July 2017

Record Keeping Policy

Date Written	*17.07.2017*
Author(s)	Registered manager
Version	*2.0*
Date Signed Off	20/07/2017
Reviewed by	

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Review Data

Initial Production

Name	Role/Department	RACI	Date
Registered manager	Registered Manager	RA	17.07.2017
Registered manager	Registered Manager	RA	06/12/2017

R = Responsible for document production; **A** = Accountable; **C** = Consulted; **I** = Informed

Change History

Version	Date	Details of Change	Author
2.0	17.07.2017	Re-write and re-structure of original policy in line with most recent legislative updates.	Registered manager

Emergency Contact Details

Name	Email	Mobile
Registered manager	fran@livein.care	

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CQC Fundamental Standards

Regulation Number	Regulation Details
Regulation 17: Good governance	Providers must securely maintain accurate, complete and detailed records.

Key Lines of Enquiry

KLOE	How this applies to Record Keeping
Effective	By keeping clear and up-to-date records we can monitor and demonstrate the effectiveness of our service.
Responsive	By keeping records of the individual needs, concerns and wishes of each Client we can provide a service that is responsive to those individual needs.

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Policy Aims

Living Carers Ltd expects a high standard of record keeping to be maintained at all times.

The purpose of this policy is to define record keeping requirements for all personnel involved in creating, maintaining, monitoring or contributing to social care records.

Clearly written, accurate and complete case records are an essential part of delivering effective social care services. Social care records:

A high standard of record keeping is fundamental to the delivery of safe and professional care. The provision of a record keeping policy provides the framework to guide professional practice.

Good record keeping helps to protect the welfare of Clients by promoting:

- High standards of care
- Continuity of care
- Better communication and dissemination of information between multi- agencies
- An accurate account of treatment and care planning and delivery
- The ability to detect problems, such as changes in the Client's condition, at an early stage.

Records are used for monitoring, investigative and audit purposes. They provide evidence that organisational and legislative requirements have been followed, e.g. that explicit consent has been obtained; other parties have been consulted; assessments of eligibility and need have been carried out; planning and review processes have been completed; mental capacity has been assessed where this is in doubt and decisions made about what is in a Client's best interests where relevant; risks have been explored and efforts made to manage or reduce them; direct payments have been offered to eligible Clients.

Records are examined during internal and external (e.g. Care Quality Commission) audits for evidence that requirements are met. Living Carers Ltd relies on the Client record to investigate serious incidents and complaints. If records are not accurate and complete, there may be no evidence that due process has been followed.

Social care records demonstrate how and why significant decisions were reached and who was consulted during the process.

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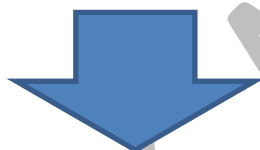
Roles and Responsibilities

Managers ensure that:

- Staff are aware of record keeping requirements.
- Social care record keeping meets the requirements of this policy and relevant legislation.
- Annual record keeping audits are arranged and corrective actions derived from internal and external audits are completed within required timeframes.
- Record keeping incidents are investigated and managed.



All staff ensure that:

- They comply with the recording requirements of this policy
- Clients are made aware of what records will be kept and why.
- Records are maintained and used in accordance with this policy and where appropriate with the requirements of relevant professional bodies.
- Record keeping problems or discrepancies are reported to a line manager.
- They participate as required in internal and external audits of social care records and complete any corrective actions required as a result of audit activities.

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Social Care Records and Client Rights

The Client is central to social care recording. Social care records contain confidential information about Clients. Clients must be:

- **Informed about what records will be kept about them and the reasons why.**
- **Routinely involved in the process of gathering information. Clients should be the first source of information.**
- **Encouraged and supported to express their wishes, preferences and views and to actively participate in assessment, planning and review processes.**
- **Informed about their rights to confidentiality and how to access their own records on request to Living Carers Ltd.**

In general Clients have rights to access all information held about them. Information will only be kept confidential from the Client for reasons permitted by law, for example:

- **Where disclosure is likely to result in serious harm to the Client's physical or mental health or condition or that of another individual, including a staff member.**
- **Where disclosure would identify a third party, other than professionals who have provided information in a professional capacity, who has not consented to being identified.**
- **Where disclosure would be likely to prejudice the prevention or detection of crime, or the apprehension or prosecution of offenders.**

Clients who consider that any part of the information held on their records is inaccurate have the right to apply to Living Carers Ltd in writing to have their information corrected or erased. Living Carers Ltd has a duty to correct or erase the inaccurate information if the Client's objection is justified. Please refer to Living Carers Ltd.'s Data Protection policy for more detailed information.

General Requirements of Social Care Records

Information may be documented by **any person involved in supporting the Client**, their family or carers.

