Policy No. 1.24
Completion of case records

It is essential that there are accurate and up to date case records for private patients who receive care in their own homes by agency nurses.

All case records are reviewed as agreed with the client or if care needs change. A detailed record of the care plan and documentation will be in the private patient's home. All care and treatment provided must be documented in the case notes and a clear record should be available for inspection at any time.

All entries in case records are contemporaneous, dated, times and signed, with the signature accompanied by the name and designation of the signatory.

Any alterations or additions must be dated, timed and signed and made in such a way that the original entry can still be read.

Agency nurses must record all care given and recommendations in the private patients case records.

In the case of private patients who decline to have records kept in their own homes, this must be documented, dated, signed and retained by the nursing agency.

Case records should remain in the home for no longer than one month or until the service is concluded, this prevents old documentation gathering in the patients home, Case records should then be removed from the private patients home and transferred, with the patients permission to the nursing agency.