NursingDirect

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THIS POLICY IS FOR:	Staff including Agency Workers (temporary workers), Commissioners and Service Users

RECORD KEEPING

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RECORD KEEPING POLICY

1. PURPOSE

1.1 To provide a framework for the expectations around record keeping and to ensure that Nursing Direct complies with good practice standards and the legal requirements for record keeping.

1.2 To comply with statutory requirements for confidentiality.

1.3 To support Nursing Direct in meeting the Key Lines of Enquiry/Quality Statements as set out by the Care Quality Commission (CQC).

1.4 To meet the legal requirements of the regulated activities that Nursing Direct is registered to provide:

- Nursing and Midwifery Council (NMC) Legislation
- Freedom of Information Act 2000
- The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- Access to Health Records Act 1990
- Data Protection Act 2018
- Coronavirus Act 2020
- UK GDPR

2. SCOPE

2.1 The following roles may be affected by this policy:

- Staff including Agency Workers

2.2 The following Service Users may be affected by this policy:

- Service Users

2.3 The following stakeholders may be affected by this policy:

- Family
- Advocates
- Representatives
- External health professionals
- Local Authority
- NHS

3. OBJECTIVES

3.1 To enable Staff including Agency Workers, in whatever capacity they have with regards to record keeping at Nursing Direct , to work according to best practice principles and within the law.

3.2 To assist with defining and improving of accountability and establishing ways of working with record keeping and the use of documented communication systems at Nursing Direct. This process evidences:

- How decisions related to Service Users care were made
- Support for Service User care and communications
- Making continuity of care easier
- Providing documentary evidence of services delivered
- Promotion of better communication and sharing of information between Nursing Direct and the wider MDT team

3.3 To support the ability to evaluate and review, clinically audit, research, allocation of resources and performance planning the way in which information is managed and recorded;

- Helping to identify risks and enable early detection of complications
- Helping to address complaints or legal processes
- Supporting effective judgements and decisions including clinical decisions where applicable

4. POLICY

4.1 Nursing Direct recognises that at times situations may change quickly, and as such, it is vital that up-to-date, clear, and comprehensive records are maintained.

Accurate record keeping is particularly important in the following areas:

- To show the CQC and Local Authorities, CCG's and other service users that Nursing Direct has effectively supported Service Users
- To provide evidence that appropriate audits and other monitoring have been undertaken
- To ensure that the latest information, guidance, and best practice has been shared with Staff including Agency Workers to support the health and welfare of Service Users
- Records of contact with family and others important to the Service User are made to show that issues of isolation have been effectively managed
- Medication records are updated and reviewed regularly, especially at times of rapid change
- Minutes of all team meetings, supervisions and training are recorded
- Records of any remote consultations or multidisciplinary inputs are maintained

4.2 Records will be generated and kept of all activities which may affect the quality of Care given, the continuity of that Care, and any business matters which affect the integrity of Nursing Direct and the safety of Service Users.

4.3 Record keeping is an integral part of the provision of care and support provided to Service Users on a day-to-day basis and it is the way that Nursing Direct Staff including Agency Workers demonstrate what care has been delivered, or not, in some cases.

4.4 All Staff including Agency Workers who supervise others during induction or training are responsible for the content and quality of the notes written whilst under their supervision. Staff including Agency Workers will ensure that they fully understand and follow their code of conduct in relation to record keeping.

4.5 All Staff including Agency Workers who make entries in records are responsible for the quality and content as well as adherence to this policy. Staff including Agency Workers understand they are responsible and accountable for meeting the requirements laid down by:

- Policies and procedures of Nursing Direct
- Their contract of employment
- The Nursing and Midwifery Council (NMC) where applicable
- The Care Quality Commission

When developing any records, particularly Care Plans, protocols and clinical records (where appropriate), it is the responsibility of the clinical team at Nursing Direct to ensure that Staff including Agency Workers are adequately supervised and competent to undertake the delegated tasks within these plans/protocols and to meet any training needs identified to support effective implementation of these plans/protocols.

