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MEDICAL STAFFING

Policy Number 1.11

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.

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;
- Request 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 client 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 or their advocates 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 client may refuse to have records kept in their home. In such cases the refusal must be in writing, dated and signed, and this will be kept on the personal file of the client by the agency.

These records remain the property of the Company and we are obliged to retain these records.

END OF POLICY