unlikely the registered will return.
- Notification to CQC must be, where possible **28 days** before the absence starts
- Changes to the details of the service or changes to how the partnership of Beyond Limits **as soon as possible**
- Change to registered manager **as soon as possible**

- Changes to location or name or business address, or director or nominated individuals

## REPORTING TO COMMISSIONERS (LOCAL AUTHORITY AND CLINICAL COMMISSIONING GROUPS)

Certain **incidents** are reportable to Commissioners and must be done so within **24 hours** of the incident occurring. Incidents must be reported immediately to your line manager. It is the responsibility of the team leader, service leaders and/or a Director to complete and send to the Commissioners (or Plymouth City Council) an incident form (keeping a copy in the file of the person we support it relates to).

Incidents include:

- Death of a person we support
- Reportable incidents of abuse
- Reportable incidents relating to Health and Safety

If you are in any doubt about whether or not you should report something, please discuss with your line manager.

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