4.6 All Staff including Agency Workers must ensure that they comply with this policy and must report any related incidents involving breaches of confidentiality (including data loss) using the risk management procedures at Nursing Direct.

4.7 Nursing Direct will comply with record retention requirements and can refer to its Archiving, Disposal and Storing of Records Policy and Procedure.

5. PROCEDURE

5.1 **Acknowledging the Importance of Record Keeping**
All Staff including Agency Workers must be aware of the following principles when completing any records at Nursing Direct:

- They provide a permanent legal record
- They may be used for audit and investigative purposes
- Records will be reviewed to aid planning and continuity of Service User Care and the running of Nursing Direct
- Times and dates should always be checked to confirm how up to date the records are
- Significant events and actions documented are:
- Evident
- Easily located
- Legible
- Easily understood
- Relevant and truthful
- Signed by the entrant

5.2 **Record Keeping - Service User Care**
Nursing Direct will keep individual records (either paper-based or digital Care records) on the Care delivered with each Service User. Nursing Direct ensures that:

- All Care records are accurate, honest, and comprehensive
- All Care records are updated in a timely fashion
- All Staff including Agency Workers understand the method for record keeping
- Records will detail all activities relating to the provision of Care including but not limited to, personal care, nutrition and hydration, medication, and tissue viability

5.3 **Types of Service User Records of Care**
The types of records that are kept relating to a Service User and their Care include but are not limited to the following documents:

- Service User Care Plans
- Service User risk assessments
- Daily Care record/log
- MAR
- Body maps
- Fluid chards
- Financial transaction record

5.4 **Formats of Record Keeping**
Nursing Direct recognises that there is no one size fits all method for record keeping and may use a paper-based and/or digital based record system. Many methods may be used for keeping records within the organisation. Nursing Direct understands the importance of having clear, concise methods for recording and logging information as well as the importance of Staff including Agency Workers understanding which method to implement at which time.

5.5 **Standards for Healthcare Record Keeping**
Standards required in record keeping may vary from profession to profession. Some standards apply to all healthcare professionals. These standards are:

- Entries must be as objective as possible, and this means writing in a way that is exactly as the person has described. This ensures that entries are precise and accurate
- Handwriting must be legible
- The time and date that the entry is made must be included. This should be in real time and chronological order, and be as close to the actual time as possible
- Each page must clearly identify the Service User by recording their name and location
- For paper-based entries, mistakes must be crossed through with a single line, signed, dated, and timed. Correction fluid must not be used. Any sheets containing errors must not be removed from the records
- Documentation must be recorded and stored, and must be accessible in chronological order
- Entries must be made in black ink where handwritten records are made
- All entries to records should be signed. In the case of written records, the person's name and job title should be printed alongside the first entry
- Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases, or assumptions but if used, must only be those in widespread use within the profession

5.6 **Guidelines for Effective Record Keeping**

- Entries made must be objective, accurate and factual
- Assumptions about people are avoided
- Observation, as well as talking and listening effectively, will enable Staff including Agency Workers to identify Service Users' needs
- The completion of documentation must never be left until the end of the working day. Records must be completed as soon after the event as possible to avoid forgetting valuable information
- Records must be contemporaneous
- Events may happen which will need to be reported immediately to the senior management team, such as accidents, incidents, serious hazards, and complaints. If there is no immediate way of recording such matters, the Staff including Agency Worker must report the event via telephone which will be recorded by employees.
- Service Users must be made aware of any information kept about them and play an active part in their own Care planning and communications. Records should evidence their awareness and involvement
- Ensure there are records and details of any assessments and reviews undertaken and provide clear evidence of the arrangements made for future and ongoing Care. This should also include details of information given about care and treatment
- Records should identify any risks or problems that have arisen and show the action taken to deal with them
- Records must not be altered or destroyed without authorisation to do so
- Records should be readable when photocopied or scanned
- Records must never be falsified

5.7 **Accessibility of Digital Records**
Nursing Direct recognises that individual Service User records are confidential, and access is only given to relevant individuals. The Service User reserves the right to request access to their records at any time and must give consent for their records to be shared with other parties in writing. Where Nursing Direct has a secure method of operating the digital care record system, which is password protected, offering access to authorised individuals only.

