

In this guide you will find...

- Why reporting matters
- Difference between fact and opinion
- How to write
 - Care plan notes
 - Messages, emails, letters
 - Accident reports etc

And more, all in one handy booklet!

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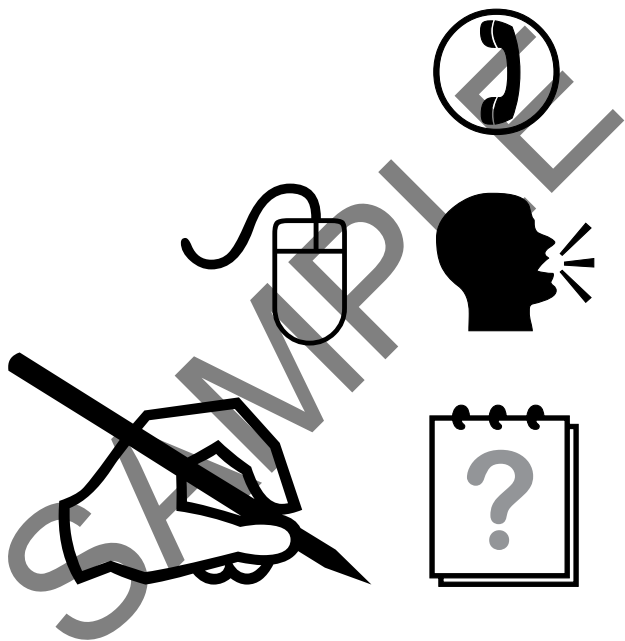


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Reporting

and other care work writing



Part of the **Learning through Work** series

Reporting and other care work writing - Part of the 'Learning through Work' series (2011)

Published by Skills for Care, West Gate, 6 Grace Street, Leeds LS1 2RP
www.skillsforcare.org.uk

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Ref: DS022

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Skills for Care is the employer-led strategic body for workforce development in social care for adults in England. It is part of the sector skills council, Skills for Care and Development.

This work was researched and written by Alexander Braddell, working to a commission from Skills for Care.

Bibliographic reference data for Harvard-style author/date referencing system:

Short reference: SfC 2011 (DS022)

Long reference: *Reporting and other care work writing - Part of the 'Learning through Work' series*, (Leeds, 2011) www.skillsforcare.org.uk (DS022)

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Using this booklet

Writing plays a vital role in care work today. It's helpful to feel confident about the writing you do at work.

This booklet explains how to write well at work. It covers:

- Writing factually
- Care plan notes, messages, accident reports, emails, letters etc
- Useful spellings... and more

The booklet is divided into **topics** (one per page). It is designed for busy people – each topic can be read in less than three minutes.

You will find **learning questions** to discuss and also things you can do to **learn more**.

Use the booklet to develop your knowledge, skills and confidence about writing at work.

How to use this booklet

- Find a couple of colleagues
- Read a topic together
- Agree what it means
- Discuss how it relates to your work
- See if your supervisor or manager agrees
- Decide how you can use what you have learned to improve the quality of care

Talking with colleagues is the key

The moment you start **talking** about something, you're **thinking** about it.

Once you start **thinking** about it, you're **learning**.

Tip Start with a topic that interests you.

Don't feel pressured – learn at your own pace and remember what they say:

Days that make us happy, make us wise!

1. Writing at work

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.



2. Care partnership

Care work is a **partnership** between people working in different places, at different times.

