Records and Record Keeping: In-depth

Summary

Record keeping includes all the paperwork and computer records that need to be kept by MKEC to fulfil their obligations in areas such as health and safety, employment law, legal protection, finance and bookkeeping, registration and, most importantly, care and medical records. This amounts to a substantial mass of paperwork and/or electronic records that must be treated and kept with due care and attention, especially where records may be sensitive or confidential.

Current government policy is to expand the use of digital methods and data collection across the health and social care services. It aspires to integrated health and care record systems and sharing of information. See Implementing digital record keeping.

Following the Covid-19 experience, it is also seeking to collect more information from MKEC that could help prevent and manage future outbreaks. This requires more record keeping by MKEC in order to comply with these mandatory requirements.

MKEC' records and record-keeping systems must comply with the corresponding care standards and regulations, the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). (See Data Protection topic for in depth discussion.)

Employers' Duties

MKEC should:

- comply with their registration requirements to have sound policies and systems for the production, use, storage and security of all records that they are required to keep
- comply with data protection and access-to-records legislation, which applies to all organisations
- make sure that they take an equally robust approach to data protection whether using manual or electronic systems
- plan and organise the people who use the services' records to make efficient use of all required information
- make sure that people's records are stored safely and only used by people authorised to use them
- make sure that records relating to people's care plans reflect person-centred values and principles

- make sure that staff records are kept up to date, safe, secure and accessible only to those who need them
- set up systems and procedures to monitor and review all aspects of record keeping in the care service
- make sure that staff are competent in matters of recording and record keeping by organising relevant training and supervision
- provide induction training on record keeping and recording practice to national workforce development standards.

Employees' Duties

Employees must:

- learn and understand all aspects of the care service's approach to record keeping
- be aware of the importance of confidentiality and data protection legislation and policies in relation to their use of the care service's records
- know how to obtain access to records when they need to use them and from whom to seek permission
- understand the consequences in terms of disciplinary action if they fail to follow the care service's policies and breach confidentiality
- become competent in recording in line with the requirements of their role and job descriptions and be open to the training provision available
- know how to make safe and effective use of manual and electronic recording systems and methods depending on what is used by the care service.

In Practice

CQC Standards Compliance

Record keeping forms part of good governance as reflected in the Quality Statement under Well-Led, which the Care Quality Commission (CQC) will be using to assess service and award ratings from 2023.

Governance, management and sustainability

We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.

Specifically the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 cover record-keeping requirements under Regulation 17: Good Governance, paragraph 2. The registered person must:

- maintain securely an accurate, complete and contemporaneous record in respect of each person receiving care, including a record of the care and treatment provided to the person and of decisions taken in relation to the care and treatment provided
- maintain securely such other records as are necessary to be kept in relation to:
  - persons employed in the carrying on of the regulated activity
  - the management of the regulated activity.

The CQC guidance on meeting this part of Regulation 17 identifies the importance of people who use the services' records being:

- comprehensive, fit for purpose, legible, accurate and up to date
- kept securely and confidentially, and only accessed, amended or destroyed by persons authorised to do so
- complete and accurate for anyone lacking mental capacity for whom "best interests" decisions are taken
- kept in line with current legislation and guidance, particularly data protection laws.

There are similar requirements for other kinds of records that must be kept, such as employees' records, policies and procedures, service and maintenance records, audits, reviews, purchasing documents and action plans in response to risks or incidents.

Employee's records must be designed and kept to comply with Regulation 19: Fit and Proper Persons Employed and Regulation 5 relating to the fitness of directors.

Achieving CQC Compliance with Regulation 17

Inspectors assess compliance with the regulations on record keeping by seeking evidence that care plans are thorough and fit for purpose, which means that they must be well recorded.