Nursing Direct understands the importance of operating a read-only system for digital record sharing, for times when information should be shared without the risk of it being amended.

5.8 **Office-based Computer Held Records**

- Personal information will be held on computers with a secure system in place to avoid the risk of breaching confidentiality
- There must be access controls in place to restrict users of the system to specific functions as defined by the system manager
- Screens must not be left unattended when the system is active
- Steps must be taken to make regular backups of computer held records
- Backups must be stored in a secure place, if possible, in a separate location

5.9 **Guidelines for Dealing with Messages**

- Write down messages clearly and legibly
- Listen carefully and check for accuracy with the person transmitting the message
- Work out a scale of urgency for transmitting messages
- If a message is left with someone else to pass on, be sure that the person it is intended for actually gets it When writing down messages, include the following:
- Name of the person sending the message
- Name of the person who is to receive the message, date, and time the message has been received and given, clear details of the communicated message and an indication of the urgency
- Whether it was a verbal message or telephone message

Where appropriate, the message should be evidenced on the relevant Service User's record.

5.10 **Confidentiality**
All Staff including Agency Workers need to be aware of the legal requirements for maintaining confidentiality and ensure that their practice, including record keeping practice, is in accordance with these requirements regarding maintaining and sharing records.

All Staff including Agency Workers need to ensure that they do not discuss Service Users in places where they may be overheard or leave records in an unsecure area where unauthorised persons may see them. This includes electronic records on computer screens.

Information that can identify a Service User must not be used or disclosed for purposes other than healthcare without the individual's explicit consent unless, in exceptional circumstances, this is required legally or where there is a wider public interest.

Staff including Agency Workers must also refer to Mental Capacity Act (MCA) 2005 Policy and Procedure at Nursing Direct.

5.11 **Data Protection**
Records kept within Nursing Direct must be reviewed, retained, and destroyed in accordance with recommended retention and disposal schedules. Staff including Agency Workers can refer to the Archiving, Disposal and Storing of Records Policy and Procedure at Nursing Direct for further information.

The collection of any information that is recorded will follow the principles set out in the UK General Data Protection Regulations, underpinned by the overarching need to gain consent from the Service User and through open and transparent discussions about how personal information is used within Nursing Direct.

Staff including Agency Workers can refer to the following policies for further information:

- Consent to Care and Treatment Policy and Procedure
- Mental Capacity Act (MCA) 2005 Policy and Procedure
- Data Protection and Confidentiality Policy and Procedure
- Access to Information Policy and Procedure
- UK GDPR suite of policies and procedures

Staff including Agency Workers should also access further guidance provided from the ICO relating directly to the management of healthcare data.

5.12 **Safe Secure Storage of Personal Information**
Within Nursing Direct there must be a secure storage area provided to maintain confidentiality within the head office for archived documentation. Within the Service User's personal/home environment, or during periods of social leave, it is recommended to the service user to ensure a safe and secure environment that maintains confidentiality.

This is subject to the agreement of the individual Service User and/or representative. If there is a refusal to retain information within their personal/home environment, then this should be in written form and kept with the main Care Plan.

5.13 **Files Away from Nursing Direct**
Any files and information that need to be transported with Staff including Agency Worker who is authorised to have access to the information, for example, if they are needed for providing Care, auditing, or a professionals' meeting, then they must be transported in a secure way. Any such documents must not be left in vehicles overnight.

5.14 **Training and Education**
Where it is identified that all Staff including Agency Worker requires record keeping and documentation training, a face-to-face training session will be organised as well as individual support on an as-and-when needed basis. The training around the security of records, the confidentiality principles, and data protection on commencement at Nursing Direct is completed on a yearly basis.

Nursing Direct will identify and support the training needs of all Staff including Agency Workers who may have specific requirements in relation to Service User records, such as person-centred planning.

