BEYOND LIMITS

Policies and Procedures

Beyond Limits provides policies and procedures to promote safe and consistent practice across the Organisation. The framework laid down within our policies and procedures lets everyone know how we work and reflects our values and mission statement. Our policies and procedures are written to help us, employees of Beyond Limits, to make good, safe decisions.

Beyond Limits expects all employees to be familiar with the contents of all policies and procedures relevant to their role and to understand how to apply them within their daily work.

None of these documents stand alone, all fit within the larger framework of the way we work and any associated policies which are particularly relevant will be directly referenced.

Records and Report Writing

This policy should be read in association with the Data Protection Policy, Health & Safety Policy, Medication Policy, Safeguarding Policy, Lone Working Policy, and the Employee Handbook.

Records & Report Writing Policy – what this means to Beyond Limits

A part of Beyond Limits registration with the Care Quality Commission (CQC) and contracting with Health and Social Care Commissioners we are required to keep good quality records, store records safely and report in given timescales certain changes, incidents and events. This is so that the people we support can be confident that their records are kept confidential, records are of a good standard and important events that effect their welfare, health and safety are reported to the regulating body, and where needed action can be taken.

This policy provides a framework which offers guidance to all Beyond Limits employees. It has been designed to give you a clearer understanding of the types of reports we write, why we write them and how to write them in the best way.

All employees will be required to write reports and keep records as part of their role.

Records and reports are the communication of information, advice, or action from one person, or a group of people, to another for a specific purpose. Often the ultimate function of a record is to provide a basis for decision and action. Records can be in a multitude of formats, these include: written, typed (email/text), forms, spoken word, phone calls, videos etc.

Storage of information, records, and reports

As we use more digital platforms we aim to reduce and minimise any paperwork or documents stored at a person's house. The home of a person being supported is **not** an organisational office. Therefore, the minimum amount of organisational records should be stored in the house. Documentation and any other information that belongs to Beyond Limits should normally be taken back to the main office for storing. This should happen automatically every three months when audits of all records are carried out, in some instances this may happen more frequently. Records must always be stored in accordance with the Data Protection Act and our Data Protection Policy. We are legally, and under our registration with CQC, required to keep certain records for certain timescales.

Why it is important to keep records that are up to date, complete, accurate and legible?

- **Your** notes could be read out in a court of law
- **Whatever** you write you may be called on to explain the rationale behind writing it
- A court of law would assume that if care is not documented then it has not been provided
- If records are of a poor standard, courts may see that as a reflection of the care being given
- The better your report writing is, the less you will need to justify and explain them

If you have difficulty, reading, writing, or using computers you should ask for help or support.

It is very important that you keep records about the support you provide for the following reasons:

- So, we can identify risks quickly and put in controls to safeguard the person
- So, we can identify where a person's needs have changed and update our support accordingly
- So, we can identify where a person is gaining skills and reduce support accordingly
- So, we can monitor the quality of support provided to people we support

- To show you have followed Beyond Limits policies and procedures
- To show you have understood your duty of care
- To show you have followed the person's Working Policy
- So that the team work consistently with the person
- To demonstrate proper and considered decisions have been made about the way we support a person
- Remember – in a court of law if it hasn't been written down it hasn't been done.

Standards of record keeping expected

Beyond Limits expects the following high standards of records from all its employees:

- To be factual, consecutive and in chronological order
- To be respectful, non-discriminatory, not to use offensive language, jargon, or subjective statements
- To be made as soon after an event as is possible
- To be dated and signed. To identify who wrote it and when
- To be legible
- Identify problems and solutions put in place
- Wherever possible to be accessible to the person you support (in language and using terms they will understand)
- Not using any correctional fluid
- Never tear pages out from a bound book or document, even if they are blank
- Do not delete, erase, alter or destroy **ANY** record unless you have been authorised to do so

Guidance on good report writing and record keeping.

Everything that we record and document as part of our work should be written with the answers to the following questions in mind:

WHO	• Are we writing for?
	• Are we writing about?
	• Is likely to read your reports?

When you write any report about a person supported you need to consider 'who' you are writing for. Staff, external professionals, person supported, families, lawyers and inspectors may all have access to reports and will be looking for different information. In many instances there will be specific forms or documents to do this.

- **Person we support:** Recording a person's wishes/choices and needs. A daily record of a person's life, goals/rehabilitation targets for them.
- **Medical professionals:** Providing evidence for medication/treatment decisions. Monitoring recognised behaviour/mood/anxiety.
- **Commissioners:** Are allocated hours of support being used? Are targets/outcomes being met? Is rehabilitation successful? Is the person being treated with support and dignity?
- **Family/Friends:** A true record of the individual's journey within our services. Comfort in knowing what goes on and that their family member is being supported to a high standard and in the right way.
- **Organisation:** Professional indemnity, identifying trends in support, outcome focused support plans, learning from experiences, preparing reports for key decision makers.

