

THE PURPOSE OF THIS POLICY

To inform staff and clients of Record keeping in the clients home policy.

Records kept in the Service Users home

In accordance with good practice, and National Minimum Standards, the agency will introduce into each home where care is provided, a procedure for recording key events and activities associated with that care.

Procedure

Record

The agency has devised a standard written record for the purposes of recording key events and activities. The care plan record contains information on:

- Name of the client;
- Time and date of every visit, with a description of the services provided;
- Assistance with medication, and other requests for assistance with medication and action taken;
- Financial transactions undertaken on behalf of the client;
- Details of any changes in the client's (or carer's) circumstances, health, physical condition and care needs;
- Any accident however minor to the customer and/or care or support worker;
- Any other untoward incidents;
- Any other information which would assist the next health or social care worker to ensure consistency in the provision of care.

Clients and/or their relatives or representatives will have access to the records in the home. These records will be kept in the home until care ceases, after which they will be transferred to the agency for safe-keeping.

A customer (or their relatives or representative) may refuse to have records kept in their home. In such cases the refusal must be in writing, dated and signed, and this statement will be kept on the personal file of the customer by the agency.