Manual for GDPR (General Data Protection Regulations) & Handling Information

During this module you will be asked some questions to simply provoke thought and test your current knowledge please have a note pad or supervision workbook to hand to make notes. Your performance will only be measured on the answers you select when completing the knowledge test at the end of the module.

Contents

Learning Outcomes

- Know how and where to find the legal requirements when dealing with and managing personal information in your workplace (GDPR 2018)
- Understand the implications of good and poor recording keeping on individuals care.
- Understand potential errors and barriers to accurate record keeping.
- Know how to write reports and records that are understood, relevant for purpose, clear, concise, factual and evidence based.
- Understand what a record is, the different types and their purpose.
- Understand how to use reports and records appropriately.
- Be aware of the professional and legal responsibilities in maintaining accurate records.

Complementary Manuals

- Medication
- Safeguarding Adults at Risk
- Malnutrition
- Fall Prevention
- Health and Safety
- Infection Control

Preface

Record keeping is an essential part of health and social care and is part of the role and responsibilities of all care workers. As Law et al (2010), states record keeping remains the primary source of communication for all health care professionals therefore accuracy of records will have a profound effect on the overall quality of care the individual receives.

If records are not completed accurately, communication between health professionals can break down resulting in poor care. Although there is no one method of record keeping, there are recognized principles and standards that can be used by all health professionals as a framework in maintaining accurate care records. Good and accurate record keeping is part of a care giver's 'duty of care' and is an important skill which needs to be performed with accuracy at all times.

Aim

The aim of this manual is to provide information on health documentation and record keeping and to gain an understanding of the standards required for accurate record writing.

Chapter One

Health care records and documentation

Accurate record keeping plays a fundamental part in providing high quality health care. Firstly, because good standards of record keeping will contribute to improving individual care and secondly accurate records will protect and safeguard the person completing the records by detailing what they have or have not done.

As a care giver yourself it's vital you do not underestimate the contribution accurate record keeping plays in these areas as well as your ability to help in ensuring it is achieved. Records that are clearly presented, legible and which comprehensively describes the care given to your clients will enhance communication between the individual with care and support needs, family and the health care team. There are many types of records used in health and social care, so it's important to discuss what is meant by the terms 'health record' and 'documentation'.

Health care record

Here are some examples of what health records are:

'A health record can be defined as a database or collection of dedicated information about a person which can be used to preserve evidence of the person's health care journey'.
'A health record is a collection of information that is unique to the individual client. It ensures that the client is correctly identified and that they receive the right treatment. This personal information can be recorded and stored in a number of formats: paper, scans, microfiche and computer (electronic).

The General Data Protection Regulation (GDPR) is a key piece of law introduced in the UK in May 2018 which as a care giver you should have a good understanding of particularly in areas associated with your role and if you haven't received a full briefing from your Manager on your GDPR accountabilities you should ask for it now. This regulation was produced in order to consistently protect an individual's personal data stored either on computers or in an organized filing system and how it is used and managed. It states that information contained in a record should be known to the client, accessible, accurate, kept up to date and secure. The client also now has the right to be forgotten which includes the deletion of all data held on that individual. The regulation also maintains the principle that all staff who have access to this information have a legal duty to protect the confidentiality of the information.

A health record is defined as `any electronic or paper information recorded about a person for the purpose of managing their health', these records will include medical and patient records, case notes, mental health notes and obstetric records.

General Data Protection Regulation (GDPR)

You are accountable for the way you manage and treat personal data of the people you care for and those who are individuals of the business you work in. Your Manager or business owner is accountable for providing you with the training and understanding of the issues surrounding the General Data Protection Regulation in the workplace, outlining the new regulation and includes what the changes mean, what is required to remain compliant for those who process personal data.

Below is a brief summary of what you should be expected to know as a minimum in terms of knowledge and understanding.

The European Commission has introduced the General Data Protection Regulation (GDPR) which will be implemented on 25th May 2018.

The regulation has mainly been implemented in order to:

• Force companies to be clearer on their data collection and usage

• Improve data protection and prevent data infringement

• Establish improved control and reactivity to prevent data leakage

These new regulations play an important role at a time when both the volume of data is increasing, and threats are growing at a similar rate.

