DUN LAOGHAIRE RATHDOWN DRUG REHABILITATION PILOT PROJECT

CASE NOTES, RECORD KEEPING AND CORRESPONDANCE GUIDELINES

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1.0 Policy Statement

Good record keeping is a central component of skilled and safe professional practice. Professionals need to keep an up to date and accurate account of service user care so that the correct care and treatment plans can be implemented. The DLR Drug Rehabilitation Pilot Partners are committed to best practice regarding all written records relating to service users. Written records refer to all written documentation including case notes, care plans, correspondence, reports, etc.

2.0 Purpose

To set out guidelines and standards in relation to written records relating to service users.

3.0 Scope

This policy refers to all staff involved in the DLR Rehabilitation Pilot and refers to all written records, including written correspondence, relating to service users.

4.0 Legislation and other relevant documents

4.1 National Protocols and Common Assessment Guidelines[1]
4.2 Data Protection Acts 1988 & 2003[2, 3]
4.3 Freedom of Information Acts 1997 & 2003[4, 5]
4.4 What you should know about information governance: a guide for health and social care staff [6]

This policy should be in conjunction with the DLR Rehabilitation Pilot: Key Working & Case Management Guideline; Care Plan Meeting Guideline; Assessment & Care Planning Guideline; Gaps & Blocks Guideline & Procedure and Confidentiality and Sharing Information Policy.

5.0 Roles and Responsibilities

5.1 **DLR LDTF Treatment & Rehabilitation sub committee** will write and disseminate this guideline and take a lead role in its evaluation and review.

5.2 **The Managers of the DLR Rehabilitation Pilot partner agencies/services** will implement this policy within their own agency/service.

The managers of the DLR Rehabilitation Pilot partner agencies/services are required to ensure that a copy of this document has been given to all staff members involved in the DLR Rehabilitation Pilot and ensure that they have received read and understand this Case Notes, Record Keeping and Correspondence Guideline.

The Managers of the DLR Rehabilitation Pilot partner agencies/services will assist in its evaluation and review.

5.3 **Key Workers and Case Managers** are required to act in accordance with this policy.

Key Workers and Case Managers will, through their managers, provide feedback on this policy for evaluation and review purposes.

[1] National Drugs Rehabilitation Implementation Committee. (2011). *National Protocols and Common Assessment Guidelines to accompany the National Drugs Rehabilitation Framework.*

[2] *http://www.irishstatutebook.ie/1988/en/act/pub/0025/index.html*

[3] *http://www.irishstatutebook.ie/2003/en/act/pub/0006/index.html*

[4] http://www.irishstatutebook.ie/1997/en/act/pub/0013/index.html

[5] http://www.oireachtas.ie/documents/bills28/acts/2003/a903.pdf

[6] http://www.hiqa.ie/publications/what-you-should-know-about-information-governance-guide-health-and-social-care-staff

6.0 Guidelines

6.1 General

6.1.1 Effective record keeping is an integral component to any intervention carried out as part of the DLR Rehabilitation Pilot.

6.1.2 Good record keeping is equally as important as face to face work; 'if it isn't recorded it did not happen'.

6.1.3 Employees represent their organisation on all external communication, so it is vital that external communications are of a standard that best represents the organisation, and the needs of the service users.

6.1.4 All written records, including correspondence, should be easily understood by all who may potentially read the document, including service users to whom it refers.

6.1.5 Staff are personally answerable under law for everything they write/don't write.

6.1.6 Service users are legally entitled to access any written records that relate to them and this should be born in mind when writing any records.

6.1.7 Records should be an open, transparent and true record of events.

6.1.8 Records should use appropriate and respectful language.

6.1.9 Records should be person centred and outcome focused.

6.1.10 All written records should be non-judgemental and factual, differentiating between opinion, judgement and hypothesis.

