



# Record Keeping

**September 2023**



## 1. Introduction

- 1.1 This Policy and Procedure should be followed in conjunction with other relevant and appropriate departmental policy, procedure or guidance.
- 1.2 The activity of making and keeping records is an important part of care and should not be seen as a distraction or burdensome chore.
- 1.3 All documents that record aspects of care can be required and used as evidence in:
  - Disciplinary Hearings
  - Enquiries regarding professional conduct
  - Matters that proceed to a Court of Law
- 1.4 Record keeping is necessary in order to serve the best interests of the people to whom they relate and enables the provision of care to be monitored.

## 2. Record Keeping: Areas of Importance

- 2.1 Record keeping applies to organisational, service and individual matters.
- 2.2 Records will be kept in the following key areas:
  - 24- hour diary
  - Locked office
- 2.3 All records should demonstrate the sequence and timing of events and all significant appointments, assessments, observations, decisions, interventions and outcomes.
  - a) Sequence – what happened before, during and after the event?
  - b) Timing – when did it happen?
  - c) Appointments – who with, where, when, duration and follow up.
  - d) Observations – what observed, where, when, who by. Are they regular planned observations or ad-hoc, unusual?
  - e) Decisions – description of the decision, who is involved, reasons, when made, review date if set.
  - f) Interventions – description of the intervention, who is involved, reason and purpose, frequency, review date if set.
  - g) Outcomes – description of the outcome, was it positive or negative outcome, what benefits, who else is affected.

## 3. Individual Record Keeping

- 3.1 When completing records relating to individuals the person's name should be stated clearly.
- 3.2 Black ink must always be used.
- 3.3 Information must be legible.
- 3.4 Words and language used should be easily understood and should not include abbreviations.
- 3.5 All entries must be dated and signed, using a full legible signature.
- 3.6 If errors are made then a line should be drawn through the mistake and a signature written over the top of the mistake. **Never erase the error or use Tippex.**
- 3.7 Record the facts and what is observed, not what is a personal interpretation of what happened. Comments and opinions must have supporting evidence.

**Fact:** "The individual slipped on the wet floor."

**Opinion:** "The individual slipped on the wet floor because in my opinion they appeared to be intoxicated."

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**COMPANY NUMBER I038594I**

- 3.8 Wherever possible entries in individual records should be **positive**
- 3.9 Remember that individuals have rights to access their personal notes and should be enabled to do so.



#### **4. Storage and retention of records**

- 4.1 All records will be retained and stored in accordance with Criteria for the Retention and Destruction of Confidential Information (see Document Control).
- 4.2 Records must never be discarded or destroyed unless the Destruction Criteria indicate and never without the approval of the Director.
- 4.3

#### **POLICY REVIEW**

This policy will be reviewed annually or in light of any changes in legislation and/or guidance.

This policy document will be reviewed in September 2024.

Signed by:

Andrew Burlison (Managing Director)