A key factor of any organisation's GDPR compliance is staff awareness and education.

Some of the important aspects of GDPR that should be covered in all training sessions:

• Principles

• Key definitions

• Lawful bases for processing

• Individual rights

• Accountability and Governance

• International Transfers

• Personal data breaches

• Security

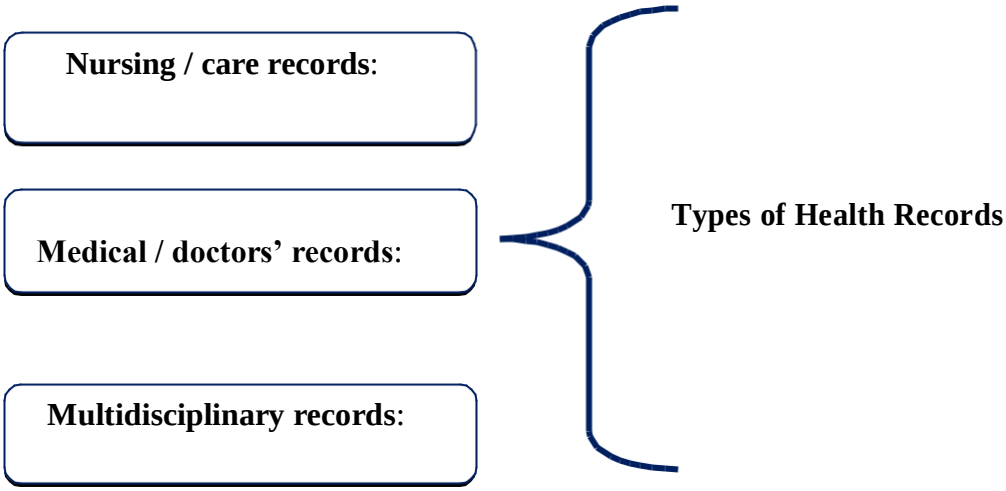
The Data Protection Bill 2017 recognises that a health record is any record which:

- Contains personal medical or non-medical information relating to a person.
- Has been written or recorded by a health professional such a doctor, nurse or care giver

Health Record Classification

While health and social care organizations are embracing developments in information technology, records / health documentation are found in a variety of formats and although there is a gradual use of electronic records, paper-based health documentation still remains widely used.

Evidence of health records / documentation can be found in health and social care settings as:



The writing of individual's records remains an integral part of the care workers role and if it is accurate, timely and comprehensive it should reflect quality care. The professional body that regulates nurses and midwives, the Nursing and Midwifery Council (NMC 2010) states that record keeping is an essential part of safe and competent care for both nurses and care givers

Accuracy in record writing should apply to all types and formats of records, regardless of how they are held, these can include the following examples:

- Clinical case records / operation records (Medical records)
- Social service case (Multidisciplinary records)
- Emails, letters, referral forms (Multidisciplinary records)
- Blood test results, X-rays (Medical records)
- Daily care notes, admission records (Nursing records)
- Risk assessment forms (Nursing / Care records)
- Accident reports and incident statements (Multidisciplinary records)
- Care charts, e.g. Food / weight charts (Nursing / Care records)
- Medication administration sheets (Medical / Nursing/ Care records)

Chapter 2

Health records functions

There are many different types of records used in health and social care the ultimate goal of accurate record keeping is to maintain the safety of the individual by protecting them from any potential mistakes in treatment or care.

For example, not recording the giving of a medicine to an individual on a medication administration record could lead to the medicine being given again and overdosing the client.

`Good record keeping is an integral part of nursing and midwifery practice and is essential to the provision of safe & effective care. It is not an optional extra to be fitted in if circumstances allow' (NMC 2010).

Prideaux (2011) suggests that health records have many functions that are beneficial to both the client and health worker.

From you own experiences can you think of any functions that health records have in your workplace?

Make some notes in on your pad or supervision book

Recording allows for the different stages of a individual's care progress to be monitored and should provide evidence of the evaluation of care. From this information individual care needs can be then adapted or changed if required.

Good record keeping also provides evidence of the actions of the care worker in supporting the client in meeting their health needs.

An example of which is in the scenario below.

