

ACS RESIDENTIAL CARE HOMES PROCEDURES

46. Recording and Reporting Care Practices

The Legislative Framework

Standard 8 of the **Residential Care Homes Minimum Standards (2011)** states that 'records are kept in accordance with professional and legislative requirements on each service users' situation, actions taken by practitioners and reports made to others'.

Record keeping is an integral part of care practice. It is a tool of professional practice and one that should help the care process. It is not separate from this process and it is not an optional extra to be fitted in if circumstances allow.

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

- High standards of care
- Continuity of care
- Better communication and dissemination of information between members of the multi-disciplinary health care team
- An accurate account of treatment and care planning and delivery
- The ability to identify risks and detect problems, such as changes in the resident / clients condition at an early stage
- The concept of confidentiality

The best record remains one that is the product of consultation and discussion between all members of the health care team and the service user. It is one that is evaluated and adapted in response to the needs of the service users. The record should enable any practitioner to care for the service user, regardless of where they are within the care process or care environment. It is an invaluable way of promoting communication between those involved in the care of the residents / clients and with the service users themselves. Good record keeping is therefore the product of good teamwork and an important tool in promoting high quality health care.

Content and Style

There are a number of factors that contribute to effective record keeping. Service User records should:

- Be factual, consistent and accurate, written in a way that the meaning is clear;

- Be recorded as soon as possible after an event has occurred, providing current information on the care and condition of the service user;
- Be recorded clearly and in such a manner that the text cannot be erased or deleted without a record change and no use of tippex;
- Be recorded in such a manner that any justifiable alterations or additions are dated, timed and signed or clearly attributed to a named person in an identifiable role in such a way that the original entry can still be clearly read;
- Be accurately dated, timed and signed, with the signature printed alongside the first entry where this is a written record and attributed to a named person in an identifiable role for electronic records;
- Not include abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements;
- Be readable when photocopied or scanned.

In addition, records should:

- Be recorded, wherever possible, with the involvement of the Service User or their carer;
- Be recorded in terms that the Service User can understand;
- Be consecutive
- Identify risks and/or problems that have arisen and the action taken to rectify them;
- Provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

Service User Involvement

Service users should be equal partners, whenever possible, in the compilation of their records. The Data Protection Act 1998, the Access Modification (Health) Order 1987, the Access to Health Records Act 1990 and the Access to Health Records (Northern Ireland) Order 1993 define their rights of access. Procedures for access must be in accordance with the Freedom of Information Act 2000.

Duty of Care

Practitioners have both a professional and a legal duty of care. Their record keeping should therefore be able to demonstrate:

- A full account of their assessment and the care that has been planned and provided;

- Relevant information about the condition of the Service User at any given time
- The measures taken by the practitioner to respond to their needs
- Evidence that the practitioner has understood and honoured their duty of care, that all reasonable steps have been taken to care for the service user and that any actions or omissions on the part of the practitioner have not compromised their safety in any way
- A record of any arrangements that have been made for the continuing care of a service user
- All personal care and support provided
- Changes in the service users' needs, usual behaviour or routine and any action taken by practitioners
- Unusual or changed circumstances that affect the service user and any action taken by practitioners
- Contact with the service users representative about matters or concerns regarding the health and welfare of the service user
- Contact between the practitioners and primary health and social care services regarding the service user
- Incidents, accidents or near missed occurring and action taken.

The frequency of entries will be determined both by the practitioner's professional judgement and the Homes Policy. Practitioners would usually be required to make more frequent entries for service users who:

- Present with complex problems
- Show deviation from the norm
- Are venerable or at risk of harm or abuse
- Require more intensive care than normal
- Are confused and disorientated or generally give cause for concern

Practitioners must use their professional judgement and if necessary, in discussion with other members of the health care team, to determine when these circumstances exist.

The approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'. Practitioners are required to use their professional judgement to decide what is relevant and what should be recorded. This applies particularly to situations where the condition of the service user is apparently unchanging and no record has been made of the care delivered.

The Minimum Standards state that there must be an entry at least once a week. Where the care delivered reflects what is recorded in the care plan the record should

clearly indicate that this would occur unless otherwise reported (exception reporting).

The NISCC Code of Conduct for Social Care Workers (6.2) states that practitioners are accountable through 'maintaining clear and accurate records as required by procedures established for your work'.

Additionally, in making a record, practitioners should also be aware of the reliance professional colleagues will have upon it. Good communication is therefore essential. Furthermore, practitioners are professionally accountable for ensuring that any duties they delegate to members of the practitioners team are undertaken to a reasonable standard.

Record Keeping – computer held records

Many practitioners are now regularly using information technology to record the planning, assessment and delivery of care. There are obvious advantages to this. Computer-held records tend to be easier to read, less bulky, reduce the need for duplication and can increase communication across the inter-professional health care team. There is no requirement to keep manual duplicates of the computer-held records and they do not replace the need to maintain dialogue throughout the inter-professional health care team. Safeguards for computer held records must be in compliance with the Computer Misuse Act 1990.

Auditing Records and Monitoring Reporting Practices

Auditing records can identify areas for practitioners training and development, and should be integrated into Supervision processes. Where reporting practices are not followed this should be addressed immediately and practitioners informed of the correct procedures.

Reporting and Referrals

The template below at Appendix 1 provides a brief guide of reporting and referral arrangements, though this is not fully inclusive of all reporting and referral arrangements. Where practitioners are not certain what they should report, they must seek advice from the Registered Manager. Remember that a record of the referral and follow up actions must be recorded in the Service users care plan.

Appendix 1.

Report to	When / Reason
The Registered Manager	If there is any change to the Service Users well-being or care needs this must be reported immediately or any incident, accident or untoward event. Care practices that are deemed not meeting required standards must also be reported immediately.
The Service Users Representative	If there is any change to a Service Users well-being or care needs this must be reported immediately, or any incident, accident or untoward event. Care practices that are deemed not meeting required standards must also be reported following consultation with the Registered Manager.
The referring Trust	If there is any change to a Service Users well-being or care needs this must be reported immediately or any untoward event. Care practices that are deemed not meeting required standards must also be reported following consultation with the Registered Manager. When a Service User is discharged following consultation with the Registered Manager. When a Service User is discharged following respite a summary report of any period of respite care is compiled and a copy sent to the residents carer in the community (if appropriate) and referring Trust in line with the residents written agreement.
The Service Users GP	If there is any change to a Service Users well-being or care needs this must be reported immediately or any untoward event. Care practices that are deemed not meeting required standards must also be reported following consultation with the Registered Manager or the mal-administration of a medicine.

<p>Relevant Health and Social Care Professionals</p>	<p>If there is any change to a Service Users well-being or care needs this must be reported immediately or any untoward event. Care practices that are deemed not meeting required standards must also be reported following consultation with the Registered Manager.</p> <p>Referrals should be made to relevant professionals who can promote the concept of safe and effective care for a Service User and contribute to the Service Users well-being.</p>
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