



Effective Record Keeping

Defensible Documentation

Exemplary documentation provides a foundation for fewer treatment errors, while reducing the number of inquiries about the treatment provided.

Failures of documentation may have serious consequences which could result in litigation

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Service User Records Should Be:

- Factual, consistent, accurate dated, timed and signed
- Written as soon as possible after an event has occurred, providing current information on the care and well-being of the Service User
- Written clearly and in black ink
- Do not leave any gaps in between entries
- Use 24 hour clock
- Comply with all aspects of GDPR 2018

- Written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can be read clearly
- Your name should be printed along side your first signature
- If initials are to be used then a record of these should be kept in the main office,
- Free from jargon, abbreviations, meaningless phrases, irrelevant speculation and offensive subjective statements



Remember!

Documentation reveals as much about you as it does
about your Service User

Be sure **your** recording reflects your honesty, dedication
and intelligence

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Recording

- Always record accurately
- Records should be objective and contain only facts
- It is your role to recognise record and report your suspicions ***not*** to investigate them

Record

what you **know**,

not what you **think** you know

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Who Can Access Your Reports?

- The Police
- SCSWIS
- HIS
- Social Work
- The Office of Public Guardian
- The Mental Welfare Commission
- Advocacy Services

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The Purpose of Keeping Records

- Information needed for making decisions
- Information to provide background and knowledge for another worker
- Information about family and contacts of people who are important to the person
- Information of other professionals involved in the individuals care
- Information to be passed from yourself to a colleague over a short space of time to ensure that the care you provide offers an element of continuity
- Information to help in planning and developing services

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Recording Accidents, Incidents and Complaints

- The Company should have written policies and procedures for the reporting and recording of incidents and complaints
- All staff should be aware of these policies and procedures and know where and how to record these
- You should know the correct procedure to take when assisting a service user to make a complaint

Complaints

- All care services are required to have a complaints procedure
- Your role is to assist service users in making complaints
- Making sure that service users are aware of the complaints procedure
- We as care staff need to learn from complaints

Accident and Incident

- All care sectors must have procedures in place for making a record of accidents and incidents
- This is required by RIDDOR regulations and also Care Inspectorate
- Accident and incident books must comply with Data Protection Act
- Know where the report forms are kept and complete as soon as possible after event