Mr. Glen Evans 79 lives in a care home; Due to arthritis he often has a poor night's sleep. He then gets tired during the day. His GP has already prescribed him pain killers to be taken at regular times during the day.
Using a pain assessment chart, his level of pain was recorded. From this assessment and information found in his care records and medication administration sheets, it was clear that his pain was not being controlled by the paracetamol and a medication review by his GP would be urgently needed.

For all those working in health and social care it's vital to recognise that health records have a very important legal and professional function. All records will be regarded as legal documents and can be called upon to be used as evidence in courts of law, at inquests and tribunals and for the purpose of official investigations.

Health records are very necessary in today's NHS and they have two main functions.

- The primary function of health records is to store important clinical information.
- The secondary function is to use the information in health records in an attempt to improve services / treatment delivered by the NHS such as accident and emergency care or the prevention of strokes in the UK.

Primary function	Secondary function
(Recording of clinical details by a health professional). These could include; • Record of treatments. • Any allergies • Current medications • Problems with any medications. • History of health conditions. • Previous illness/operations e.g. • cancer, stroke, epilepsy • Blood results, tests or x-rays. • Personal details / lifestyle information • Name of GP/ Social worker etc	Using the information and data in NHS records to improve services. E.g. increase resources in staffing levels or improvements in waiting times for operations. To monitor the spread of, or risk from a particular disease, e.g. flu. Asthma, diabetes. To be used in the field of clinical research. E.g. medication treatments

Accurate health records should always give a factual account of what care has been given. Records, particularly risk assessments, should not only provide details of the actual care given but should provide clear information of why the decision was made to initiate this type of care.

Therefore, any decisions or the reasons behind care actions or changes in treatment must always be written in a person's record. This is very important for care givers when demonstrating compliance with legislation; for example, the 'best interest' principles of the Mental Capacity Act (2005).

Records should also show if the individual has declined any care or treatment and what alternatives have been offered to support the individual following this decision.

Good Record Keeping - Example

During the day, care givers observed that Mrs. Peach hardly drank any fluid. It was noted that she often left most of her drink in the cup. Concerned about her lack of drinking, the care givers decided to observe her fluid intake through the use of a fluid balance chart. However, they failed to record in her daily care notes that she frequently refused drinks offered to her especially in the evening.

Recording accurately that Mrs. Peach was refusing to drink could have alerted the staff to investigate the reasons why she was refusing and enabled them to put in measures that would help in addressing any underlying problems or concerns.

In addition, this is a good example of how writing a full account of the refusal of Mrs. Peach to drink and the subsequent actions then taken by the care givers to monitor her fluid intake would have supported the care staff in the event of a complaint being made against them.

Good record keeping therefore should always clearly document the decisions and actions being taken by the care staff on behalf of the individual.

Functions of records can also include:

- Good communication between health professionals.
- Observation charts, e.g. blood pressure, pulse, temperature.
- Risk assessments such as pressure sores, falls prevention.
- Monitoring health and safety e.g. accident books, food safety
- Evidence of daily care - daily record sheets, care plans.
- Decisions / choices / consent made by the client
- Outpatient clinic letters. Visits to other health professionals. Details of family input or decisions made on a client's behalf

Chapter Three

Record keeping quality

In this Chapter the effects and consequences of good and poor record keeping will be discussed. Good record keeping will:

- Improve information sharing
- Support communication
- Be proof of care delivered
- Demonstrate best practice

Information sharing improvement

Accurate record keeping allows for the sharing of information between all members of the health care team and should relate to the whole individual. The complete needs of the individual must be taken into consideration when planning their care requirements. This is called having a person-centered approach to care and these care needs should include **P.I.E.S**

- The physical needs
- The intellectual needs
- The emotional needs
- The social needs

The following scenario will illustrate such a personalized approach.

Mrs. Sinn Oe Cho is a new admission to the Meadow View care home. 6 weeks ago, while trying to get to the toilet at night she had a fall which caused a badly bruised wrist. She has lost confidence in walking without support of a care giver and finds it difficult to cope at home. In agreement with Mrs. Sinn Oe Cho, on admission a falls risk assessment was performed which identified several risk factors which could result in another fall. It was identified that she had not had her eyes tested for almost three years and had not had a GP medication review since her fall. In addition, she had not had an assessment of her walking and balance.

