Care Plans and Daily Support Records

It is of vital importance that service user daily support records – i.e. the support plan (or ‘care plan’) and accompanying documents such as nursing/care notes, medication record and financial transactions – are completed fully and accurately to reflect the support that has been provided and any outcomes achieved during each shift. Completing these records is as much a part of the support as personal care or nursing; the task should not be viewed as optional.

The importance of recording information at each visit cannot be stressed enough. The records made form part of the history of the individual as well as being a legally valid record of the work that staff have carried out. Without good detailed records misunderstandings can occur and staff can be accused of not completing their work satisfactorily; there are instances where staff have been subjected to serious accusations and legal proceedings because there was no proof that they had followed the support plan.

Records may include documents for specific purposes such as for medication (see: “Administration of Medications” page Error! Bookmark not defined.).

There may be documents to complete for both PNL and the commissioning organisation (e.g. local authority/PCT). Be sure to complete all the required documentation and properly store or forward them on to the relevant persons.

Procedure

On arrival at an individual’s home you should read the support plan and risk assessment, even if you are a regular worker for this person. You should also review the last entries in the support notes for messages that may have been left by previous staff/visitors; there may be information of vital importance such as a new doctor’s appointment or changes to the medication, personal care or manual handling regimes.

At the conclusion of the visit you must record:

- The date and times of arrival and departure
- How the person appears at that visit (well, quiet, in pain, etc.)
- The tasks you have undertaken
- Any tasks on the support plan NOT undertaken, and why
- Anything abnormal (e.g. “did not eat her breakfast” or “possible rash forming on leg”)
- Accidents, incidents
- Complaints and suggestions made by anyone, any requests to deviate from the care plan
- Anything you reported to the office or local health/care professionals and who you reported it to
- Any phone calls made or visitors admitted to the home
- Your name (printed) and signature
- Any risks that have arisen and show the action taken to minimise them

(Other sections in this handbook refer to record-keeping, for example, for Medication records: see “Record-keeping” page Error! Bookmark not defined.; for Financial Transactions: see “Handling Service Users’ Money”, page Error! Bookmark not defined..)

Recording simple statements such as “All care given” or “Care as per plan” are NOT acceptable. Records must be:

- Factual, consistent, accurate and complete
- Recorded in such a way that the meaning is clear. Handwriting must be legible; avoid abbreviations and jargon. If abbreviations must be used it is important that they are unambiguous, universally understood and do not rely on the context to transfer meaning
- Relevant and useful. Use your professional judgement to decide what is relevant and what is not but remember: courts of law take the approach that if it hasn’t been written down it ‘did not happen’.
- Objective not subjective; factual not emotive. In other words, talk about what you see, not about what you think, and don’t let your own emotions come across in your writing.

In the unlikely event you need to alter your own or another healthcare professional’s records you must document your name, job title and sign and date the original document. All alterations need to be clear and auditable. If you
need to alter any paper records, the recording needs to be clearly scored through with a single line and the amendment made clearly beside it.

- No records should ever be destroyed by you
- You must not falsify records

On occasions you may have issues that you feel should be recorded but are concerned about writing them down where others can see them. In this instance you should write or speak to your supervisor as soon as possible and make notes for yourself about the issue. These notes may be very important at some time in the future. PNL will record the details at the office.

Whenever you report anything verbally to the office or local health/care professionals you must make a note of the date and time and name of the person you spoke to.

Remember: If it is not written down – it did not happen

Ownership of Support Documents

If the care package is funded by the local social services or health authority the support documents may largely belong to them and older/superseded pages may be removed from time to time (typically on a monthly basis) for review and storage at their premises, however PNL may also have its own set of documents that need to be completed in parallel. If the care package is privately funded the documents will probably belong to PNL.

If you are asked to return PNL-owned documents to the office please do so promptly, following the instructions contained in the “Confidentiality” section.

Also see “Confidentiality”, page Error! Bookmark not defined.; “Timesheets”, page Error! Bookmark not defined.

The Content of Support Records

If a service user’s care plan does not appear to contain information about any of the following contact the office immediately:

- A full list of the care and services to be provided to the service user and the objectives they are designed to facilitate
- Clear detail showing when and how care is to be delivered and specific needs and preferences are to be met
- The medical condition and needs of the service user (whether temporary or on-going) with associated drug charts; details of physical, mental or learning disabilities; preferences and rules associated with food and drink including whether or not any allergies/intolerances or nutritional requirements
- A record of the limits of the service user’s mobility with explanations of how staff should assist the service user
- Directions for the use of any equipment; contact details to report any equipment breakdown or servicing requirement
- The limits of duty/responsibility for specific types of worker (e.g. registered nurses, health care assistants) for nursing/care tasks, administration/assistance with medication, etc.
- What to do in the event of reasonably predictable emergencies, e.g. the failure of a successor to report for duty where continuous care is required
- Contact details of the next of kin, GP and pharmacist and, as applicable, social worker, care manager, hospital consultants, transport organiser, therapists, school, college or workplace contacts, and other persons/organisations involved in the care and social needs of the individual
- Clear information about whether/how staff should assist with finances or the handling of personal property and valuables, PIN codes and passwords, etc.
- Any role staff have in helping to promote and achieve social and community interaction, education or work, intellectual stimulation and play
- A risk assessment
- Sufficient blank forms and documents to ensure the recording of service notes for at least the next 10 days
All care plans must:

- Contain clear, precise, unambiguous information
- Be current with the date and author of the last review clearly visible
- Laid out in such a way that relevant facts can be found quickly
- State how staff should help and encourage the service user to achieve the maximum possible self-determination, independence and dignity whilst respecting and special cultural or religious beliefs
- Where there is a potential cross-over of responsibility e.g. care assistant/parent or PNL nurse/district nurse, a clear record of will do what.

If there are two service users within the home each should have their own care plan and support records.

Care plans and risk assessments must be formally reviewed by an authorised care needs assessor at least annually and following any change to the service user’s condition/needs/preferences. You must contact the office if you feel a care plan is due for re-assessment.