6.1.11 All records should demonstrate the use of anti-discriminatory and anti-oppressive language and practice.

6.1.12 Staff are responsible for ensuring that all written records are of a high standard in relation to spelling, punctuation and grammar.

6.2 Case Notes

6.2.1 A case note is a written account (electronic or manual) documenting the work carried out with an individual or individuals.

6.2.2 Case notes are kept in the service user files or on the electronic management system for all service users being key-worked or case managed within the rehabilitation pilot.

6.2.3 Case notes give details and evidence of each and every worker's contact (of all types) with the service user and are reflective of the work undertaken.

6.2.4 Case notes should record; phone calls, meeting outcomes, decisions, worker actions, actions of external agencies and agreements related to the service user, as well as service user progression/ regression and other facts that are considered important by the service user or worker.

6.2.5 Case notes should give details of the service user's own contribution (or an advocate on their behalf) to their record, their desired outcome(s) and whether, in their opinion, this was achieved.

6.2.6 Case notes must be written based on observation/ evidence and should be written following the guidelines below.

6.3 Good Practice in Record Keeping

6.3.1 All data, information received by phone/fax/ post/email relating to any service users should be placed in the service user file.

6.3.2 All written records should be kept in a locked filing cabinet, with the key held only by staff members involved in relevant service provision. (Refer to Confidentiality & Information Sharing Policy).

6.3.3 The service-user's name, date of birth should be on all documentation. (Care-plans, case notes, etc).

6.3.4 Always record that consent to share information has been sought at the first point of contact or where this is not possible at the earliest opportunity thereafter and signed (Please refer to Confidentiality and Sharing Information Policy 7.3 Acquiring Consent to Share Information).

6.3.5 Records should be clear and brief:
- 6.3.5.1 All records should be written in a way that the service user is able to understand.
- 6.3.5.2 All records should be written in plain English avoiding abbreviations and 'text' language and should use complete sentences.
- 6.3.5.3 Records should include only essential and relevant details.

6.3.6 Written records should be timely and logistic:
- 6.3.6.1 Records should be written as soon as possible after the event.
- 6.3.6.2 Records should be recorded in chronological order of events and contacts.
- 6.3.6.3 Records should be recorded by time (24 hour clock) and date of events (day/month/year) as well as who was the originator (source) of the information and signed (responsible).
- 6.3.6.4 Additions to existing entries must be individually dated, timed and signed.

6.3.7 Records must be objective and factual:
- 6.3.7.1 Reports should be written in the third person, do not use I.
- 6.3.7.2 Reports should describe what is observed and evidenced.
- 6.3.7.3 If an incident has not been observed, but is relevant to service user care, then it must be clearly stated i.e 'the service user reports that…'. If for some reason a more subjective statement needs to be made, the recorder should acknowledge this is a subjective opinion.

6.3.8 Where possible records should use the service users own words.

6.3.9 Any alterations to records should be made by striking a line through the incorrect information and initialling and dating the alteration. The use of correction fluid is not permitted.

6.3.10 Written records should be written legibly.

6.3.11 The following common errors in record keeping should be avoided:
- 6.3.11.1 Dates, Times and signatures omitted.
- 6.3.11.2 Illegible handwriting.
- 6.3.11.3 Abbreviations.
- 6.3.11.4 Phone calls not recorded.
- 6.3.11.5 Use of correction fluid.
- 6.3.11.6 Completion of records many days after the event.
- 6.3.11.7 Unprofessional terminology, colloquialisms, jargon and clichés.
- 6.3.11.8 Opinions mixed with facts.
- 6.3.11.9 Lack of details/ too much detail.

7.0 Implementation plan.

This guidelines will be disseminated by the DLR Rehabilitation Pilot partners to the relevant managers within their services /organisation for distribution to all staff involved ion the DLR Rehabilitation Pilot by….

8.0 Audit & Review

For the first year of the pilot this policy will be audited and reviewed after 3, 6 and 12 months. Thereafter they will be audited and reviewed annually unless otherwise required.

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