Everyone involved needs **up-to-date, accurate** and quite **detailed information** about

- The person
- Their care plan
- What the other partners are doing

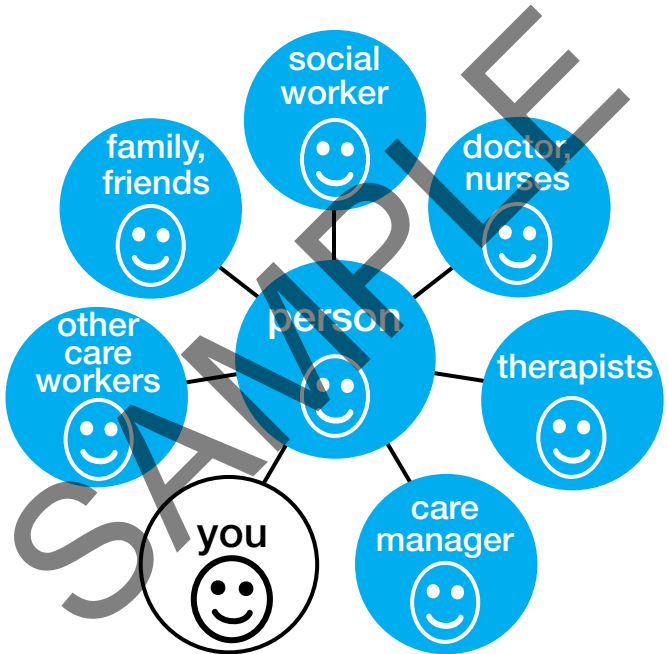
Writing is the quickest, easiest and safest way to **share information** between the partners.

What we write keeps them in touch with the person and their needs. The partners rely on our records and reports to know when the person's needs are **changing**.

Learning question

How do your records and reports help the care partners know when a person's needs are changing?

Care partners



[Learn more](#)

Find out who your care partners are.

3. Writing checklist

We write to **share information** with our care partners. To help them find that information our writing should be:

- **Timely:** done as soon as possible (while fresh in our memory)
- **Easy to read:** clear handwriting, accurate spelling, black ink (it photocopies well)
- **Dated, timed and signed**
- **Complete:** all the necessary information
- **Accurate:** correct details (names, times, dates etc)
- **Clear:** plain English that everyone (including the person) can understand, no abbreviations, no jargon
- **Factual:** just what happened, no opinions, comments, assumptions or guesswork
- **Respectful** of the people in our care: no judgements, no personal comments

Talk to the person

Person-centred care means tailoring our care to the needs of the person. It is part of treating people with dignity and respect.

Talking to the person about what we write helps us (and our care partners) to better understand the person's needs.

It also helps us to avoid writing things that are incorrect.

Learning question

What problems might arise from writing incorrect information?



4. Who reads our writing?

What we write at work may be read by many different people:

- The person, their family
- Colleagues and care managers
- Other partners (e.g. social workers, doctors)
- Inspectors
- Lawyers, police and other officials

People who use care services have a legal right to see our information about them.

Other care workers read what we write to understand the person's care needs.

Care review meetings base care decisions on what we write.

What we write may be (and often is) used in **complaints, investigations and legal cases.**

In any one of these situations, you may be asked to **explain what you have written.**

That's why it is important to write clearly, factually, accurately and respectfully, involving the person wherever possible.

Keeping records is part of good practice (i.e. something we **know** works well).

Did you know?

A record is **any recorded information**.

We create a record whenever we write down information, e.g. care plan notes, chart entries, phone messages, emails etc.

Learning question

Listen to an experienced care manager:

Record keeping is an important part of the job, not an add-on. Safe and skilful care workers keep good records.

What is your view?

5. Confidentiality

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.



6. Report writing

When we describe the care we give to a person, we are writing a **report**.

The care partners use our reports to help plan the person's care.

That's why our reports must be **factual**.

Listen to this conversation.

You look upset.

It's Mrs Smith. She threw a hairbrush at me.

What! Are you OK?

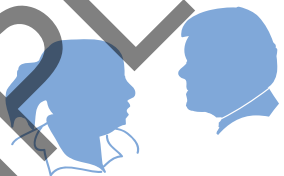
Yes, it missed. But she was so angry. And she called me names. She called me a thieving bitch.

But she likes you. What's got into her?