This information was accurately recorded and shared with her GP and members of the care team. The GP reviewed her and reduced her medication. She was referred for an eye test and to the community physiotherapist. At night, a commode was placed near her bed, and call bell placed within her reach. A night light was left on and the night staff made sure that she was checked on hourly. With the consent of Mrs. Sinn Oe Cho her family was also informed of the actions taken.

Communication improvement

In the case of Mrs. Sinn Oe Cho having the right information in her health records enabled the members of the care team to consult with each other, talk with her family and respond quickly and appropriately to meet her care needs. The process demonstrates how communication can be improved through accurate records.

Proof of Care

Health records must show proof of care given as well as the health care worker involved in providing it. The record should clearly explain the reasons for the care or treatment provided to an individual. This will allow health workers to quickly identify problems re-assess the individual's needs and then plan to put measures in place that are better suited for the individual.

Stevens & Pickering 2010 suggests that providing this proof or evidence is vital in maintaining continuity of care and avoiding errors in care. This has been well demonstrated in the scenario of Mrs. Sinn Oe Cho where carrying out a falls prevention risk assessment identified several risk factors which could have caused her to fall again.

Following this assessment, the home's care staff were made aware, referrals made to the appropriate health professionals, and with the agreement of Mrs. Sinn Oe Cho and her family, care interventions were put in place to prevent further falls.

Best practice demonstration

A health record must always identify the care worker who has made the entry in the records. This information proves who has delivered the care to the individual. Identifying the care worker who has written in the records makes them responsible and accountable for what they have written.

McGeehan 2007 states that written entries in records will be viewed positively as being completed by a skilled care giver whereas a poor record could give the impression that the standard of the care worker is poor and therefore they may be viewed negatively.

What would you think about the person who wrote this?

Susam dint feel rite this morning, says that she got gut ache or someting. She left most of her food, so I gave it to Bert, waste not want not!! but not sure how much she had drunk. I reckon she needs a no 2.She sould be put on a chart, none in notes trolly maybe matron could get some. I think she wet herslerf today after I dressed her, but she had no more clean pants so I had to put on a pair of Elsies. Elsie won't mind as she don't even know whether she has any on or not. Cn't find her bootom set of teeth?? Lost again in the laundary i bet. Suan up in day room now what fun!
Signed *joyce smith*

Fraser (2010) suggested that where a care giver maintains neat and accurate records, it could be assumed that they will adopt the same approach to their care. If records are `sloppy' and badly written, we may guess that the care being given is poor.

Outcome of record keeping:

- Improved standards and continuity of care.
- Improved communication between care staff.
- Correct account of the delivery of care and how the care was planned.
- Alerts staff to problems and allows them to respond quickly.
- Show aspects of care that have not been done as well as those that have.

Outcome of poor record keeping

- Errors of treatment e.g. medication errors.
- Inaccurate care is given due to poor communication.
- Important vital signs observations not recorded e.g. blood pressure and so information not passed on to the person in charge or the Doctor.
- Risk to the health and safety of an individual with care and support needs and care givers e.g. failure to document moving and handling.
- Individuals missing pre-booked outpatients' appointments or clinics.
- Poor morale / dissatisfaction from individuals and their relatives.

Chapter Four

Legislative and professional issue

Ensuring good records is a serious aspect of care and is the professional responsibility of all care givers. Therefore, they should have an understanding of the most important laws which are associated with health records

General Data Protection Regulation (GDPR)	From 25 May 2018, most processing of personal data by organisations will have to comply with the General Data Protection Regulation. (GDPR)
The Data Protection Bill 2017	Information stored in any way, whether on paper or computer must be confidential and secure. People have the right to see their own records.
Freedom of Information Act (2005)	This allows a person to request information from a public body such as the NHS.
The Care Quality Commission (CQC)	The CQC is the body which regulates and inspects care providers. Guidance on meeting the record keeping requirements of the Health and Social Care Act 2008 can be found in their publication 'Essential Standards of Quality and Safety' which can be found at www.cqc.org.com
CQC: Regulation 20- Outcome 21 (Records)	People's personal records must be accurate, fit for purpose, held securely and remain confidential.

