Legal Reference

1.0 **Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

Outcome Statement

2.0 **Service users can be confident that:**

- Their personal records including medical records are accurate, fit for purpose, held securely and remain confidential.
- Other records required to be kept to protect their safety and wellbeing are maintained and held securely where required.

2.1 **This is because we comply with the regulations and will:**

- Keep accurate personalised care, treatment and support records secure and confidential for each service user.
- Keep those records for the correct amount of time.
- Keep any other records the Care Quality Commission asks them to in relation to the management of the regulated activity.
- Store records in a secure, accessible way that allows them to be located quickly.
- Securely destroy records taking into account any relevant retention schedules.

2.2 To ensure that the service provider meets it's statutory, regulatory, organisational and individual requirements to document and record services provided in line with "best practice".

2.3 To ensure that there exists a document recording and storage system which ensures that accurate, and correct information is readily available to those people who require it at the point of use.

2.4 Staff will be required to maintain accurate records which will be held in the service users home.
These records will contain information which is considered confidential. It is important, therefore, that staff and service users are aware that arrangements made to keep confidential information secure (e.g. kept in a locked drawer) are observed.

2.5 The company cannot be held liable for the confidentiality of information or records where the information is shared by, or with the permission of, the service user.

2.6 All staff are required to comply with identified standards of documentation, record keeping and report writing.

Policy Statement

3.0 We believe that service users, staff and visitors should be provided with safe systems. This includes being assured that the staff keep accurate records. We are committed to this in relation to Records and record keeping by the following.

3.1 Service users can be confident that their personal records for their care, treatment and support are properly managed because:

- The service has clear procedures that are followed in practice, monitored and reviewed, to ensure personalised records and medical records are kept and maintained for each service user.
- Records about the care, treatment and support of service users are updated as soon as practical.
- Verbal communications about care, treatment and support are documented within personal records as soon as is practical.
- Records about care, treatment and support are clear, factual and accurate and maintain the dignity and confidentiality of service users.
- Records are securely stored and transferred internally between departments and externally to other organisations, when required.
- Protocols exist with other organisations for secure information sharing.

3.2 Records about service users are used to plan appropriate care, treatment and support to ensure their rights and best interests are protected and their needs are met.

- The record of the current interaction is linked with any previous records that exist for that person, whenever the service is able to reliably identify the person.
- They, or others acting on their behalf, and relevant staff, are aware of and can access, and where appropriate, contribute to the record.
- They are assured that safe and secure records management arrangements will continue to be in place for the legally required period should the registered provider close operations.
- Where a request for access to a record is made, all legislation and guidance in respect of Freedom of Information Act 2000 and the Data Protection Act 1998 and the General Data Protection Regulations 2018 are followed by all staff.
- Wherever they are relevant to the service, the following records are kept

and for the periods of time stated:

a. Risk assessments; retain the latest risk assessment until a new one replaces it

b. Purchasing excluding medical devices and medical equipment; 18 months

c. General operating policies and procedures; retain the current version and previous version for three years

d. Any incidents, events or occurrences that require notification to the Care Quality Commission; three years

e. Use of restraint or the deprivation of liberty; three years

f. Detention; three years

g. Maintenance of the premises; three years

h. Maintenance of equipment; three years

i. Electrical testing; three years

j. Fire safety; three years

k. Water safety; three years

l. Medical gas safety, storage and transport; three years

m. Money or valuables deposited for safe keeping; three years

n. Staff employment; three years following date of last entry

o. Duty rosters; four years after the year to which they relate

p. Purchasing of medical devices and medical equipment; 11 years

q. Final annual accounts; 30 years.

3.3 Takes into account relevant guidance, including that from the Care Quality Commission which may be from time to time published.

3.4 Service users can be confident that:

- Their social care records for adults are kept or disposed of in accordance with the Data Protection Act 1998 and the General Data Protection Regulations 2018 and are retained for at least three years from last date of entry.
- Their social care records for children are kept or disposed of in accordance with the Data Protection Act 1998 and the General Data Protection Regulations 2018 and are retained for at least 80 years 80 years from last date of entry.

Procedure

4.0 The manager is responsible for ensuring that staff understand the need for clear accurate records to be kept. Where required, the manager should arrange such training as may be necessary to meet the required standards

4.1 All staff should be guided through recording and record keeping as part of the induction programme for staff.

4.2 Whilst it is appreciated that some staff are less confident in writing and documentation than others, it is a fundamental requirement of the implementation of continuing care that reports and records are passed from one person to another, from one team to another or from shift to shift.

4.3 Where a staff member makes an error in a record or report, they should strike a single line through it and continue with the correct text.

4.4 There are no circumstances under which the use of correction fluid is acceptable.

4.5 Where an error in recording requires a page to be deleted from a record, the staff member should simply strike it through with a single line from the top left corner of the error to the bottom right of the error.

4.6 No staff member should remove a page from a book, or folder. This includes recording systems that are held in ring binders or other such loose leaf systems. Each page should be clearly numbered and contain the date at which the first entry on that page was made.

4.7 All Staff should be familiar with the Report Writing Fact Sheet which accompanies this procedure and is located in the "Reference Material" Section.

The Following Evidence Will Demonstrate That The Required Outcomes Are Being Met And Relevant Standards Achieved

5.0 There is evidence that:

- Staff have been trained to undertake report writing to an agreed standard
- The manager has reviewed reports written and acted where these have been found to be not to the required standard
- No correction fluid has been used
- Errors have been correctly managed
- Pages are numbered sequentially
- All records are signed, dated and timed
- Records reviewed are legible

Training Required

6.0 Staff should be aware of the following:

- Documents should always be completed in black ink unless specifically stated otherwise.

- Documents should be legible without scribble, crossing out or correction fluid.
- If in doubt about what to write, practice on a piece of paper first until you are happy with the wording.
- All documents retained by the service have a retention period. Check to make sure how long documents have to be retained before disposing of them.
- All staff should have been trained in record keeping and report writing as part of the induction process

Forms And Referenced Documents For This Procedure

7.0 Reference - Report Writing Fact Sheet