The handling of information governed by legislation

The handling of information is governed by legislation, Codes of Practice and policies of them employers. The main piece of legislation which relates the handling of information safely is the Data Protection Act 1998. This act governs the storage and use of information about individuals which is collected by organisations. This applies to both electronic and manually written records. Relevant aspects of the Act include:

-The information should only be used for the purposes explained when it was collected. -The information should not be disclosed to anyone who has no right to know it. The information collected should be relevant and contain no more than it is necessary for its purpose. -The information should be accurate when collected and where necessary kept up to date. -Individuals should have access to the data held about them. -Appropriate security measures should be taken to prevent unauthorised access to data. The Data Protection Act does not require care workers to keep secrets; it is possible to share relevant information and important details with others. However this is usually only done on a need to know basis.

The “ need to know” policy works in junction with The Caldicott Principles as well as the Date Protection Act. The Caldicott Principles has six principles which guide the maintenance and sharing of personal information in health and social care settings. Another piece of legislation which relates to handling of information is The Health and Social Care Act 2008. This Act relates to keeping accurate and confidential records, storing records safely and destroying records safely. The details from this law are incorporated into the compliance Guidance for social care settings issued by the CQC.

Policies and legislations on data handling affects my work and work role, as care assistants use and update information on service users on a daily basis. For example updating a service users care plan is completed so that it is suitable for their needs. As well as filling in their personal care charts and daily files, to ensure that they are up to date. Care assistants also need to share information with their colleagues, so that those who need to be informed about various issues know. Creating records are a way of ensuring continuity of care, demonstrating patterns of behaviour and protecting the carer.

Records should always be up to date, accurate, complete and legible. Records must be made as soon as possible, which insure that information is not forgotten. For example accident and incident reports should always be done as soon as possible so that important information isn't forgotten. Records must also be factual and evidence based opinion, this means recording exactly what happened, which may mean that angry expressions and swear words may have to be recorded. Carers must insure that they write clearly, so that it is easy for others to read. Files need to be legible so that concerning bodies who may read the records can do so easily.

Lastly records must always be signed by the individual who wrote the record, dated and time of recording. At Clifden house records that are used on a daily basis such as care plans, accident and incident books are stored in a filing cabinet which is shut at all times. The filing cabinet is situated in the main reception area. Although it is not in an entirely secure area, as it is by the main entrance of the building where residents and visitors walk through and could gain access to the records, it is considered safe and secure

because it is in viewing distance of the nurses’ station where there will always be a member of staff present.

If a visitor or resident was to open the filing cabinet, then a member of staff would be near enough to prevent them from doing so. Records that are not used on a daily basis by care staff are kept in the managers’ office within another room that is securely locked when there is no one in the office. The records relating to the care of an individual contains sensitive information and must be kept securely. Records can be kept both manually and electronically, there are storage systems that help ensure security.

Manually written records should always be stored in a lockable cabinet, should be kept tidy, which makes it easier to locate files and know if any are missing. If manual records have been moved to another secure place then this should be documented, so other carers know where to look. If completing a record, ensure that people who do not work within the organisation are observing. With electronic records and data, there would always be a password. If possible hard copies of the records should be kept in a secure place, just in case the computer data is lost.

It is important to ensure that all members of staff know how, where and why to store records correctly. To ensure all staff are aware of this, staff are told this during their induction period and shown how to when shadowing another member of staff when they first start their job. If staff do forget to put records back, then other members of staff will politely remind them to ensure the files do not get lost or into the wrong hands. Care assistants have

to complete records on a daily basis, and also have to support others, such as new staff to complete records when they don't know how to.

For example I had to show a new member of staff how to write an accident report. This was done by taking the new member of staff to a quiet area shortly after and went through the accident and how to write it, so that it was factual and evidence based, reasonably simple, signed and dated. Another example of demonstrating how complete a record would be going through a care plan, to show what must be updated daily. Again I took the new member of staff to a quiet area and went through the care plan oh what must be written each time, and how to write it so that details are accurate but still polite.