The CQC will assess compliance with the relevant parts of Regulation 17: Good Governance by checking that the care service:

- keeps accurate personalised care, treatment and support records for each person
- makes sure the records are kept secured and confidentiality is maintained
- keeps the records for the correct amount of time
- keeps any other records that the CQC asks them to keep in relation to the management of the care service
- stores records in a secure, accessible way that allows them to be located quickly
- securely destroys records that have passed their minimum retention period.

Managers should list and set up a system for regularly monitoring and reviewing all the records that they are required to keep, making sure that they are up to date, accurate and generally fit for purpose. Relevant staff can be delegated to carry out these functions in line with their areas of responsibility.

The quality ratings awarded by inspectors will be adjusted in line with the level of compliance for all the above features.

Wales Standards Compliance

Under the Regulation and Inspection of Social Care (Wales) Act 2016, the record keeping for all care services is regulated in line with Regulation 55: Records of the Regulated Services (Service Providers and Responsible Individuals) Regulations 2017.

Regulation 55 requires MKEC to:

- keep and maintain all required records accurately and up to date
- meet the requirements of the Data Protection Act 2018 (and by implication the General Data Protection Regulation (GDPR)
- keep them securely and have arrangements to keep them securely in the event of the service closing
- ensure electronic records are password protected
- have a policy and procedures for the management of records
- ensure staff are aware of the policy and have clear understanding of the procedures for managing records (this includes training in information security and action to be taken where personal information is compromised)
- have a policy and procedures for people who use the services to have access to their own records and any other information held about them by the home
- retain an adult's care records for at least three years from the date of the last entry (there are different requirements for children).

Regulation 74 also imposes a duty on service providers to "ensure there are systems in place for keeping of records", which should conform to information governance standards as required by the GDPR.

Scotland Standards Compliance

In Scotland, the need for high-quality recording practice is reflected throughout the national health and care standards, *My Support, My Life*, particularly under section 4: "I have confidence in the organisation providing my care and support".

Compliance procedures

The records required for inspection purposes fall into four main categories. They must be well organised and kept in good order. There might be of course other kinds of records, but which are less important for compliance purposes.

1. People who use the service's records. They should be divided into sections with the key information regarding current care plans and treatment needs at the front or kept separately so that staff know precisely what they are required to do and can continue doing so from the recording that is carried out. This section should include relevant information about consent, any communication needs (in line with the Accessible Information Standard) and emergency contact details. Other sections will include biographical information and needs assessments including risk assessments (on which the current care plan will be based), correspondence, etc all of which can be referred to as needed.

2. Staff records. Key information showing evidence of safe recruitment — full employment history with gaps having been explored, qualifications, references and satisfactory DBS checking should be readily available to an inspector. Supervision, appraisal and training records should also be accessible for inspection purposes.

3. Health and Safety records. These should show that premises, facilities and equipment are all currently fit for purpose with safety checks and servicing histories. They should be kept as a body of information, sub-divided as relevant.

4. Quality Assurance. These records include the monitoring, reviewing and auditing schedules of care plans, risk assessments, people receiving care and stakeholder surveys, etc and the recording of their completion.

Record Keeping Principles

As shown in the Policies menu, care services should have policies on record keeping, data protection and access to records. The record keeping policy should outline its recording and record keeping principles and how it sets out to comply with the current regulations. (See the model policy on Record Keeping.)

To comply with the requirements a care service should carry out the following.

- Have clear procedures for the development, use, monitoring and reviewing of all personal records such as needs assessments, risk assessments, care plans, medical records and reviews.

- Keep a record for each person which remains fit for purpose, accurate, kept up to date and clearly organised.

- Instruct staff to make their record entries as soon as possible after carrying out any task or after an incident to be recorded such as a telephone conversation with a person's relative. This is to keep them up to date and accurate.

- Instruct staff to record any verbal communications about a person's care, treatment and support on the appropriate personal record as soon as is practical.
- Constantly check that people's records are clear, factual and accurate and maintain their dignity and confidentiality.
- Have a system for securely storing the records.
- Have clear procedures, which comply with the relevant legislation, for people to obtain access to any records from within or outside the service when they need to do so.
- Have clear procedures for securely sharing information with any external professionals, agencies or organisations, which in general should follow "need to know" principles.