No idea! I just went in as normal to help her get dressed and she started screaming at me.

What did you do?

I just left. I feel really upset.



Now compare two reports of what happened.

Report 1

Mrs Smith behaved unacceptably today.

Report 2

I knocked at the door. Mrs Smith said, 'Come in,' but when she saw me her face went red. She shouted, 'Get out, you thieving bitch!' She threw the hairbrush she was holding at me. It hit the wall beside me. I left the room at once.

Report 2 gives **factual** information. It says what happened, in the order it happened.

Report 1 gives us **no** information about what happened. It is **not** a factual report.

Learning question

Which report would the care partners find more useful – and why? Do your colleagues agree?

7. Writing about behaviour

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.

8. Is it really a fact?

If a colleague asked you the difference between **fact**, **assumption** and **speculation**, what would you say?

Let's start with **fact**.

A fact is something that has definitely happened, e.g. *Mr Clark had toast for breakfast*. Facts exist in the real world. Other people can check them. Facts are **objective**.

What if I'm not sure?

Ask yourself these questions:

Did I see or hear it happen?



Yes > *Then it's a fact.*

No > *Then how do I know about it?*

Someone told me.



Did I check what they said was right?

Yes > *Then it's a fact.*

No > *Then it's just hearsay. All I can write is that someone told me it happened.*

Assumption

If we accept something is true **without proof**, we are making an assumption (i.e. assuming), e.g.

I'm sure Mr Clark had toast for breakfast. He always does.

In fact, today he didn't. He had fruit.

Mr Clark had toast is an **assumption**.

Speculation

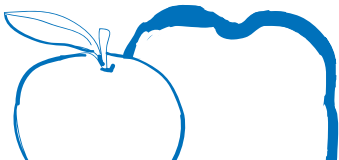
If we **guess** the reason for something, we are speculating, e.g.

Mr Clark was talking to himself. I think he was hallucinating.

In fact, he was just singing to himself.

I think he was hallucinating is **speculation**.

Watch out! It is easy to mistake assumptions and speculation for fact.



9. Avoid comments

Page 6 showed two ways of reporting what happened with Mrs Smith.

Report 1 said:

Mrs Smith behaved unacceptably today.

This is **not** factual information.

It is **comment**, or **opinion**.

What is an opinion?

Opinion is what we **feel** or **think** about a thing.

The care worker may honestly feel that Mrs Smith's behaviour is *unacceptable*.

That does not make it factual information.

Why not?

All in the mind

Opinions are **subjective**.

They exist only in our mind.

That is why two people can hold different opinions about the same thing, e.g. *Mrs Smith behaved unacceptably today* or *Mrs Smith was confused and very agitated today*.

Look how opinion can creep into a report.

How we feel about something

Mrs Smith called me a thieving bitch. **Fact**

I feel abused by Mrs Smith. **Feeling**

In my report I write:

Mrs Smith was abusive. **Opinion, or comment**

What we think about something

Mr White had two bowls of pasta today. **Fact**

I think that is too much food. **Judgement**

In my report I write:

Mr White ate too much. **Opinion, or comment**

Comments do not belong in factual reports.
Avoid them simply by **sticking to the facts.**

Learning question

How could involving the person when you write a report help you stick to the facts?

10. Specific and in full

Help the care partners by presenting information as clearly as possible.

Be specific

Avoid vague words like *a little*, *a lot*, *a long time*. Always write **exactly** what happened.

Don't write ~~*Mrs Peters drank a lot of water*~~

Do write *Mrs Peters drank three glasses of water.*

Don't write ~~*We went for a short walk.*~~

Do write *We walked to the high street and back.*

Don't write ~~*Jamila had a good day.*~~

Do write *Jamila played cards with Sharon.*

Avoid abbreviations

Abbreviations cause confusion.

- Not everyone understands them
- They may mean different things to different people

Don't write *p/u* or *b/e* or *b/fast* or *NOD*.

