RECORDING EVIDENCE BASED PRACTICE

The Safeguarding Framework

Why is recording evidenced based practice important and how does it relates to adult safeguarding?

- Adult safeguarding from the outset has paid attention to effective practice but also for effective case recording and statistical monitoring of practice outcomes.

- Social workers and relevant staff are required not simply to maintain accurate case records but to do so in such a way the information can be used for monitoring data.
- Better monitoring of data should enhance the understanding of risk and provide evidence of what works in adult safeguarding, but should also lend itself to inform management decisions such as resource allocation.

Why do we need to record keep?

- Accurate and up to date record keeping is essential for a number of reasons.
- It can help identify welfare concerns at an early stage
- It can help teams identify patterns of concerns/ abuse.
- It can help practitioners and managers to manage safeguarding practices including decision making, action taken and joint strategies with other agencies
- It can provide evidence to support professional challenge, both within internal teams and working with external agencies.
- It can support agencies to demonstrate actions to reduce impact of harm to an adult at risk.

Recording keeping

- It helps to evidence robust and effective safeguarding practice in inspections and audits.

The Care Act 2014 – a new framework for adult safeguarding

- The Act places new duties and responsibilities on local authorities about care and support for adults, and adult safeguarding.
- The Act uses the phrases ‘ adults at risk’ and adults with needs for care and support’ rather than vulnerable adults.
- The new statutory framework clarifies and enhances the duties, roles and responsibilities of local authorities and their partners. It strengthens the multi-agency strategic and collaborative approach to adult safeguarding and is not simply a continuation of business as usual.

Key adult safeguarding principles

- Empowerment- support for individuals to make their own decisions.
- Proportionality – the least intrusive or restrictive intervention appropriate to the risks presented.
- Protection – supporting those in need as a result of abuse or neglect
- Partnership- working across services and communities to prevent, detect and report neglect and abuse.
- Accountability – enabling service users and leaders to challenge agencies for their responses to those at risk of harm.
- Prevention – taking action before harm occurs or risk escalates.

Safeguarding Adult Reviews (SARS)

- The Care Act 2014 placed a duty on Safeguarding Adults Boards to carry out and publish in annual reports the conclusions and recommendations of SARs where serious abuse or neglect has contributed to the death or serious harm of an individual, and where there is concern about how professionals and agencies have worked together,
- The purpose of any review is to learn lessons and improve future practice. There are a variety of models for conducting reviews but the critical need is for transparency, candour and analysis.
- The purpose of SARs is not to apportion blame or establish culpability, but to learn and implement lessons from a case about how agencies and professionals worked together.

SARs Cont’d

- The purpose is also to disseminate examples of good individual practice and effective inter- agency working.
- At their best SARs are quality improvement reports, to be drawn upon for learning for service improvement.
- A SARs library can be found on the SCIE website.

Common themes that consistently emerge from SARs. Practice with individuals.

- Poor engagement with individuals and their carers.
- Delayed or inadequate assessments, services and reviews,
- Ignorance of a person's history and chronology.
- Lack of relationship- centred, assertive, authoritative practice.
- Poor mental capacity assessments

Organisational culture

- Lack of management involvement.
- Neglect of supervision, training and staff workloads.
- Lack of compliance with statutory requirements and guidance.
- Defensive, closed and isolated agencies, evidence of bullying and fear, concerns neither escalated or addressed, unwilling to acknowledge issues.

The team around the adult

- Poor communication and information- sharing between agencies, silo working and threshold bouncing
- Insufficient challenge and concerned curiosity; professional optimism, unclear roles, inadequate recording.
- Law experienced as hard to understand and use.

Governance

- Failure to spot and address problems and risks.
- Insufficient oversight of management and organisational performance.
- Serious incidents not appraised
- Uncertainty about the conduct of SARs and failure to follow through on action plans.

Failure to record

- If you are not risk-assessing appropriately and recording your decisions and rationale correctly, you are putting your authority at risk of litigation and vulnerable individuals at risk of serious harm.

- Often, following a safeguarding incident, a social worker will say they decided to take a particular course of action for reasons X, Y and Z, without having any written evidence to refer back to in order to justify that decision.

- An independent review will want to know what information the social worker knew at the moment they made a particular decision, what additional information did they seek, if any, and what alternative courses of action they considered, including the reasons why they decided against these."

Workforce Development

- Failure to properly document the safeguarding decision-making process is often the result of a lack of training.
- Some social workers, and even some managers, may not fully understand how to evidence their decision-making, which is why it is important to find a way of training front line staff and managers in relation to record-keeping.
- Furthermore, staff need to be more aware of the concept of ‘defensibility’ when recording their decisions

Any questions