Your Care Associates

Your care success is our future

Your guidelines to monitoring the recording in care records

When choosing your method of monitoring you may like to consider the following examples:

- **A week's worth of entries for one person who uses your service** – you are expecting the record to provide you with a detailed overview of daily life for that person. This method also provides you with opportunities to cross check entries with other records e.g. food or fluid charts, signing of creams, accident forms etc and ensure staff are completing all associated, relevant records as you would expect. Your organisation will have its own audit trail of records that require completion in certain circumstances.
  This method allows you to identify common errors or highlight concerns which you can then feed back to your staff team and individual staff who need assistance or prompting to understand the records they are expected to complete. It will provide you with an indication of the quality of care records in your service.

- **Several entries for the current day** – this method allows you the opportunity to present your findings to staff at the time and can also be recorded as a group supervision. The benefits of this are that you can identify ways of recording that do not describe actual events and work with staff in deciding how to provide essential information.
- **A focused supervision session for a particular member of staff** – this may be a new member of staff or an existing member of staff where you are choosing to spend time mentoring them towards improving their writing skills. They can bring examples of entries they have made to you and together you can discuss the content.
- **Identifying entries for demonstration purposes** – choose entries that are both good and bad examples of writing records. Extract the entries from the record and present them a way that does not identify any person. These extracts can be used in staff team meetings or group supervisions to prompt discussions on writing records.

We recommend that you use all the above methods over a period of time.

Whichever method you choose, writing **a brief report** on why you chose it, your findings and actions you have taken will all provide evidence for several outcomes on your Provider Compliance Assessment.

Monitoring specific areas of your service should be part of your ongoing self-assessment and quality assurance programme.

Monitoring your staff team demonstrates a commitment to improving the safety and well being of people who use your service.

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MONITORING OF CARE RECORDS

Please take the time to consider **each point** before moving on to the next. Trying to identify all the points at the same time will inevitably mean you will miss both good and poor examples of recording, which defeats the object of this exercise. If you are using **more than one record** go through all the sections for one **before** moving on to the next. Number them consecutively in the 'What you have found' section. You will also need to check and cross reference the detail in entries for some sections to ensure you have a robust audit trail as evidence for CQC.

The process becomes easier and faster as you get used to it.

Name : **Date of monitoring:**

Monitoring method:

(Choose from the guidelines)

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Care record	What you are looking for	What you have found Provide examples of good and poor record keeping Number separate records where you are considering more than one
Presentation	Colour of ink used? Is it legible? Are you able to understand it? Are the sheets numbered? Are mistakes crossed through with a single line so they can still be read, then initialled and dated?	
Overall tone of the content	How it reads - Is it respectful? Is there a sense that this person and how they feel truly matters?	

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	Does it promote their dignity? Does it respect their confidentiality?	
Care record	**What you are looking for**	**What you have found** **Provide examples of good and poor record keeping** **Number separate records where you are considering more than one**
Actual content	Is it accurate? – check Is it clear? Does it say what it needs to say? Does it contain opinions? Is what is written relevant? Does it contain any meaningless statements?	

	Is it free from stereotypes or 'labels' for people? Does it state what action needs to be taken, if appropriate? Are any events missing? GP, OT, CPN etc (cross reference with other records) Are abbreviations used? Are these widely understood? Dated (day, month, year)? Signed? Can you identify that person? Timed? Using 24 hour clock	
Personal references	Does the record clearly describe, where relevant: What assistance and support has been provided? How independence and use of remaining strengths has been promoted?	

Care record	What you are looking for	What you have found Provide examples of good and poor record keeping Number separate records where you are considering more than one
Personal references cont.	How the person has spent their day or night? Does the record clearly describe, where relevant: What their experience of daily life is? Any issues or concerns they have raised? – check Health issues? - check	
Direct or indirect reference to other records	Does the record make reference to an issue/concern/event that you would expect to see recorded elsewhere? Has the corresponding record(s) been completed as you would expect?	

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Summarise your findings and any actions you need to take

Findings – good and poor practice	**Action required**

Write a brief report to include the reason for monitoring, the method you used and why, examples of good and poor practice and actions you will be taking/ have taken. Remember if you are using this as a basis for supervision you will need to record this activity for each staff member also.

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