Record Keeping

First name:

Surname:

Company:

Date:

Please complete the above, in the blocks provided, as clearly as possible.
Completing the details in full will ensure that your certificate bears the correct spelling and date.
The date should be the day you finish & must be written in the DD/MM/YYYY format.

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Record Keeping

Contents

N.B: We are aware that official practice is to use the terms “service users” or “people using this service” to describe those receiving care. We prefer the term “client” and use it throughout our training package.

Key:

worksheet

important

Record Keeping

Learning outcomes.

- Define what is meant by records and documentation.
- Identify the purpose and function of records and documentation.
- Understand the effects of good and bad record keeping.
- Identify the legislation involved in record keeping.
- Understand the principles of good record keeping.

Fundamental standards.

The fundamental standards are the standards by which CQC will inspect social care. The standards are based on the regulations from the Health and Social Care Act and CQC have changed the focus for the purposes of inspection.

The fundamental standards are those standards that no care setting must fall below.

The standards are based on five areas as follows:

Safe.	People are protected from abuse and avoidable harm.
Effective.	People's care, treatment and support show quality of life and promote good outcomes, and providers should show evidence to prove it.
Caring.	Care should be person centred involving dignity and respect, and compassion.
Responsive.	Following correct working procedures as agreed by your workplace and as set out in the client's care plan.
Well led.	Management leadership and governance should ensure all of the above happens. Staff training should be recognised and openness and fairness be apparent.

These areas are known as key lines of enquiry or KLOES. Each KLOE has a set of criteria which CQC use to check whether the fundamental standards are being met.

Record Keeping

The fundamental standards are as follows:

Person centred care.	Ensuring that those receiving the care are at the centre of all decisions.
Dignity and respect.	Providing the client with dignity and respect in all aspects of their care.
Need for consent.	Asking the client's permission before carrying out tasks that affect them.
Safe care and treatment.	Following correct working procedures as agreed by your workplace and the client's care plan.
Safeguarding service users from abuse.	Following agreed working and safeguarding procedures and being aware of signs and symptoms.
Meeting nutritional needs.	Being aware of dietary needs, working with the care plan, ensuring clients have the right equipment and conditions to eat.
Cleanliness, safety and suitability of premises and equipment.	Carrying out required checks of premises and equipment, implementing cleaning rotas and carrying out safety checks.
Receiving and acting on complaints.	Having a complaints policy and procedure in place that is accessible to all and act in accordance with the policy when dealing with complaints.
Good governance.	Ensuring that all aspects of the workplace is overseen and policies and procedures are implemented and monitored regularly.
Staffing.	Fit and proper persons employed. Fit and proper person requirement for Directors is followed.
Duty of candour.	Relevant information must be volunteered to all persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.

Our Redcrier manuals will provide your staff with training to support attainment of the fundamental standards.

Record Keeping

Introduction.

In today's ever changing care environment, accurate records and documentation remain absolutely essential. In 2010 the Francis Inquiry, a high profile investigation into standards of health care in a NHS Trust, stated that the writing of accurate records has a profound effect on the overall welfare of the client as they promote high standards of clinical care and allow for effective communication between the client, family and all members of the care team.

Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that providers must maintain accurate complete and detailed records in respect of each person using the service.

As part of its inspection regime, the Care Quality Commission (CQC) monitors the standards of records and documentation in establishments such as nursing and residential care homes. Although there is no one method of record keeping, there are recognised principles and standards that can be used by all health and social care professionals as a framework in maintaining accurate care records.

Accurate record keeping is regarded as a social care worker's duty of care; an important skill which needs to be performed with workplace policies and procedures in accordance with best practice guidelines and local policy.

Aim.

The aim of this manual is to provide an awareness of the principles of maintaining accurate record keeping and documentation.

Written in accordance with current best practice guidelines and related literature, it is suitable for all care workers to update and develop their knowledge and skills in record keeping.

Record Keeping

Unit One

The purpose and functions of records and documentation.

Initially, we need to consider what is meant by the terms ‘record’ and ‘documentation’. Then we will look at the different types of record and documentation that you use in your own work environment.