Common recording principles apply to both manual records and to electronic record keeping systems, which the Government is encouraging MKEC to develop.

Ownership of Care Records

Who owns a care record? This is not an easy question. The following points might be noted.

1. On the one hand, the care provider is legally required to keep a record of how it provides each person's care and support, and to keep their records for at least three years following the end of service. This implies that the record (manual or electronic) is the care provider's property.
2. On the other hand the information included in the record is personal to the subject of the record, who must consent to its being recorded, shared and used, and who has the right to see what is being written about them. In this respect they "own" the content, and continue to do so after end of service while still a living person with a right to access that information and to control how that information might be used.
3. The Data Protection Act ceases to apply after death. Although the legal position of care records is unclear, they might be treated in the same way as health records. These are subject to the Access to Health Care Records 1990, which allows:

    a. the dead person's personal representative, eg executor of will or administrator of the estate

    b. someone who might have a claim from the death

    c. a Court or other public body to obtain access if thought necessary.

    A person is also entitled to make an advance directive (or include in a will) granting a designated person future access to their information.

4. The above points suggest there is shared ownership of the records, which has implications for storage and access. In principle there is nothing against, and much to be gained from records being kept by or in the possession of the person who uses the

services, assuming they can be kept securely and confidentially (to avoid ineligible people have access). This is common practice in domiciliary care but less so in care homes.

5. It follows that electronic records should be subject to the same principle of "shared ownership" and made readily available to the person to find out what is being written about them. This availability should be built in to their design, use and security.

6. Except where the person has died, the care provider will need the person's consent to retain their records after end of service, an issue which might be included in the initial service agreement to avoid later uncertainty or disagreement over ownership. The confidentiality of any "third party's" information included in the records must also be considered in any request for access of past records.

General Guidance: Purposes of Keeping Records

Care service managers and staff should be aware of the different purposes of their records. They can then make sure that staff record information to meet the identified purpose.

Records need to be kept for the purposes of:

- accountability
- decision-making
- contributing to positive outcomes for the people receiving the service
- capturing important information that otherwise might be lost
- monitoring, reviewing and quality assurance
- promoting information exchange and communication.

Recording Principles

It is important to convey to staff that people have a right to see what is written about them. Care staff who contribute to a person's records must learn that their recording should be:

- understandable — every reader should be able to understand what has been recorded
- relevant to purpose — recording should always be to the point
- clear and concise — keep the record as simple as possible
- accurate and factual — stick to the evidence
- checkable — it should be possible to verify what has taken place from the record
- inoffensive — it should not cause offence to anyone reading the report

- not based on stereotypes or generalisations that label people — the record should be about the person.

They should be made aware that different parts of a care plan require different types of recording. They should thus be made familiar with the different recording frameworks that are used in the service — MAR charts, monitoring forms, etc — and the procedures for completing them.

The same applies to non-care staff who are required to keep records relating to their areas of responsibility, eg making health and safety checks or after completing cleaning schedules.

Recording on Care Plans

Care services should adopt a policy of linking all recording to a person's plan of care so that they are both needs- and outcome-related.

Example 1. "To help Gloria (her preferred mode of address) keep in touch with her friends [reflecting a need/personal goal] it has been arranged for her to attend every Thursday the club where they used to meet [a means of meeting the need]. She is taken there by her daughter or other family member [practical means]."

The care plan record should then reflect that the assessed need is being met because of the agreed actions being taken with any explanation as to why they might not have been carried out. "Gloria went out as arranged on 21 January but missed this week because of a cold."

Having a clear record should then help with the monthly review, which should discuss with Gloria and possibly her relatives if she is happy (ie the outcome) with this part of her care plan. If she is not, the reasons can be discussed and the plan can be modified or changed in an open-handed way.