Do write *passed urine* and *bowels opened* and *breakfast* and *nurse on duty*.

How to correct a mistake

It is easy to make a mistake when writing notes or filling in a document at work.

If this happens just draw **one line** neatly through the mistake, so it can still be read.

Write in what you want to say then add the time, date and your initials in small letters by the alteration.

*visit from her ~~daughter~~ ^{son} L. F. 09.30
6 May 2012*

This shows it was a genuine mistake, not an attempt to alter care records.

Learn more

Ask your manager to show you some well-written notes and reports. Ask your manager to explain exactly what is good about them.

11. Care plan notes (1)

A person's care plan sets out the help they need to live as independently as possible.

We write **notes** in the care plan to record our **day-to-day contact** with the person.

Providing we report the **right things** in enough **detail**, our notes keep the care partners up-to-date with how the person's needs are

- Being met
- **Changing** over time

Care plan notes can help the care partners really get to know the person.

What to write

- What **happened** when we tried to meet the person's care needs
- Anything new we learn about the **person** that could help us meet their needs
- Anything they **tell** us about their needs
- Anything we **observe** about their needs

Before you write, ask yourself

Are there any changes in the person's

- Ability to care for themselves? e.g. personal hygiene, eating and drinking
- Health and well-being? e.g. ability to move, energy level, mood, interest and attention
- Environment giving rise to health and safety concerns? e.g. faulty appliances

Did you learn anything new about the person's

- Interests? e.g. *grows flowers as a hobby*
- Family? e.g. *new grandchild*
- Personal history? e.g. *used to sing in a choir*

Learning question

Why should you make sure the **person** knows and agrees with what you write in their care plan?

12. Care plan notes (2)

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.*

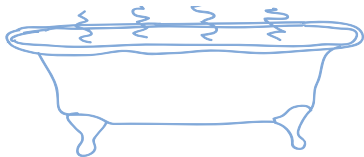
What if there is a problem to report?

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.



13. Writing a message

Imagine this.

Someone tries to contact one of your colleagues on their day off. You agree to take a message for your colleague.

What should you include in the note?

Information to include

- Who the message is for
- When the message was taken (time, date)
- Who the message is from
- How to contact the person
- The message
- How urgent the message is
- Who took the message (to answer any questions about the message)

Anything else?

Learning question

Imagine you are taking a message, but the person leaving the message hasn't volunteered all this information. What should you do?

Printed message forms remind us what to write.

Message

To:

Time:

Date:

From:

Phone No:

Message:

Returning
your call

Will call
again

Please
contact

Urgent

Message taken by:

Learn more

With a colleague, practise taking messages face-to-face and on the phone (call each other).

14. Forms, charts

Forms, charts and record sheets often require little writing, just a word or a number, the time and date, your signature or initials.

However little writing they require, the information they collect is important, e.g. for

- Monitoring changes in people's health and well-being (to support care planning)
- Regulations and legal requirements
- Quality inspections
- How your work is organised

Learn more

You are responsible for recording the information so it is a good idea to understand

- Who needs it and why
- How accurate the information needs to be
- How confidential it is

If you don't know, ask your manager.

With your forms and charts, do you know...

- Exactly what information is required?
- Where to write the information?
- How to write it (e.g. in black ink)?
- Any special requirements (e.g. use the 24 hour clock when writing times)?
- When to complete the document (e.g. at the time or at the end of the session)?
- What to do with the document (e.g. leave it where it is or hand it in to the office)?
- What it looks like when it is properly filled in (ask your manager to show you)?
- What to do if you can't fill it in?

Tip Ask if you need help (better safe than sorry).

Learning question

How easy is it for other people to read your handwriting?

15. Accident / incident reports

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**.

16. Emails

Emails have a set layout.

From: (your name)

Sent: (when you sent the message)

To: (who you sent it to)

Subject: (what your message is about)

Dear X

Explain why you are emailing.