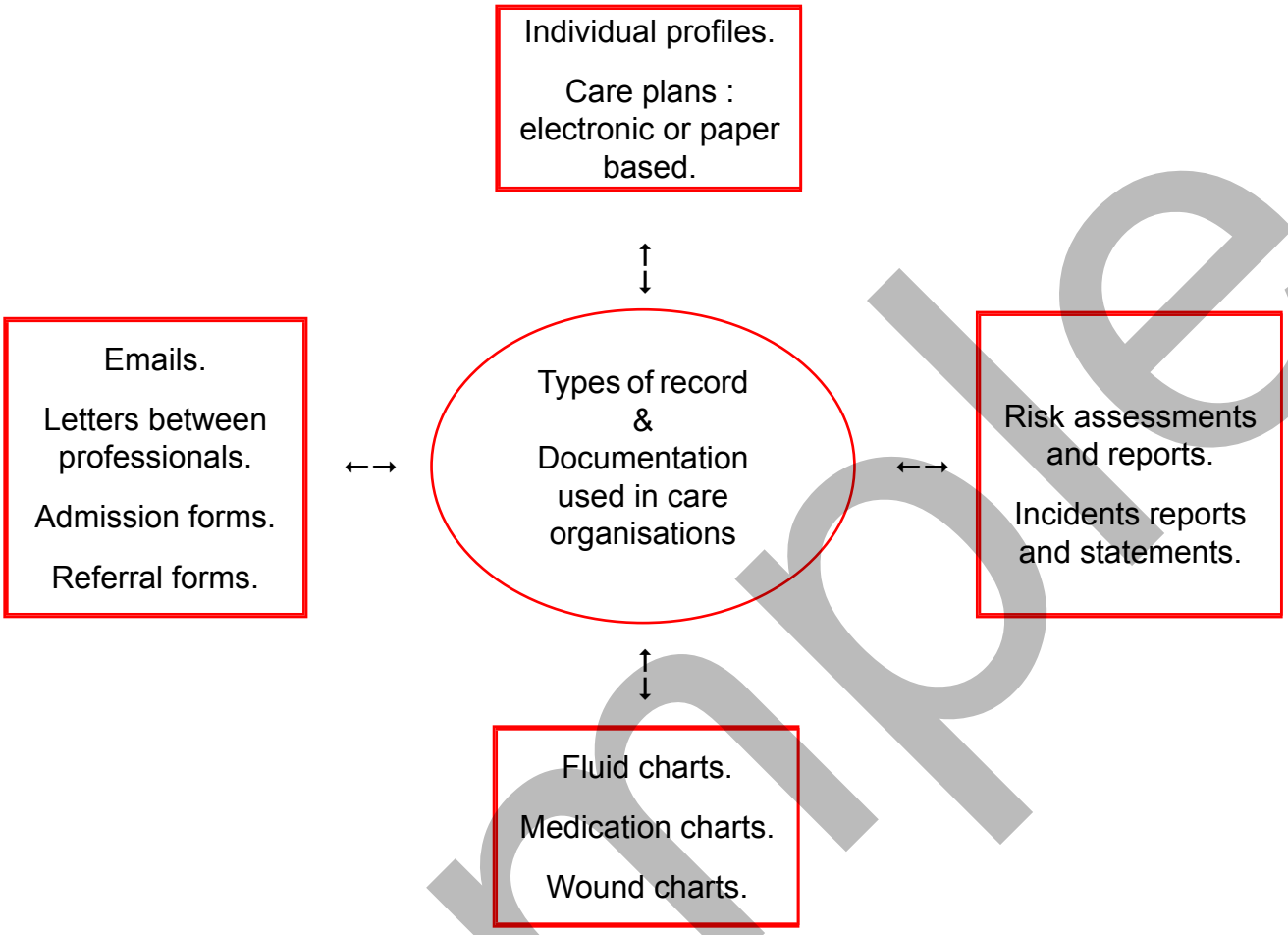
> The Collins English dictionary defines documentation as documents supplied as proof or evidence of something.
>
> The dictionary also defines records as a document or other thing that preserves information.

Different types of records.

Although the use of electronic records is increasing, and records and documentation can come in a variety of different formats, the use of paper based records remains common place.

Record Keeping

Records kept in care sector organisations can include the following:



Broadly speaking records can come under three main headings:

- **Care and nursing records** – admission forms, daily care plans, food and fluid charts, baseline observation charts, weight charts, advance care planning documents, wound charts.
- **Medical / doctors' records** – pathology / laboratory reports, blood results, client case notes, operation notes, prescriptions, x-ray reports.
- **Multidisciplinary records** – social care reviews, speech and language therapy (SALT) assessments, dietician reviews, occupational health reports, eye check records.