Example 2. "To enable Mrs A to dress herself or with minimum assistance, which will also improve her movement and co-ordination, give her a sense of achievement and restore her confidence, which she very much needs."

The care plan record should then reflect how the goal is being achieved and the assessed need has been met. For example: "With prompting Mrs A is now able to zip up her cardigan (whereas last week she could not get her fingers around the zip to pull it up)."

Having a clear record should then help with the monthly review, which should discuss with Mrs A and possibly her relatives how much progress she has made with her care plan and what more needs to be achieved. The review will record any difficulties or hold ups that have been experienced and further goals and tasks will need to be moderated accordingly.

(Examples of record sheets that follow this approach can be found in Resources in the Care and Support Plans topic.)

Care Records

Care records need to be suitably detailed, but the level of detail required will vary according to each person's needs and the requirements of the service. For example, the records of a person receiving reablement care would need to include rather more detail, such as what specific assistance was given for each task and what they did for themselves.

Record-keeping is an essential component of the service. If staff are complaining that they do not have time to complete proper records, then this must be addressed. Domiciliary services can carry out service reviews and ensure the staff are using their time effectively, then request extra time from the service commissioner if required. Care homes can do the same, and if necessary adjust their staffing levels.

Care workers using a mobile device to electronically record care records should do this in the person's home before they leave, as they would with paper records. Where the system used includes the recording the location of the staff member making the record, managers should check this at every audit to ensure that staff are recording when and where they should be.

Recording Methods and Tools

MKEC should pay close attention to the development of appropriate recording methods and tools that enable them to comply with the current standards and regulations. They could use one, or a combination, of the three following methods for any record keeping purpose.

The "closed" recording method

This uses various forms and checklists that require simple facts or a choice from a limited set of possible responses. For example, this method might be used in a "person receiving care satisfaction" survey, where people who use the services are asked to rate how pleased they are with the services being provided.

The main drawback of this method is the lack of detail in the information provided, which will need to be added to from other methods before it has practical value, eg if needed to create an improvement plan. Another drawback is that checklists and similar examples of closed recording tend to produce shallow thinking and responses.

Managers should discourage staff from adopting a "tick box" mentality in their recording practices. They should use the closed recording method only when they are clear that it will achieve their purpose, and this will usually be in combination with other methods.

MAR charts use the closed recording method, because it is the best way of having accurate and reliable information on medicine administration.

The "semi-structured" method

"Semi-structured" formats provide headings but then considerable scope on the contents and style to be used in completing the information requirements. Such formats usually require judgments and opinions or recommendations to be formally included.

Examples include assessment reports, including risk assessments; support plans and reports to other agencies.

Here it is important to ensure that all assessments and judgments expressed are well supported by evidence and facts. Needs assessments and care plans require this approach to accommodate the different contributors to the process, including the person who is subject to the assessment or care plan.

The "open" method

"Open" formats provide minimum structure and maximum scope for recording and reporting a wide range of information such as a daily log or "incident" book.

For example, in some care services staff might be encouraged to contribute to a daily diary to assist the exchange of general information such as forthcoming events that need attention, and on common issues. It should be kept in an accessible place and used by staff and people who use the services after training in its use. Diary entries should be initialled. The diary should not be used to record personal or confidential information; its use should be limited to general information exchange.

Encouraging an Open Approach

A care service is legally required to maintain care plans, needs assessments, risk assessments, case reviews and incident records, and to keep certain confidential notes and records relating to people they support as essential components of its day-to-day running.

Tensions and complaints about access to information and records can be reduced if the care service has fostered an atmosphere of openness and respect, in which people who use the services, family, friends and staff all feel valued and that their opinions and rights matter. This can be done in the case of record keeping by encouraging staff to involve the person whenever records are being written. This helps to involve the person more fully in their own care and the purpose of the record can be explained and understood.

By developing an atmosphere of "working together" with the person and their relatives, anxieties will be greatly reduced. This approach should give people who use the services confidence in the systems of record keeping and make them aware of their rights to confidentiality and to have access to personal information.