Other people may request access to records but should do so only after permission has been granted, this would normally be via the Service Leader or Director and may also require consent from the person supported. Follow the Data Protection Policy for guidance on this.

It is also important to consider the Goal, Audience and Structure of a report or document.

- **Goal:** What is the aim of the report? What is the context of the report? What are we trying to achieve?
- **Audience:** Who has asked for the report and why? What does the audience already know about the person or situation?
- **Structure:** Is there a set format that needs to be completed? What are the main events/points that need to be covered? Should the report be written in a formal language? First or third person?

Who is the report written for? People we support, their family, staff and other professionals may not understand some of the terminology you use in everyday conversations.

WHAT	• Do we need to record?
	• Is the purpose of the record?
	• Do we not need to record?

The following is a summary of the most common types of reports you will be expected to complete within your role at Beyond Limits. This is not exhaustive:

- **Daily Notes, Handover Notes, Staff Communication Records and Emails.** It can also include things like meeting minutes and any other correspondence around the person being supported, their support team, family, other staff, professionals, Beyond Limits employees and the organisation itself.
- **Health & Safety Checks:** Documentation such as fire safety checks, temperature logs, accident and incident reports, safety assessments etc.
- **Finances:** all staff will have responsibilities with finances, and you will need to document all transactions made with support money, complete weekly checks, and handle money. You may also have additional responsibilities with personal finances.
- **Medication:** If the person you support takes medication you may have responsibilities to help them manage this. You may need to record when a person took their medication, maintain a list of their medication, auditing medication weekly and recording any medical appoints they attend.
- **Monitoring charts**: For food/fluid intake, sleep, bowel movements etc. Typically, there would have been an assessment done to establish a need to monitor such things.

Each person supported has a Health & Safety, Finance and Medication folder that contains various forms and reports you will need to complete on a regular basis so make sure you familiarise yourself with these. There are also separate policy and procedure for each of these areas. The persons Working Policy will also provide you with precise details on your exact responsibilities.

When you complete an Accident or Incident report you need to make sure that you not only give clear information about what led up to the event occurring, but also how you managed the situation. This can then be used by others as a learning tool to help prevent it happening again.

WHY	• Are we writing this report?
	• Do we need this report?
	• Is it important?

When writing a report or record it is important that you always bear in mind **WHY** you are recording this specific information.

Record keeping and documents are recorded to ensure that legal requirements are met and necessary standards are reached. A good record can clarify decisions, provide understanding and rationale to support plans, as well as helping to evidence what level of intervention/interaction is working and what may not be working. We need reports so that we can accurately review, evidence and support choices, decisions, standards of care, education and the provision of care and support.

There should be a purpose to what you put in your report; it should not be a list of everything you know but it should demonstrate the factual information and evidence that you have observed including your actions or omissions and your reasoning behind them.

HOW	• Do we know what to record?
	• Do we record fairly and accurately?
	• Do we present our report?

Any report must contain relevant information about the person supported at any given time and the measures you have taken to respond to their needs. Evidence should be given that you have understood and honored your duty of care, that you have taken all reasonable steps to support the person and that any actions or omissions on your part have not compromised their safety in any way.

Any unexpected events that occur in the person's day should be recorded or any visits that the person may have from other members of the community team (e.g. GP, dietician, chiropodist) or family members and how the person has responded to that.

Reports should always be factual, consistent, accurate and a true account of what has happened. They must not be written in a subjective or judgmental style. The report should focus on what the person providing care has observed, what was done, and how the person responded.

- **Subjective** means it is based on or influenced by personal feelings, tastes, or opinions rather than facts.
- **Judgmental** describes someone who forms opinions without reason, usually harsh or critical ones, about people.
- **Objective** means it is not influenced by personal feelings or opinions in considering and representing facts.
- **Do not include abbreviations and jargon.** Professional language should be simple and direct. Check the language you use will be clearly understood by those who are reading it (i.e. other carers, staff from other countries, inspectors or other people outside of the organisation)
- **Do not use meaningless phrases like "slept well" or "had a good day".** Better to say "*Mr Smith slept for 8 hours, getting out of bed only once to use toilet*" or "*Mr Smith spent a quiet day not wishing to interact with others, but enjoyed a visit from his friend who called this afternoon*". This is being **Objective** stating exactly what happened rather than being **Subjective** by saying why you believe someone slept well or what he or she did during the day to make you believe it was enjoyable for them.
- **Do not make offensive, subjective statements –** such as "sweet, old lady, pleasantly confused".
- **Do not predict outcomes or make a diagnosis when recording –** this may be inaccurate or misleading to other members of the team.
- **Rather than label someone confused, it is better to describe the actions** the person is doing which leads you to believe they are confused.

Quality of records and communication with all external parties/stakeholders is a direct measure of the service we provide.