No records may be handwritten. Records must be accurate, clear, concise, fit for purpose, based on facts verified with the Client and / carer or others and written in a way which **maintains the dignity and confidentiality of the person concerned.**

All information must be entered into the person's **electronic record within Living Carers Ltd's system**. Relevant paper based and other information must be added to the electronic record so that a complete record is maintained within the system.

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Information must be added to the record in a timely manner **no later than 3 working days after the event** and preferably on the same day. This ensures that the record remains up to date. If critical information cannot be recorded immediately, the responsible person must relay the information to another staff member so that the record can be updated without delay.

Information must be recorded in the ongoing record in **chronological order.** Records entered retrospectively must clearly identify the date to which the record refers.

Social care records must be **easy to understand** as they may be read by others, for example other people involved in the Client's care and by managers. In some circumstances they may be read by people external to Living Carers Ltd. For example, the Client may request access to information within social care records or a record may have to be produced in court.

Social care records must:

- **Be written in plain English. Terms unlikely to be understood by a lay person should be avoided if possible, or defined and explained. If abbreviations are used, the words must first be written in full with the abbreviation identified in brackets.**
- **Be written from a professional and objective perspective based on verified facts and / or observation.**
- **Be written in black- if written by hand**
- **Signed and dated**
- **Respect the Client's / carer's rights and dignity. Records must not contain any expressions which may give offence especially on the basis of race, culture, religion, age, disability or sexual orientation.**

Records should distinguish between verifiable facts and opinions and should follow basic guidelines:

- **Professional opinion should be based on assessments, observations, facts and evidence.**
- **If facts can be verified by evidence, this should be referred to in the ongoing record – for example, that a specific document was sighted or that information was confirmed by the Client's general practitioner.**
- **Records should state whose opinion is documented, for example the allocated worker or another person.**
- **Where facts are disputed or opinions vary, the record should identify the differing views of the parties involved.**

Social care information is often drawn from a wide range of sources. The primary source of information should be the person whose needs are to be met. **Records must identify the source of the information when it has been obtained from third parties**.

Standardised forms/documentation approved by a manager for use in their service area must be used. All relevant fields within standardised electronic documentation or on paper forms must be completed. Fields relating to areas not relevant to the Client's or carer's situation, for example during a limited or proportionate assessment, may be left blank.

Complaints will be recorded within the Living Carers Ltd complaints system rather than within the social care record.

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Key Question: What needs to be included in Social Care records?

Where appropriate, information about potential risks should be entered onto Living Carers Ltd's electronic system. Case warnings must be justified by the worker, authorised by a line manager and added to the electronic record by a team administrator. Case warnings must be reviewed by the worker at each review/reassessment and removed from the record if no longer applicable.

Details of interested parties, for example the Client's general practitioner, carer, holder of a lasting / enduring power of attorney, authorised person (in the case of direct payments) or other formal representative. Where there is a lasting power of attorney, the record should indicate whether powers relate to property and financial affairs, health and welfare, or both.

An assessment of Client / carer needs against national eligibility criteria. The primary need for support, which may change over time, must be documented. Details of joint/combined assessment processes must be documented where relevant.

Evidence that the Client / carer has been provided with a written copy of the assessment and the eligibility determination, including the reasons why any / all needs are ineligible.

Evidence of refusal of an assessment where applicable.

Appropriate consents signed by the Client or others authorised to act on their behalf.

An assessment of mental capacity if there is any doubt about the Client's capacity to provide consent, and confirmation that due process has been followed to make best interests decisions. Best interest decisions must be clearly recorded and records must confirm that there has been the least possible restriction on the person's rights and freedom of action and that proposed deprivation of liberties are authorised.

A plan as agreed with the Client / carer which clearly defines assessed needs, how needs will be met, how meeting needs will promote wellbeing and achieve Client / carer outcomes, how the personal budget is made up and includes a review date.

Evidence that the Client / carer has been provided with information and advice where appropriate.

Evidence that the Client/carer has been provided with a copy of the plan together with personalised information about what can be done to reduce needs and to prevent / delay the development of other needs.

Where appropriate, an up to date photograph of the Client if quick recognition of the Client is essential, for example a photograph may be required if a Client goes missing from a residence or day care centre.

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The Ongoing Record

Observations, relevant contact and attempts to contact the Client, their family, carers, other colleagues, professionals or other significant people must be included in the Client's ongoing record. The record must state what the discussion was about and who took part in discussions. Telephone or other messages left for or received from other parties must be documented. Missed or cancelled scheduled visits must also be recorded.

All actions or decisions taken must be documented in the ongoing record which should demonstrate that:

- Important decisions, including those taken within supervision, have been appropriately considered. The record should show who was consulted, who made the decision and why the conclusion was reached.

