Headway North West London

Record keeping Policy & Procedure

[Creation, management, storage and destruction]

1. Policy Statement

Headway North West London (HNWL) is committed to the principle of maintaining accurate, comprehensive, clear and complete records of care provided for all service users. The records will be kept for the appropriate periods as laid down in legal and national requirements and safeguarded against damage, loss or improper usage.

To ensure transparency, managing and maintaining services user's rights and confidentiality, this policy should be adhered to by all members of staff or volunteers.

Users may be entitled to access the information we keep about them under the Data Protection Act 1998.
If there is any information from third parties, for which there is no permission to share, this should be kept in a restricted access section of the service user's records and you should contact your line Co-ordinator for further guidance if the service user or any other unauthorised individual requests to see this information.

2. Related HNWL policies/procedures:

You should be aware of the following HNWL procedures which are also applicable:

Confidentiality Policy
Data Protection Policy and Procedure

2. Staff Responsibilities

2.1 Co-ordinator/ Senior Person

- Responsible for ensuring that all records are maintained and stored for all service users in accordance with the policy and procedure in place

and ensuring that it is adhered to by their members of staff and/or volunteers.
- Responsible for destruction of records in accordance with policy and procedure
- Responsible for ensuring that all staff, volunteers and service users have access to and are aware of this policy
- Responsible for ensuring that safeguards are in place to protect the interests of the service user.

2.2 Staff

Will be responsible for reading, being aware of and complying with this policy and procedure. A failure to comply with this policy may be deemed as a disciplinary offence.

All staff should to be aware of the policy and procedure and where appropriate be aware of professional guidance on record keeping for clinical staff.

Staff who are responsible for care plans management must have had training in the provisions of the Data Protection Act 1998

All staff working with care plans must have specific induction and update training including training on service user confidentiality and on the security of records, particularly electronic care records.

All staff working with care records are reminded that it is a disciplinary offence to disclose confidential information to unauthorised individuals

3. Audit Plan

The Co-ordinator/ senior person will monitor adherence of the policy and report findings to the Trustees. The Trustees will also review the policy and update the policy as appropriate from time to time.

4. Scope

This policy applies to all staff, volunteers, and Trustees or Board of Directors. The procedure aims to set out the steps by which care records are created, the requirements of staff to complete the records appropriately and the requirements for the management, handling, storage and destruction of care records

5. Procedure

Creation of care records

Staff and/or volunteers should ensure that:

- All service user's care records should be kept in their own individual folders, which holds all papers securely, allows insertions to be made and clearly indicates the location of each part of the care record.
- Each personal record should have a unique identity eg Name of HNWL Service, initials and date of birth of service user.

Completion of the record

Care should be taken to ensure that information is recorded precisely for the purposes for which it serves and no others. The objectives include:

- To assist accountability, i.e. to demonstrate the achievement of required standards of practice

- To help decision making, i.e. to provide accurate, up to date, unprejudiced information, which support the making of informed decisions.

- To convey, interpret and understand behaviour and events, i.e. to record as accurately as possible impressions and observations of events.

- To manage effectively and to review and evaluate service provision, i.e. there is always a need for good accurate and reliable management information.

- To exchange information and communicate efficiently, i.e. to help team work, continuity and consistency of practice.

More specifically:

- To provide a baseline assessment record against which improvement or deterioration may be judged

- To provide a record of any problems that arise and the action taken in response to them

- To provide evidence of specific support required, interventions carried out and service user responses

- To include a record of any factors (physical, psychological or social) that appear to affect the service user.

- To record any specific requirements to care and support needed

- To record the chronology of events and the reasons for any decisions made.

Entries in the service user's care plan must be:

- written legibly in ink *(black ink)*
- clear and unambiguous
- dated
- timed
- recorded at the same time or soon after the observation/ incident or following an evaluation of the session
- signed by/ countersigned by the person making the entry who is responsible for the support with the person's name and designation next to the signature
- It is not good practice to use abbreviations in care records and these should be avoided as much as possible. If abbreviations are used add as an appendix a locally agreed list of acceptable abbreviations will need to be inserted into the care records.
- Alterations are made by scoring out with a single line, so that the original entry can still be read alongside the correction. Liquid paper, adhesive paper or Tippex must **not** be used to delete on error.
- Any alteration should also be initialled and dated.
- If it is the local policy that if a student writes in the Service user record, all entries must be countersigned by the Co-ordinator or senior worker responsible for the service user's support.
- All staff must be aware of the right of the service user to have access to the record and give careful consideration to the language and terminology used.

Legal status of the care record

- The service user record/ care plan is a confidential document whether in writing or computerised form. Access to it is therefore restricted but it should be available to all members of the staff team, excluding volunteers.
- Access to it without the service user's consent is therefore restricted, but it should be available in its entirety to members of the staff team, and to all other professionals insofar as it is necessary for them to carry out their professional duties
- The originator must ensure that an entry made in to a care plan is accurate and based on respect for truth and integrity.

- Any document, which records any aspect of care of a service user can be required as evidence before a court of law.
- The maker of any care plan can be required by a court to give evidence

Computer held records

- Care plans held on computer must be password protected to avoid the risk of breaching confidentiality
- There must be access controls to restrict users of the system to specific functions as defined by the system Co-ordinator.
- Screens should not be left unattended when the system is active.
- If the service user is away from the screen, the access controls must be activated
- There must be a local procedure as to how entries into the computer records are authenticated in the absence of a written signature. Each entry must clearly indicate the identity of the originator of the record.
- Steps must be taken to make regular back ups of computer held records on disc, tape or other similar mediums.
- Backups should be stored in a secure place, if possible in a separate location

Storage of care records

- All records held within Headway must be safeguarded against loss, damage, or use by unauthorised persons by keeping care plans in secure controlled locations at all times, for example in locked rooms, locked cabinets or security protected computer systems.
- Authorised personnel must have access to the stored care records at all reasonable times.
- All care records must be kept for a minimum period of seven years after death or discharge.

Copying records to other media, duplicate and replacement records

- A local procedure for the copying of records onto other media for storage reasons should be in place. This needs to include who is authorised to do this and the time period after which records are copied.

Destruction of service user records

- Care plans must be destroyed once they have been retained beyond the *statutory retention period after either a] leaving the service or b] death of the service user. [*7 years as agreed with the Data Protection Information Commissioner]
- Records must be destroyed in such a way as to ensure that confidentiality is not breached (this will usually be by shredding the

entire content of the record if paper held or by deleting the content of records held on electronic media. Discs and tapes must be destroyed)

- Where records are incinerated by an external contractor, the process is monitored and the company is required to give a written guarantee with regard to confidentiality.