Give any information the recipient will need to understand your message.

Say what action you want the recipient to take, by when.

Best regards

Your name

Your contact details

(possibly including your job title and the name of your organisation)

Write the **topic** of your message in the **subject** line. This tells the recipient (the person receiving the email) what your message is about.

Include any action you want the person to take, e.g. *Care plan review – please attend.*

Greet the recipient by name, e.g. *Dear Chris.*

Keep the **message** as short as possible, but do include any information the recipient will need to understand and respond to your message.

Highlight key information with bullet points.

Use proper sentences. Avoid abbreviations, initials and jargon (they often confuse people).

Close by saying what action you want the recipient to take, e.g. *Please confirm you can attend this meeting.*

Email etiquette

Writing in capitals is seen as **shouting** in email.

Don't write ~~PLEASE RESPOND ASAP.~~

Do write *Please respond asap.*

Learning question

Is an email a record? (If you're not sure, see page 4.)

17. Letters

How to write a letter

- **Plan** what you want to say
- If possible, **start** with a rough draft
- Make the **topic** clear from the start
- **Explain** why you are writing
- Give the recipient any **information** they need to understand and respond
- Say what **action** you want the recipient to take
- Keep it **simple** and **to the point**
- Use **short** sentences and paragraphs
- **Avoid** abbreviations, initials and jargon
- **Check** your draft and cut out any unnecessary words or sentences
- **Check** spelling, grammar and punctuation (this is called proof reading)
- **Write** out the final version

Layout for a letter

Your address
Your phone number and email

Today's date

Name of recipient
(i.e. person you are writing to)
Recipient's address

Dear X

Heading: what the letter is about

Main body of the letter, explaining why you are writing and giving any information the recipient will need to understand what you are saying.

What action you want the recipient to take, by when.

Best regards
Your signature

Your name

18. Risk assessments

To safeguard the people we support, we identify hazards, assess the level of **risk** they pose and devise **control measures** to reduce the risk.

We record this in a risk assessment so that everyone understands how to work safely.

What to write

- Concise description of hazard, e.g. *high, narrow stairs, danger of falling*
- How likely a fall is, e.g. *high likelihood*
- Concise description of control measure, e.g. *always grip hand rail*

Useful terms

Hazard = anything that might cause harm, loss or damage to the person, visitors or workers

Risk = how likely something is to happen

Control measure = items or actions to reduce the risk of the hazard causing harm, loss or damage

Risk assessment questions

- How does this activity **happen**?
- **Who** is involved in the activity?
- Who **else** might be present?
- What **hazards** are present?
- **How** might these hazards cause harm, loss or damage to the people present?
- How **serious** would the harm, loss or damage be?
- How **likely** is harm, loss or damage?
- Can the hazards be **removed**?
- If not, what can be done to **reduce** the
 - **seriousness** of the hazard?
 - **likelihood** of its causing a problem?

Learning question

How does writing a risk assessment support choice, dignity and independence?

19. Quiz

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.

20. Useful spellings

Soundalike words

Accept *an invitation*

Except *except for her*

Expect *it to happen*

Brake *stop the car*

Break *the glass*

Hear *a noise*

Here *is your lunch*

Loose *screw*

Lose *the key / game*

Of *son of*

Off *switch off the light*

Passed *in the street*

Past *before now*

There *it is*

They're *they are*

Their *house*

To *give it to him*

Too *hot, let it cool*

Two *cups of tea*

Threw *the ball*

Through *the door*

Wait *for a moment*

Weight *heavy*

Way *do it this way*

Weigh *on the scales*

Wear *gloves*

Were *you asleep?*

We're *we are*

Where *did you put it?*

Your *coat*

You're *you are*

Could *of* or could *have*?

When we speak, we often shorten *could have* to *could've*.

It sounds like *could of*, but it isn't.