- Incidents, safeguarding concerns and consequent actions are documented. Potential risks, particularly to safety and welfare, must be assessed and explored in appropriate depth. The record must include actions taken to mitigate / manage risk and whether actions resulted in risks being reduced, removed or remaining unchanged.

- The Client has, to the extent that this is possible, been fully involved in all decision making. Where relevant, the record should confirm the involvement of a specialist assessor / planner; where communication or other support has been provided; and the involvement of independent advocates where the Client has substantial difficulty in being involved in assessment or planning processes and has no other appropriate person to support them.

- Interpreters have been used where appropriate. The record must state whether the interpreter was a (named) staff member, family member/friend or another person.

- The option of direct payments has been routinely offered to all eligible people throughout planning and review processes.

- Where appropriate, an offer of care and / or support has been declined. Requests for access to personal information and information sharing have been appropriately managed.

- Referrals have been made to other services / organisations where appropriate and the reasons why the record has been closed or transferred elsewhere.

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Security of Records

All records must be held, managed and transferred in accordance with Living Carers Ltd policies. Records must be protected from inappropriate and unlawful access both when working within Living Carers Ltd facilities and when working remotely.

People who have access to Living Carers Ltd records are authorised to access only information and records which are necessary for their legitimate work duties

Confidentiality, Information Sharing and Consent

Where Client / carer information will be shared, held within joint recording systems or accessed by partner agencies or external personnel on a regular basis, arrangements for information sharing and data security must be formalised within an information sharing protocol or other written agreement.

All information must be used in accordance with the requirements of the Data Protection Act 1998 and disclosed to others only with consent. People must be confident that the information held within Living Carers Ltd records will only be disclosed with their consent or when a legal duty or a power overrides this requirement.

Written consent to obtain or release information must be gained from the person concerned. Consent to share information may be full or limited and must be stored within the Client's / carer's record. If the Client / carer does not consent to information being sought from or provided to other agencies or organisations, the record must confirm that any potential risks and limits to service provision have been explained.

In some circumstances, Living Carers Ltd has a legal duty to disclose information without consent, for example because of a court order or to prevent, detect or prosecute a serious crime. Living Carers Ltd may also share personal information without consent when there is concern about an individual's safety, or a serious risk to the public, our staff or other professionals. All information sharing must comply with Living Carers Ltd policies and with current information sharing agreements and protocols.

Requests for information, information sharing and decisions not to share information must be documented in the Client's / carer's ongoing record.

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Safeguarding

Adults:

All suspected or alleged safeguarding concerns must be raised with a line manager and must be managed in accordance with the requirements of the Mental Capacity Act (2005) and legislation relating to Deprivation of Liberty (2007). Living Carers Ltd has a duty to instigate a safeguarding enquiry where an adult with care and support needs appears to be experiencing or is at risk of abuse and neglect. Safeguarding procedures must be followed and documented.

Standardised documentation is available for use in the assessment of mental capacity, Client best interests' decisions and deprivation of liberty.

Children:

Personnel who become aware during their work of actual, suspected or alleged safeguarding concerns about a child or young person must raise the matter with a line manager with a view to making a referral to the local authority's Children's Services Helpdesk.

SAMPLE

Text Messaging, Fax, and E-mail

Living Carers Ltd policies for record keeping, information storage and information management apply to all records including those within electronic media.

Text messaging – both outgoing from staff and incoming from Clients and other people involved in casework:

- Text messages must only be made from or received by mobile phones issued Living Carers Ltd.
- All contact with others must be regarded as professional contact. For this reason, based on the information received, judgement must be used when responding to a text message.
- No Client / carer identifiable details must be transmitted.
- The message, telephone number, date and time of all incoming and outgoing text messages must be recorded in the Client's / carer's record. Messages must then be deleted from the mobile phone to maintain confidentiality.

Fax – all faxed information relevant to case work must be added to the Client's record.

Client / carer information should only be transmitted by fax if/when it is possible to verify that the information is been sent to the correct recipient.

Email - the content of emails related to case work must be included in the Client's / carer's record. Where appropriate, emails should be edited and prefaced within the record so that the relevance of the emails to casework is clear and the record remains as concise as possible.

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Key Points to Take Away

Records are used for monitoring, investigative and audit purposes. They provide evidence that organisational and legislative requirements have been followed

Social care records demonstrate how and why significant decisions were reached and who was consulted during the process

All actions or decisions taken must be documented in the ongoing record

All records must be kept for 6 years from the date of the last point of contact with a Client

Policy Review

This policy will be reviewed by the Registered Manager at least annually to make any updates and amendments necessary to ensure the policy conforms to current legislation, reflects current practice and expectations.

Authorisation and Signature

This Policy is the official and authorised version agreed by the Directors of Living Carers Ltd. All employees are expected to work in accordance with this policy and failure to comply with this policy could result in disciplinary action.

Registered Manager

06.12.2017

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