APPENDIX 2

Guidelines for Good Documentation

The first question is who are you recording information for (the Trust, you & colleagues, the Patients)?

- Write in language everyone can understand… jargon only serves to exclude people, so if it has to be used add an explanation
- Less use of abbreviations, or clearly reference what they mean
- History is a collaborative process… avoiding making assumptions based on history that are not substantiated in the present… be clear about the relative weight being given to historical information as it links to the present
- Quality chronology of events (an event diary) is about the accuracy of dates and the detail of information (inc. creating a timeline electronically)
- Recency and frequency of events could reflect urgency
- Include a specific focus on individual's strengths and protective factors
- Reference decisions against something!
- Focus on *safety* rather than risk (i.e. we assess the risks in order to increase a person's safety)

Remember

Risk/safety management works best when a Patient's strengths are recognised alongside the possible problems they might encounter and with which they might present. Every time *a problem* is identified, a strategy should be suggested and explored, *building on the strengths* of the Patient.
The emphasis should always be on a recovery approach and on the next stage in developing the Patient's ability to cope when they are feeling vulnerable or as if difficult demands are being placed on them.