Always write *could've* in full as *could have*.

Mrs Peters told me that her daughter could have stayed the night.

~~Not *could of* stayed the night.~~

It's the same for *should have* and *would have*.

Never write *should of* or *would of*.

Always write *should have* and *would have*.

She should have stayed the night.

~~Not *should of* stayed the night.~~

She would have stayed the night.

~~Not *would of* stayed the night.~~

Useful spellings (a – d)

A to Z spelling dictionary

The words below are arranged alphabetically.

A a abdomen, abdominal, able, ability
abuse, abusive, accident, accidental
accidentally, access, accessible, accessibility
accommodate, accommodation, ache
adjust, adjustment, admission
admit, admitted, adolescent
give advice, advise someone
age, ageing, allergy, allergic
ambulance, analgesic, ankle
anxiety, anxious, appraisal, appraised
arthritis, arthritic, assess, assessment
authorise, authority, aware, awareness

B b behave, behaviour, belief, believe
bereave, bereavement, bottom
bowl (container), bowel (intestines), a breath
breathe, breathing, bronchial, bronchitis

C c carbohydrate, care, careful, carefully
caring, casualty, catheter, catheterise, cerebral
chiropractic, chiropractor, choice, choose, chose
chosen, Christmas, clarify, clarification
client, clinic, clinical, clinician
cognition, cognitive, comfort, comfortable
commode, communicate, communication
community, complicated, complication
confidence, confident, confidential, confidentiality
constipate, constipation
contaminate, contamination
continence, continent, contribute, contribution
council (local government), councillor
counsel (advise), counselling, counsellor
crumb, crumble, cribbage, crisis, criticise

D d defecate, defecation (getting rid of faeces)
deficient, deficiency, dementia

Useful spellings (d – k)

demonstrate, dentist, dentures
depressed, depression, dermatologist
deteriorate, develop, development
diabetes, diabetic, diagnose, diagnosis
diarrhoea, diet, dietary, dietician
dignity, dignified, disability, disabled
discrimination, disease, dispose, disposable
domiciliary, doubt, dumb

E e emergency, emotion, emotional
empathy, empathetic, enough, enable
environment, environmental, environmentally
epilepsy, epileptic, equal, equality
establishment, exercise
experience, expression, expressive

F f facial, faeces, faecal
faith, fibre, fingernail, flammable
fluid, fracture, friend

G g genes, genetic, gynaecology

H h halal, hazard, hazardous
health, hoist, hospice, hospitality
hygiene, hygienic, hygienically

I i identify, identification, identity, immune
immunisation, impair, impairment, incident
incidental, incontinence, independence
independent, independently, individual
individuality, inform, information, inhale, inhaler
injure, injury, instruct, instruction, intimidate
intimidation, iron, ironing

J j jaundice, judge, judgemental, juvenile

Kk kedgeree, kidneys, kilowatt
(next of) kin, knee, knickers, knife, knives
knit, (door) knob, knock, knot
know, knowledge, knuckle, kosher

Useful spellings (l – p)

Ll liver, lymphatic system

Mm malignant, malnourished
medication, medicine, membrane, memory
memorise, meningitis, menopause
menstruation, mineral, miscarriage, mobile
mobility, monitor, mucous, muscle, muscular
myocardial infarction (heart attack)

Nn nausea, nerve, nervous
notify, notification, nutrient, nutrition

Oo obese, obesity, objective
observe, observation, obsession, obsessive
occupational, oesophagus, oestrogen
oncology, ophthalmic, opinion
opportunity, opposite, optical, optician
optimism, optimistic, orientation, orthopaedic
osteopath, osteoporosis, oxygen