Importance of Being Non-judgmental

Information given by third parties should be verified, firstly with the person and/or their family, partner or close friends, as well as with other professional sources (all with the person's permission) and against information that is held in the user's file.

Reports on people should be written in a language and format that the subject can read and understand. If a person has another reading language, they might need a translator or interpreter. If the person is unable to read, eg because of learning difficulties, they might need a recording format that uses signs or graphics.

Managers should pay close attention to the possible use of discriminatory language in the home's records. They should check carefully that the person being written about is not being unfairly labelled, eg as a troublemaker or problem, which can influence other readers' attitudes to that person.

This applies particularly to certain groups of people, eg "senile" describing someone who might become occasionally confused, "precocious" describing the behaviour of a young woman, or "aggressive" when describing the attitudes of black men or women solely because of their colour.

It is also important to avoid discouraging staff from recording because they are frightened of being accused or challenged on the grounds of using discriminatory language.

Managers should make a point of raising these issues in training and staff supervision, using any feedback from monitoring and reviewing procedures in their efforts to develop the standards of recording practice required.

Data Security

All data, and particularly sensitive or confidential data, must be stored securely. Manual records such as personnel files and care files of people who use the services should be kept in locked filing cabinets, preferably within an office that is locked when unattended.

Information obtained from Disclosure and Barring Service (DBS) checks should be kept separately in line with the DBS Code of Practice. (See sample policy Disclosure and Barring Service: Handling and Security of DBS Disclosure Information.)

Care must be taken when working on confidential files that they are put away securely and not left out on a desk when people could walk by and see them.

Information governance

Providers of care homes with nursing should know about the Information Governance Alliance: *Records Management Code of Practice for Health and Social Care 2016* (generally referred to as the Records Management Code of Practice), which was introduced under the Health and Social Care Act 2012.

The code will apply if an adult social care provider's care records are integrated and used with NHS records of people who use the services. This will be the situation of many care homes with nursing, especially those that have contracts with local Clinical Commissioning Groups, which might then expect the services they commission to apply the Records Management Code of Practice.

Included in a contract could be a requirement that the care service will achieve the information governance quality standards as set out in the Code of Practice, by regularly completing the Information Governance Toolkit (IGT), an online self-assessment framework that has become standard for NHS bodies and partner organisations to use. The IGT meets the requirements of the General Data Protection Regulation (GDPR). (See also Information Governance under the General Data Protection Regulation Policy.)

Data Protection Act 2018 and the General Data Protection Regulation

Care services that hold manual or electronic records for people who use the services and employees must comply with the Data Protection Act 2018.

The Data Protection Act 2018 provides the national legislative framework for the implementation of the internationally applicable GDPR.

For detailed information, see Data Protection and GDPR topics.

See also the model policies on:

- Data Protection and Compliance with the General Data Protection Regulation
- Information Governance under the General Data Protection Regulation.

Retention of records

The regulations require care services to keep all records up to date and to make them available for inspection. It should be noted that records of people who use the services must be kept for a minimum of three years from the date of last entry, eg after they have moved on or died. There does not appear to be any change in the rules governing the retention of other types of record. Retention guidelines include electronic as well as manual records. (See Employers' Factsheet for full list.)

Scanning records

Scanning a copy of a record is the same as making a photocopy and would be subject to the same data protection and retention requirements as the originals. There is nothing to prevent care services storing records in scanned format instead of paper format — it would be a local decision. As the electronic version becomes a facsimile of the original and replaces it, there is no need to keep the paper records. The data protection and retention issues would be common to all eventualities.

Caldicott Guardians

The Caldicott Report of 1997, *The Review of Patient-Identifiable Information*, made several recommendations for "regulating the use and transfer of person identifiable information between NHS organisations in England and to non-NHS bodies". The recommendations of the Caldicott Committee have since defined the confidentiality agenda for NHS organisations for several years.