What is written in care records is the responsibility of the person who has made the record. No one else can be held responsible for it. Care givers should not write care records on behalf of any other care giver. Care givers must keep up to date with relevant best practice guidelines, policies and processes for completing health records within their own working environment (A nominated person or data controller will be in charge of this in your company and should be able to give you a full copy of their policies and procedures and complete comprehensive training in line with the guidelines and your role). This is because any care giver could be summoned to court to give evidence in relation to what took place during that period of care (Dimond 2008).

Duration of Record Keeping

As has been previously discussed all care workers are legally accountable for what they have written in health records, they also need to remember that all individuals need to be aware of what records we keep of them and why from the start of any individual relationship, whatever we write in a record and be able to request to view any records of their personal data themselves. For these reasons all entries need to be clear, intelligible, factual, and free of demeaning statements and value judgements.

Health records must always meet the legal requirements set by the General Data Protection Regulation and Freedom of Information Acts. Currently;

- GP records are kept for 10 years after the death of a client.
- GP records relating to children are kept until they are 25 years old.
- Maternity records are also kept for 25 years.
- Mental health records are kept for 20 years.

The accuracy of records written by care giver is crucial when defending the care giver practices either in a malpractice lawsuit or investigation. Cases may be won or lost based on the quality of documentation.

Accurate record keeping can be seen as a `shield' in defending health professionals against legal action. In law courts, poor records mean poor defence, while no records mean no defence (Smith & Field 2011).

Obstacles to Good Record Keeping

The reasons why care staff are not able to write accurate health records remains a point of debate but the most common barriers to record keeping appear to be the following:

- Workload pressures resulting in lack of time to complete the records.
- Staff may not consider record keeping such a high priority compared to the individual's care.
- Staff view writing records as a chore.
- Too many distractions and unexpected events.
- Lack of staff training, directives, supervision or support
- Lack of resources, paperwork, forms.

- Staff may have a fear of making mistakes, punishment, breaching individuals' rights, possible litigation.
- IT system knowledge gaps and system breakdowns.

Professional Considerations

Care duty

All care providers have a duty of care to individuals with care and support needs. This means they must aim to provide high quality care to the best of their ability. If you are unable to achieve this then you must always report to the manager and explain the reasons why you are unable to do so.

Accountability

The principle of accountability applies to all health care providers. To be protected from legal action if things go wrong you must be able to show that you were following appropriate guidelines, policies and procedures, and the law. Evidence of this should be found in the records you create.

> You are individually accountable for the care you provide and the consequences of your working practices.

Registered nurses are accountable under the NMC's code of professional conduct, and care givers are accountable for their own work under their workplace policies and Skills for Care (DOH) Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England, and 'Compassion through practice' the values encompassing the 6 C's

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage
6. Commitment

Secrecy

The information stored in an individual's health records is highly confidential; therefore, care givers must ensure that it is only ever shared with appropriate people directly involved in the care of the individual. Your workplace should have policies and procedures for information sharing and maintaining confidentiality and you should be trained in all areas of individual's personal data care.

Computer records must be protected and there must be systems for identifying exactly who accessed information. All companies should have an effective process for managing password protection/security and the access levels for all individuals. There must also be a clear policy on reporting any breaches of your systems if or when it happens.

Chapter Five

Record keeping guide and principle

As discussed in other units, care workers have a duty to ensure that all entries in
An individual's records are accurately written. However, as there is no comprehensive, universal standard for record keeping, what should good accurate recording consist of and what are the principles of good record keeping for a care worker to follow? In its document record keeping: Guidance for nurses and midwives, the NMC (2010) provide a template on the principles of good record keeping.

NMC (2010): Principles of good record keeping, style and content

- Clear, legible handwriting must be used.
- All entries must be signed by the person writing them.
- Use a full signature unless policies allow for the use of initials.
- Entries should include the date and time using the 24-hr scale
- Records must contain information, which is factual, accurate, relevant and comprehensive.
- Risk assessments must identify potential risks and outline actions taken.
- Records must communicate effectively at all times.
- Do not alter or destroy records unless authorised to do so.
- Amendments must be signed and dated. Original entries must be clear and readable.
- Clients / significant others should be involved in the record keeping process.
- Avoid medical jargon, language must be understood by all.
- Records should be readable when photocopied or scanned. Use black ink
- Sarcasm or humorous abbreviations should not be used. Use authorised abbreviations only
- Records must never be falsified or tampered with.
- Black ink should be used at all time
- Don't use correcting fluid, cross through errors with a single line, sign and date.
- Records must be held securely.
- Entries must be written in chronological order and as soon as possible after the episode of care / activity.