P p paediatrician, palliative
pancreas, pancreatic, paracetamol
paralysis, paralysed, Parkinson's Disease
pathogen, patience, patient
percutaneous, pH scale
pharmaceutical, pharmacist, pharmacy
phobia, physical, physically
physiotherapy, placebo
pneumonia, podiatry, podiatrist
portion, positive, positively
posterior, posture, postural
practice, practical, practitioner, practising
precaution, prefer, preference
preferred, pregnancy, pregnant
prejudice, prescribe, prescription
present, presentation, pressure, pressurise
prevent, prevention, preventive
primary, proceed, procedure, procedural

Useful spellings (p – s)

profession, professional, profoundly deaf
prostate, protect, protective, protein
provide, provision, psychiatric, psychiatrist
psychiatry, psychological, psychologist
psychology, puree, pureed (mashed)

R r radiology, radiologist, radiographer
Ramadan, rapport, reassure, reassurance
receipt (shopping), recipe (food), recreation
refer, reference, referral, referred, referring
reflex, reflexes, rehabilitate, rehabilitation
relation, relationship, religion, religious
reminisce, reminiscence, renal
request, require, resident, residential
respire, respiration, respiratory system
responsible, responsibility, resuscitate
resuscitation, retina, review
rheumatism, rheumatic, rheumatoid

role, rota, routine

S s safeguard, schedule
screening, secure, security
sedate, sedative, self-esteem
self-manage, sense, sensory
signify, significant, skeleton, skeletal
sluice, social, socialisation
solicitor, soluble, solvent
sore (ulcer), special, specialist
sphincter, sputum, stamina, status
stereotype, stimulate, stimulation
stoma, stomach, stomach-ache
stroke, substance, substantial, substantially
supervise, supervision, supervisor, supervisory
surgery, surgical, surround, surroundings
swallow, swallowing, symptom, symptomatic
syringe

Useful spellings (t – z)

T t tabard, temperature

therapy, therapeutic, thumb, thyroid

tissue, toenail, toilet, toiletries, tranquilliser

trauma, traumatic, traumatise

tubercular, tuberculosis, tumour

U u ulcer, ultrasound

urethra, urine, urinary, urination

V v vaccine, vaccinated, vaccination

vascular, vegetable, vegetarian

vein, venous, ventilate, ventilation

vertebra, vertebrae, violence, violent

virus, viral infection, vitamin

volume, voluntary, volunteer

vulnerable, vulnerability

W w wheelchair **X x** x-ray **Z z** zimmer

Add your own useful spellings here:

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SAMPLE

What next?

If you want to develop your writing skills, you may find another booklet in this series useful.

It is called **Writing skills** and it covers all the essentials – grammar, punctuation and more.

For more on developing your care work knowledge and skills, including qualifications:

- Visit the **Skills for Care website** at
- www.skillsforcare.org.uk
- Go to the *Developing skills* section

Learning through Work series

- > Reporting and other care work writing
- > Writing skills for care workers
- > Talking about bodily functions and feelings
- > Physical health
- > Using numbers in care work
- > Number skills for care workers
- > Talking about how much, how often

Psst! One last tip: **Telephone spelling**

Some letters sound like each other:

b c d e g p t v all have an ee sound

a j k share an ay sound

i sounds like **y** and **m** sounds like **n**.

When spelling a word over the phone, avoid confusion by saying *M for Mike*, or *T for tango*. Here is the most widely used system:

<u>A</u> lpha	<u>B</u> ravo	<u>C</u> harlie	<u>D</u> elta
<u>E</u> cho	<u>F</u> oxtrot	<u>G</u> olf	<u>H</u> otel
<u>I</u> ndia	<u>J</u> uliet	<u>K</u> ilo	<u>L</u> ima
<u>M</u> ike	<u>N</u> ovember	<u>O</u> scar	<u>P</u> apa
<u>Q</u> uebec	<u>R</u> omeo	<u>S</u> ierra	<u>T</u> ango
<u>U</u> niform	<u>V</u> ictor	<u>W</u> hisky	<u>X</u> -ray
<u>Y</u> ankee	<u>Z</u> ulu		

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