Central to the recommendations was the appointment in each NHS organisation of a "Guardian" of person-based clinical information to oversee the arrangements for the use and sharing of clinical information. Subsequent work has extended the requirement to appoint Caldicott Guardians into Councils with Social Care Responsibilities (known as CSSRs).

Since then, developments in information management in the NHS and CSSRs have added further dimension to the Caldicott role, which are discussed in the latest *Caldicott Guardian Manual*. The guidance is reviewed annually and the manual will be updated as required.

Care homes providing nursing and other care services involved in the regular passing of data related to people who use the services should be aware of the Caldicott Guidance. However, it can be seen that the above Caldicott principles will have informed their own confidentiality policies and procedures.

Freedom of Information Act 2000

Public services need to have record-keeping systems that enable them to respond to any requests for information under the Freedom of Information Act 2000.

Care services are less likely than other services to be required to respond to requests under the Act. However, they should ensure that their record keeping and archiving systems are organised so that they can comply with any request made under the Act.

Organisations are expected to be able to respond to requests as a rule within 20 working days of receiving the request, ie about one full month.

Training

New staff should receive training on the care service's approach to record keeping as part of their induction training. Staff new to care work are required to achieve a Care Certificate (or equivalent learning outcomes in the Wales and Scotland induction frameworks), which includes requirements under Standard 14: Handling Information, to:

- describe the agreed ways of working and legislation regarding the recording, storing and sharing of information
- explain why it is important to have secure systems for recording, storing and sharing information
- demonstrate how to keep records that are up to date, complete, accurate and legible
- explain how, and to whom, to report if they become aware that agreed ways of working have not been followed.

The above competences apply to all staff.

All staff should have up-to-date training on data protection principles, access to records procedures, confidentiality and good practice for entering information on people's records.

Staff responsible for data control, protection and information governance should receive training in line with their roles and responsibilities.

All staff who use the care service's computers should receive training to develop the required skills and understand health and safety requirements.

List of Relevant Legislation

- Data Protection Act 2018
- Regulation and Inspection of Social Care (Wales) Act 2016
- Care Act 2014
- Social Services and Well-being (Wales) Act 2014
- Health and Social Care Act 2008
- Freedom of Information Act 2000
- Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2017
- General Data Protection Regulation 2016
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Further Information

Publications

- *A Guide to Confidentiality in Health and Social Care* (2013), Health and Social Care Information Centre, available on the NHS England website
- *Guidance for Providers on Meeting the Regulations* (March 2015)
- The *Records Management Code of Practice* (2021), available on the Transform England website
- *Report on the Review of Patient-identifiable Information* (The Caldicott Report) (1997), Department of Health and Social Care, available on the GOV.UK website
- *Statutory Guidance for Service Providers and Responsible Individuals on Meeting Service Standard Regulations* (Wales) (Parts 3–19 of the Regulated Services (Service Providers and Responsible Individuals) Regulations 2017), available on the CIW website
- *The Caldicott Guardian Manual 2010*, Department of Health and Social Care, available on the HSCIC website

Organisations

- **Care Quality Commission (CQC)**
- https://www.cqc.org.uk
- The Care Quality Commission is the regulatory body for health and social care in England. It monitors, inspects and regulates health and social care services.

Updated 10/04/2024

- **Care Inspectorate (Scotland)**

- http://www.careinspectorate.com
- The regulatory body for health and social care in Scotland.

- **Care Inspectorate Wales (CIW)**

- http://www.careinspectorate.wales
- The inspectorate is the independent regulator of social care and childcare in Wales. It registers, inspects and takes action to improve the quality and safety of services.

- **Information Commissioner's Office**

- https://ico.org.uk
- The Information Commissioner's Office is the UK's independent authority set up to uphold information rights in the public interest, promoting openness by public authorities and data privacy for individuals. It handles compliance with email marketing legislation known as "PECR", the UK's amended version of the EU General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018.
