

If It's Not Written Down... Did It Ever Happen?

Why record keeping is probably the most misunderstood superpower in health and social care.

Let's be honest. If I had a pound for every time someone sighed dramatically and said: "Why do we have to write everything down?" I'd probably have retired by now... somewhere warm... with a dog, unlimited chocolate and absolutely no paperwork.

Record keeping is one of those things that nobody gets excited about. Nobody wakes up in the morning thinking: *"I can't wait to complete my documentation today!"*... I get it. It's rarely the glamorous part of the job. But, here's the thing.

"It might just be one of the most important things you'll ever do for the person you're supporting"

"But I told my manager..."

One conversation I have in training happens over and over again. A care worker says: "I've told my manager loads of times that something isn't right." So, I ask one question. *"Did you document it?"* ... Silence.

Sometimes they shake their head. Sometimes they say, "Well... no." Or... "I did mention it." Or my personal favourite... "I didn't think it was important to write it down when I had already told someone." Here's the uncomfortable truth. Managers cannot evidence what they don't know. Managers cannot escalate what they cannot evidence. This is why they are always saying to you **"DOCUMENT IT!!!"**. It's not that they can't do anything or won't do anything. It's that **they need you** to do your job first and document it.

Health professionals cannot investigate what they cannot see. Inspectors cannot judge what doesn't exist on paper. Courts certainly can't rely on, "I definitely remember mentioning it."

Healthcare doesn't run on memories. It runs on evidence.

Imagine this...

Imagine you take your car to the garage. You tell the mechanic, "It's making a funny noise." "What sort of noise?" "I don't know...a noisy annoying sound" "When does it happen?" "Sometimes, not always." "How long has it been doing it?" "No idea. Maybe a few weeks, or maybe last year it happened first, not too sure" "Does it happen when it's hot? Cold? Fast? Slow?" "Not sure." The mechanic doesn't know where to begin and tells you to come back when it's making the noise, because it's not doing it now. You leave feeling frustrated because the mechanic couldn't diagnose the problem. Now replace the car with a human being. Suddenly the stakes become much higher.

The epilepsy example

Today I was teaching epilepsy awareness. One of the biggest messages wasn't actually about seizures. It was about observation. One seizure might look very different from

another. Perhaps the person's eyes rolled back. Perhaps they fiddled with their clothing. Perhaps they became unusually quiet beforehand. Perhaps there's a particular smell, movement or behaviour that always appears first that nobody noticed but you. Perhaps the seizure lasts forty seconds this time instead of three minutes. These tiny details can completely change clinical understanding.

Doctors, specialist nurses, neurologists and other healthcare professionals make treatment decisions using patterns. Patterns are built from observations. Observations become evidence through documentation.

That support worker writing careful notes at 3pm on a Tuesday may never meet the consultant making decisions six months later. But those notes might be sitting on the consultant's desk. That record could influence diagnosis. Medication. Investigations. Future care. Imagine that.

A support worker's handwriting helping shape specialist medical treatment.

That's not "just paperwork." That's partnership working in healthcare, to meet better outcomes for our service users.

Less emotion. More observation.

Families often have one enormous disadvantage. Love. Love changes the way we see things. Love changes what we notice. Love changes what we remember. Love changes how we describe events. When someone you love has a seizure, falls, becomes confused or suddenly changes, emotion naturally rushes in. That's completely understandable.

Support workers have something incredibly valuable. Professional distance. Boundaries. Not because they care less. Quite the opposite. Because they're trained to observe.

Not... "It was awful." But... "The seizure started at 14:16. The person's head turned to the right. Rhythmic jerking began in the right arm before becoming generalised. Cyanosis was not observed. Recovery commenced after one minute forty seconds."

That information is gold. It's objective. It's measurable. It's clinically useful. It's VITAL information for that person and their health and wellbeing.

Documentation is communication.

Sometimes people think documentation is for managers. It isn't. It's for the next shift. It's for the GP. It's for the neurologist. It's for safeguarding. It's for CQC. It's for families. It's for commissioners. It's for coroners if the worst should ever happen.

It's for you.

Every record becomes part of one long conversation between professionals who may never meet each other. The care record is the conversation.

"Nothing ever gets done."

Another sentence I hear regularly. "I keep telling people but nothing changes." Again... Did we document it? Because when concerns are documented properly, something powerful starts to happen. Patterns emerge. Three incidents become seven. Seven become twelve. A deterioration becomes visible. A safeguarding concern becomes evidence. A medication side effect becomes undeniable. One isolated concern can be dismissed. Twenty accurately documented concerns become impossible to ignore. One entry might be interesting. Twenty entries become evidence. Fifty entries become a pattern. Patterns save lives.

Documentation gives your concerns a voice that doesn't disappear when your shift ends.

C.A.R.E

I always tell you in training "Cover your a record EVERYTHING.
But why do we have to cover our butts?"**

Good documentation protects you. **YOU ARE IMPORTANT.** There's no shame in saying that. Sometime later someone may ask: "Well what did you observe?" "What action did you take?" "Who did you inform?" Without documentation you're relying on memory. Memory is a wonderful thing. Until it isn't. Good records protect good staff.

Simple.

I don't know about you, but I can barely remember what I did yesterday, let alone the conversation I had with Mrs Jones in room 5, at 7pm four weeks ago on a Tuesday. But I could tell you all about it if I had made a record of it.

And then there's CQC...

The CQC isn't obsessed with paperwork because it is full of geeky inspectors who just love reading care notes over a cup of coffee and a crumpet. They're interested because records tell stories. Can they see deterioration? Can they see escalation? Can they see person-centred care? Can they see good effective care and appropriate responses? Can they see risks being managed? Can they see decisions being made for the right reasons?

If it isn't documented... No one ever sees any of it. That includes your care genius in that crucial moment. How can anyone know it ever happened?

You're not "just" a support worker.

I wish we could remove the word "just" from healthcare. Support and care workers often tell me, "I'm just a carer". But the carers are often the people who spend the most time with individuals, they are often the experts in that individual services users' life. They notice the tiny changes. The smile that's disappeared. The appetite that's reduced. The new bruise. The increasing confusion. The different walking pattern. The slight tremor. The change in mood. The seizure that's subtly different from yesterdays. These are the first chapters of someone's healthcare story. The care worker (YOU) is often the first author.

So next time...

The next time somebody asks you to document something... Don't hear: *"Do more paperwork."* And silently notice your little inner voice saying "whatever, I'll do it later"

Hear: *"Help us understand this person."*

Hear: *"Help us spot the pattern."*

Hear: *"Help us keep somebody safe."*

Hear: *"Help us make the right clinical decision."*

Because every accurate record you write could become the missing piece of a puzzle that someone else is desperately trying to solve. And that.....is far more powerful than most people ever realise.

Final Thought

Documentation isn't about ticking boxes. It isn't about pleasing managers. It isn't about creating folders full of paper. It's about protecting people. It's about protecting yourself.

It's about giving every healthcare professional who comes after you the very best chance of understanding the person in front of them. Because in health and social care, observations fade. Memories blur. Conversations are forgotten.

But a well-written record can quietly change someone's life long after you've gone home.

Now... go and write it down. 🧐

See you in the training room

Rosie