5.15 The above methods can be applied to the following types of record keeping:

- Service User Care/clinical records
- Staff including Agency Workers communications
- Memos
- Diary and handover systems between Staff including Agency Workers
- Meeting minutes
- Audits and report writing
- Supervisions or appraisals
- Letters, e-mail, or fax communication

6. DEFINITIONS

6.1 **Staff including Agency Workers**

6.1.1 **Staff**
Denotes the employees of Nursing Direct Healthcare Limited.

6.1.2 **Agency Workers**
Refers to individuals who are contracted with Nursdoc Limited or another employment business as an Agency Worker (temporary worker) provided to Nursing Direct Healthcare Limited to perform care services under the direction of Nursing Direct.

6.2 **Nursing Direct**
Nursing Direct, also known as Nursing Direct Healthcare Limited, is the entity regulated by the CQC (Care Quality Commission) and responsible for the care service provision, contracted to provide homecare services to service users in their homes, in placements, essential healthcare facilities and in the community.

6.3 **Nursdoc Limited**
As the sister company to Nursing Direct Healthcare Limited, Nursdoc Limited acts as an employment business, specialising in providing staffing solutions to the healthcare sector.

6.4 **CQC (Care Quality Commission)**
CQC throughout this policy, the term "CQC" refers to the Care Quality Commission (CQC) which is the independent regulator of health and social care in England.

6.5 **Assumption**
A thing or event that is believed to be true or certain to happen without proof

6.6 **Jargon**
Special words or expressions used by a particular profession or group that may be difficult to understand

6.7 **Abbreviations**
A shortened form of a word or phrase

6.8 **Handover**
This is the transfer of responsibility and accountability for some or all aspects of care to another person on a temporary or permanent basis

6.9 **Health Record**
A 'health record' means any record which consists of information relating to the physical or mental health or condition of an individual and has been made by or on behalf of a health professional in connection with the care of that individual

6.10 **Records**
Records are defined as 'recorded information, in any form, created or received and maintained by an organisation in the transaction of its business or conduct of affairs and kept as evidence of such activity'

6.11 **UK GDPR**
- The General Data Protection Regulation 2016/679 is a regulation in EU law on data protection and privacy for all individuals within the European Union and the European Economic Area. It was implemented on 25th May 2018
- Following the UK leaving the EU, the General Data Protection Regulation has been retained in UK law and will continue to be read alongside the Data Protection Act 2018. Some technical amendments will take place to ensure that it can function in UK law

OUTSTANDING PRACTICE

To be ' outstanding ' in this policy area you could provide evidence that:

- Service Users are fully involved in the production, assessment, and evaluation of their care records
- Themed audits take place to ensure compliance with this policy
- Systems and processes are in place, which are efficient and regularly reviewed with regard to communication to Staff including Agency Workers and Service Users
- Where issues have arisen with regard to communication and record keeping, there is a 'no blame' culture in Nursing Direct, but opportunity is taken to reflect on practice, review and implement changes for better outcomes
- Feedback from sources such as external visiting professionals, Service Users, Staff including Agency Workers and families is positive in relation to communication systems and record keeping

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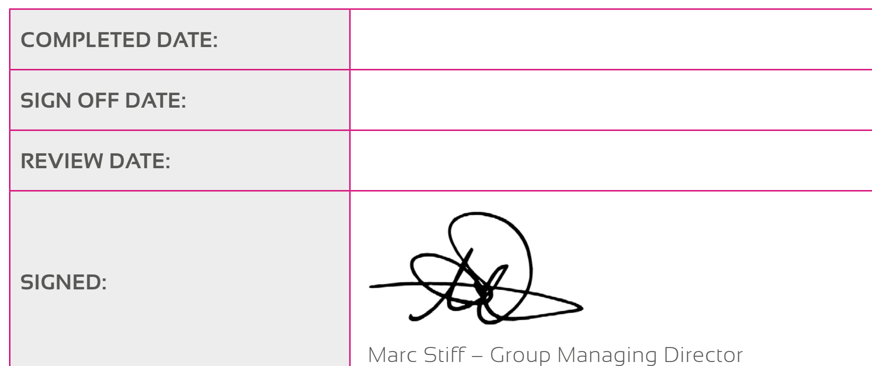
SIGNED:	 Marc Stiff – Group Managing Director