The introduction of a structured framework using the mnemonic R.E.C.O.R.D F.A.C.T will provide care workers with a set of principles for good record keeping that can be applied when completing health documentation.

Guide and Principles of Accurate Record Keeping

R.E.C.O.R.D F.A.C.T

(R) **Responsibility.** All entries made in records should be accurately dated, timed and signed with the full signature. In written records the person's name and job

title should be printed alongside the first entry. Initials should only be used when indicated by local policy.

(E) **Errors.** Errors made in records should not be erased or hidden. White correcting fluid should not be used. Instead the error should be scored out with a single black line with `Error' written over it, signed and dated.

(C) **Comprehensiveness.** Entries made in records should be comprehensive and communicate effectively all aspects of the health journey e.g. assessments, reviews, future plans, on-going care and treatments.

(O) **Original.** Original handwriting should be legible and understandable, and the meaning should be clearly identifiable.

(R) **Readable.** Records that need to be photocopied or scanned must be readable. All entries should be made using black indelible ink.

(D) **Don't diminish.** Entries in records should not use abbreviations to convey information unless they are specified in local policy.

(F) **Factual.** All entries should be made without the use of meaningless phases, irrelevant speculation or opinions. Offensive and subjective statements should not be used.

(A) **Accurate**. All information contained in records should be accurate, based on professional judgement and never falsified. Records are never neutral, they will either support or condemn.

(C) **Consistent.** All information should be consistent and written in order of occurrence (Chronological order).

(T) **Timing**. Entries made in records should be written at the time of the event or as soon as possible afterwards (Contemporaneous)

Dimond (2008) identified some common errors found in record keeping that care workers need to be aware of when completing care records and documentation. These include:

- Times and dates omitted
- Ineligible handwriting, poor spelling and inappropriate abbreviations.
- Use of correcting fluid and covering up of errors
- Records of phone calls (e.g. to social services) that omitted the name of the recipient (e.g. social worker).
- No signature.
- Absence of information about a client. Omission of date of medical reviews, records of tests.
- Delay in completing the record; sometimes more than 24 hours elapsed before the records were completed.
- Records completed by someone who did not undertake the care
- Inaccuracies of name, date of birth and address.
- Unprofessional terminology, e.g. `what a weight!!'.
- Meaningless phrases, e.g. `off his legs this morning'.
- Opinion mixed up with facts e.g. `the client should go on a diet'.
- Subjective, not objective comments e.g. ` strange behavior today, he's not right'.
- Using hearsay e.g. information gained from family members or visitors.

Abbreviation Using

It is not normally good practice to use abbreviations as they can be misunderstood; however, some may be useful as long as they are easily recognisable and agreed by your employer.

HCA, BP, Temp, SW, Physio, DNAR, UTI, MDT, RN, CD, MCA, DOA, BO, BD, IVI, BB, NBM.

B	O	U	D	B	B	R	T	B
B	B	W	T	D	M	H	D	M
P	H	Y	S	I	O	C	C	I
T	E	M	P	D	N	A	R	V
A	O	D	M	B	N	N	U	I

Once you have found the abbreviations can you explain their full meaning by completing the following table:

Abbreviation Example	Meaning?
HCA	
BP	
TEMP	
SW	
PHYSIO	
DNAR	
UTL	
RN	
CD	
MCA	
MDT	
DOA	
BO	
BD	
IVI	
BB	
NBM	

Conclusion

Accurate record keeping is an essential part of health and social care and is the responsibility of all care workers. Good standards of record keeping will improve the quality of individual care and should be seen as the documented evidence of the care provided.

This manual has discussed issues surrounding record keeping, in particular its effects on the individual and the role of care worker. The manual offers a framework for care workers to develop their knowledge and skills ensuring their record keeping is in accordance with current best practice.

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