- Failure to record accurate information can have serious consequences. We need to ensure that the people we support are treated effectively and appropriately
- It can provide an objective record of the persons supported care that can be used in court or in the event of a complaint
- Provide a record for the person of their time in the service
- Contribute to the development, implementation and review of the plan for the person

- Identify and respond to the person's needs
- Help recognise and establish patterns in the person's life and/or behaviour
- To support the provision of consistent, high quality care
- To demonstrate that the service meets regulatory requirements

Although for professional reports it may be necessary to use technical language, the extent to which we do this will depend on the audience. Slang and colloquial terms should always be avoided, unless it is a direct quote from an individual which is clearly indicated. Acronyms should always be spelt out in full the first time they are used in a report. For Example: Care Quality Commission (CQC).

A professional report should give the reader EASY access to a logical evidence-based account of the issue in question. Start with the facts, which can then be analysed to form any recommendations. This order helps to make things within the report flow naturally.

All reports and documents are reviewed as part of our quarterly audit process as the very minimum standard. This supports the organisation to identify areas for training required to those completing the reports and documents which is acted on in a timely manner.

Data Retention

We are legally required to keep certain records for certain timescales:

- Risk assessments – **destroy only once a new one replaces it.**
- Record of purchase of medical devices and medical equipment – **18 months**
- Operational policies and procedures (current and previous versions) – **3 years**
- Incident, events or occurrences reported to CQC – **3 years**
- Use of restraint or deprivation of liberty – **3 years**
- Log book of housing related maintenance requests - **3 years**
- Maintenance of equipment – **3 years**
- Electrical testing – **3 years**

- Fire safety – **3 years**
- Water safety – **3 years**
- Medical gas safety, storage and transport – **3 years**
- Staff employment – **3 years after last entry**
- Duty rotas – **4 years after year they relate to**
- Purchase of medical devices and equipment – **11 years**
- Final annual accounts – **30 years**

Reportable Incidents

Certain **incidents** are reportable to CQC and must be done so within **24 hours** of the incident occurring. There is an electronic form to complete.

https://www.cqc.org.uk/guidance-providers/notifications/notification-finder

A copy of the list of reportable incidents is kept in the main office with the Service Leaders and Registered Manager who are responsible for signing off all incident report forms.

Incidents must be reported immediately to your line manager. It is the responsibility of the Registered Manager or Director to complete and send a CQC notification via the portal (keeping a copy in the file of the person we support it relates to).

These incidents are:

- Serious injuries to a person we support resulting in an impairment of the sensory, motor or intellectual functions which is not likely to be temporary (head, sight, or hearing injuries)
- Serious changes to the structure of a person we supports' body (breaks to bones, trauma to the body)
- A person we support experiencing serious prolonged pain or psychological harm (a break down, on-going pain)
- The shortening of life expectancy of a person we support (identification of serious illness)
- Incidents that have required treatment to prevent death
- Injuries that if not treated may result in one of the above.
- Applications to deprive a person we support of their liberty
- Incidents reported to or investigated by the police including a person going missing, assault or malicious damage, theft of property or money belonging to a person we support.
- Allegations of abuse

- Events that appear or threaten to prevent Beyond Limits continuing to be able to carry out their regulated activities including insufficient number of suitably qualified and skilled staff
- An interruption of the supply of electricity, gas, water or sewage to the premises of the organisation lasting for a continuous period more than 24 hours
- Physical damage to the organisational premises which is likely to have a detrimental effect on the provision of services to the people we support
- Failure of fire alarms or other safety devices owned or used by Beyond Limits where this might have an effect of the support of a person lasting for a continuous period more than 24 hours.

Other CQC notifiable events:

The **death of a person** we support must be reported to CQC and must be done so within **24 hours** of the death occurring. There is an electronic form to complete via the portal. It is the responsibility of the Registered Manager or Director to complete and send a CQC notification (keeping a copy in the file of the person who had died).

Notification to CQC of changes:

Changes to the management and people in day to day charge of Beyond Limits business must be reported to CQC.

- If the registered manager is likely to be absent from work for more than 28 days continuously notice must be given to CQC unless it is an emergency change then it must be within **5 working days**. The notification must include the expected length of absence, the reason, arrangement to cover their role, name and address and qualifications of the person who will be covering the absence, any proposed date for reappointment if it is unlikely the registered manager will return
- Notification to CQC must be, where possible **28 days** before the absence starts
- Changes to the details of the service or changes to how partnership of Beyond Limits **as soon as possible**
- If Beyond Limits becomes insolvent or bankrupt **as soon as possible**
- If Beyond Limits closes **as soon as possible**
- Change to registered manager **as soon as possible**
- Changes to location or name or business address, or director, or nominated individuals

Reporting to Commissioners (Local Authority and Clinical Commissioning Groups)

Certain **incidents** are reportable to Commissioners and must be done so within **24 hours** of the incident occurring. Incidents must be reported immediately to your line manager. It is the responsibility of the team leader, service leader or Director to complete and send to the Commissioners (PCT or Plymouth City Council) an incident form (keeping a copy in the file of the person we support it relates to).

Incidents include:

- Death of a person we support
- Reportable incidents of abuse
- Reportable incidents relating to Health & Safety