



Record Keeping



Aim:

To identify good practice in recording, sharing, storing and accessing information in a social care setting.

Objectives

Describe the care workers responsibilities in handling of information.

Describe how to maintain records.

Identify the legal requirements when dealing with records.

What is record keeping.

- Documentation.
- Writing notes.
- Passing on information verbally.
- Receiving information.
- Understanding where information needs to be stored in a care setting.

Records

- Care plans.
- Incident forms.
- Mar charts.
- Food and fluid charts
- Turning charts.
- Risk assessments.
- Contenance records.
- Body maps.



Why do you need to record in a health and social care setting

- It is a legal requirement.
- If there are any changes in care or condition.
- Audit trail for CQC.
- Ensures consistency.
- Promotes accountability.
- Risk management.
- Person centred approaches.

Why do you need to record in a health and social care setting.

You must record all your actions, to demonstrate an audit trail of care and service delivery

Anything of a serious nature, such as diseases, serious injury or death

How to maintain records

- Good practice in health and social care settings relies on multidisciplinary teamwork.
- To ensure that the team is able to support people efficiently and effectively, it needs up-to date, complete , accurate and legible records.
- Records must be completed in a timely fashion, and include facts rather than opinions
- Staff must have time to complete records clearly so no mistakes are made and information is not missed

How to maintain records.

- Written in a way that can be understood, no jargon, clear hand writing.
- Recognising the difference between fact and opinion.
- Written as soon after the event as possible.
- Unbiased language.
- Precise, relevant, signed and dated.
- Kept confidential.

Regulation 17

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

To meet this regulation; providers must have effective governance, including assurance and auditing systems or processes.

Key principles of the General Data Protection Regulations 2018.

- The Data Protection Act 1998 ceased to exist in May 2018, we now have the General Data Protection Regulations, these came in to force in May 2018,

The key principles of GDPR:

- Processing should be lawful, fair and transparent - individuals/data subjects must be clear on what personal data you are processing and why.

Key principles of the General Data Protection Regulations 2018.

- Personal data shall be collected for specified, explicit and legitimate purposes
- If you wish to use personal data for another purpose you will need additional consent/grounds for processing.
- Personal data must be adequate, relevant and limited to what is necessary
 - care providers should only have access to relevant health and medical records.

Key principles of the General Data Protection Regulations 2018.

- Personal data shall be accurate and kept up to date - out of date or inaccurate information should be deleted/removed and under regular review.
- Personal data shall be kept for no longer than is necessary - personal data no longer needed should be destroyed. (You must still comply with statutory requirements to keep documents for their relevant retention period.)

Key principles of the general Data Protection Regulations 2018.

- There must be appropriate security in place in respect of the personal data - security measures are needed to prevent unauthorised processing or destruction and all staff must know the steps to protect the data.
- Personal data includes but is not limited to any information that can identify an individual, email addresses, telephone numbers, HR records, DBS information, medical records, photos, ID numbers and home addresses.

Legal document.

- There are legal issues relating to record keeping.
- You are responsible for what you write down.
- Anything that you write could become a public record.
- You could be formally asked to explain your records in the event of an incident or complaint.
- Under the GDPR 2018, individuals have the right to see what has been recorded about them.

Confidentiality

- Confidentiality in Health and Social care refers to all personal and sensitive information about a person. This could be either written or verbal.
- This can be achieved by speaking in private, ensuring files are stored in a locked cupboard. Any files held on computer will need to be password protected and all information can only be accessed by authorised personnel.
- You may have to disclose information if an individual or others are at risk or abuse is suspected or reported. This is on a 'need to know' basis.

Confidentiality

- Writing records in private.
- Files are labelled as confidential.
- Shredding information when it is not needed.
- Using passwords on the computer.
- Using locked cabinets.
- Checking the identity of the person that would like to access the information.
- Files and records not left lying around.

Further research

<http://www.mimslearning.co.uk/good-record-keeping/activity/4668/>

<https://www.cqc.org.uk/guidance-providers/adult-social-care/what-good-looks-digital-records-adult-social-care>

<https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016>

Further research

<https://www.scie.org.uk/publications/guides/guide46/underlyingcauses/recordingkeeping.asp>

<http://www.skillsforcare.org.uk/Documents/Standards-legislation/Code-of-Conduct/Guidance-on-the-Code-of-Conduct-for-support-workers.pdf>

Any other Questions?



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