Record Keeping

Due to the variety of records and the different types of information held, it is understandable why the keeping of accurate records is crucially important in maintaining the overall continuity of the client's treatment and care. It also protects the client's health and safety by preventing potential mistakes in treatment.

Good record keeping is in maintaining good practice, and is essential to the provision of safe & effective care. It is not an optional extra to be fitted in if circumstances allow (NMC 2010).

Good record keeping allows a client's progress to be monitored and a history to be developed so care provisions can be planned and put into place to meet the needs of the client.

Clear accurate records also allow for the continuing evaluation of care provided and identify whether alternatives are necessary in order to meet the needs of the client. An example of which is in the scenario below.

Mr Teddy Collins, 84, is a client of a residential home. He is complaining of joint pain in his right knee, it is worse at night and his sleep pattern is frequently disturbed due to the pain. His GP has previously prescribed him two paracetamol tablets to be taken four times a day.

Following a discussion with Mr Collins, an assessment of his level of pain was performed using a pain assessment chart. From this and other information gathered from his nursing records and current medication administration sheets, it was concluded that his pain was not being controlled by the paracetamol.

Therefore an urgent re-evaluation of his pain relief was requested from his own GP.

Records also have a very important legal function. Classified as legal documents all and any health documentation can be called upon to be used as evidence in the following situations;

1. Courts of law, civil and criminal.
2. Coroners' courts.
3. Tribunals.
4. Investigations surrounding complaints of care provision.
5. Internal employment disciplinary cases.
6. Fitness to practice cases of an individual health professional.

Record Keeping

In its fact sheet (Health Records: Overview) www.nhs.uk the NHS England state that health records play an important role in modern healthcare and currently they have two main overall functions:

Primary function.

The primary function of health care records is to record important clinical information, which may need to be accessed by health professionals involved in the care of the client. The information contained in health records includes:

- The treatments clients have received.
- Any allergies the client has.
- Is the client taking any medication.
- Has the client any adverse reactions to any medications.
- Has the client any chronic (long lasting) health conditions such as diabetes or asthma.
- The results of any health tests such as blood tests or x-rays.
- Any life style information that may be relevant, such as whether the client smokes.
- Personal information, such as age, employment, address.

Secondary function.

The secondary function of health records is to improve public health and the services provided by the NHS, such as treatments for cancer or diabetes. Health records can be used:

- To determine how well a particular hospital or specialist unit is performing.
- To track the spread of, or risk factors for, a particular disease, e.g. winter flu.
- In clinical research, to determine whether certain treatments are more effective than others.

Record Keeping

Accurate records and documentation are fundamental in providing a comprehensive and accurate account of care given. They support the continuity of client centred care and ensure clear accountability as they show exactly who did what.

Documentation is essential to show what decisions were made and why and this may be necessary to demonstrate compliance with legislation, for example the 'best interest' principles of the Mental Capacity Act.

Good records provide a way of detecting problems and care alternatives and are effective channels of communication between the client, family and carers.

Purpose / function of clear accurate records.

- Assessment, planning, intervention and evaluation of care - admission form, daily care planning sheets.
- Communication between health professionals – staff handover sheets, doctor's ward rounds.
- Physiological functions & activities of living - observation charts, e.g. blood pressure, pulse, temperature, fluid and diet charts.
- To record health and safety issues - accident books, risk assessments, critical incident sheets.
- To provide evidence of daily care - daily record sheets, care plans.
- Details of clients' choices, consent and decisions for care - advance care planning, living wills, treatment options, DNAR decisions, use of restraint belts, use of bed rails.
- Supporting evidence for decisions and interventions made by health professionals - wound care charts, social services reviews notes, reviews by SALT team.
- Details of family input or concerns - social services care reviews, nursing notes.

Record Keeping

Unit One Questions

1. How can clear accurate records support the continuity of client centred care?

2. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 states that providers must maintain _____ complete and _____ records in respect of each person using the service.

3. List three situations whereby health records and documentation can be used as legal evidence?

1.
2.
3.

4. The primary function of health records is to record important clinical information. Give 3 examples of what this information should be.

1.
2.
3.