EFFECTIVE REPORTING AND RECORD-KEEPING IN HEALTH AND SOCIAL CARE SERVICES

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Introduction:

Practices for reporting and record-keeping are important in healthcare. These activities are also useful in the social care field. The field is very delicate that the use of data or information can ensure perfection and a high level of effectiveness of activities. In the healthcare setting, the importance of record-keeping and maintaining is of high importance because it helps to make decisions in favor of patients. It is not by choice to ensure record-keeping in the areas of health and social well being (ICO.org, 2018). Legal and regulatory parameters in health and social care are strict, so that it remains under the limits of law and legislation. In this context, requirements for recording may not necessarily link with external aspects, but they also have a link with the internal environment of a care setting. In the application of regulatory and legal aspects of the practice, it is worthwhile to consider and implement technology in record-keeping practices along with reporting mechanisms so that it can serve the purpose of a care setting (Wright, 2013). Therefore, a care setting should abide by law and regulations and it should ensure record-keeping and reporting by keeping local and national policies in view. This paper has taken all these perspectives about records and information management in the care setting.

Legal and Regulatory Aspects:

A scenario helps to answer on legal and regulatory aspects in the given case that the Secretary of State for Health has ordered the national regulator to compile a report on data management and process in health and social care centers. The description of related aspects around law and regulations would help the care setting to know these aspects in its practices.

Aspects of record-keeping around law and regulations call for dealing with information confidentially and ethically. The information-sharing should take place with people who require

that information. A care setting contains highly personal information about a person, and its protection is a legal and regulatory requirement. It also increased the level of trust and increased the level of safety for patients. In a particular case or scenario, the record-keeping was centrally important for the health and life of the patient. Moreover, reporting of data should also take place with relevant people (Wright, 2013). It is a regulatory obligation of a person in authority in a care setting to share the information. That person may be an individual's neighbor, friend, family member, professional taking care of the individual, any social or health care workers, and any other individual or worker who is fulfilling the responsibility of providing social and health care to an individual in a care setting (ICO, 2017).

It is also a legal and regulatory requirement that information handling takes place with care. Handling of information is important because it would involve protection and authentic use of the information of any individual taking health and social care. Practices for keeping and maintaining records or information make an inevitable part of health care delivery that is part of the personal practice activities. Some laws and legislations may help to know why it is necessary to keep records and report it. Data protection act 1998 offers guidelines in this regard. There are general data protection regulations or GDPR, which are helpful in this regard. Data protection act 1998 ensures the protection of information obtained in the healthcare setting. The processes of holding, recording, using, and disclosing information make the whole process of data protection. The whole process is part of the data protection act, 1998. The GDPR regulates the use of information that must be in line with the confidentiality of the information and the need of the organization for the information (ICO.org, 2018).

In the care setting, it is also essential for a registered person on the scene to protect and make the information safe from any exploitation or misuse. The Health and Social Care Act 2008 has

different provisions that should guide a care setting to adopt favorable practices towards record keeping and reporting (Griffith and Tengnah, 2010). The reporting provisions in the law and regulation ensure accountability because the registered person has to report to a person in higher authority. Therefore, the care setting should abide by these aspects from the aspects to keep and report data related to law and regulations so that it can come up with expectations of the national regulator after the sad demise of an individual in the care setting (IGA, 2016).

Consequences of Non-Compliance:

In the given scenario where an individual has died of negligence as his record was not maintained with the care setting. Non-compliance with record keeping and reporting has led to criticism in the care setting. Death as a result of negligence in health and social care has deteriorated the image of the care setting, and it is highly necessary to have a check to keep and report record so that a care setting may get full knowledge of every patient (Duffy and Gillies, 2018).

Requirements of Internal and External Recording:

As per the scenario here, the new staff has to know the material about compliance with health and social care settings. It is better to consult with the legislation and protocols to know about the requirements of internal and external recording in the care. The death of the patient in the care setting has noted that the local hospital refused to share the health record of the patient with the family member. The family member had a power of attorney for the patient, but the refusal to provide access to the record is the indication that there is a lack of compliance with the law in this scenario. Therefore, the following section contains the requirements for internal and external recording requirements in healthcare.

It is essential to have the information of an identified individual regarding every aspect of his health, including his physical and mental well being. It is the requirement to keep the record so that the recognition of a patient can be possible. A care setting may choose to record the information in an electronic or manual form. The records management, NHS code of practice 2006 provides a policy emphasizing health and social care professionals to have the record of any individual taking care. This policy comes under the jurisdiction of the NHS. It is an internal requirement in a care setting to have demographic information about the individual getting care (Cowan and Haslam, 2006).

Internal and external recording requirements make it mandatory to record the information on paper documents or electronic documents. The types of electronic documents include a recording of care plans, medicines, nutrition, and documents used for prescribing tests. Recording requirements may be fulfilled with the help of several tools and options available in a care setting. For instance, chart notes, history of patients, referrals and consultation letters, and medical reports are some health records used in a care setting. Internally, correspondence, clinical forms, and medication lists also play an important role in fulfilling recording requirements (ICO, 2017).

External requirements of recording are set in light of legal and regulatory requirements. Public Records Act 2005 governs and make sure from health care organization to keep records safe. There is a keeper of records who is answerable to parliament, and the management of healthcare organizations must manage records. It is the responsibility and obligation of every healthcare professional to observe accountability as they produce and use records and information of patients and service users. Therefore, a care setting has to meet the legal requirement in an attempt to store records of patients (Walsh and Antony, 2007).

In the given scenario, the patient has to face death because of a lack of storage or use of records. It is the internal and external requirement to store manual and electronic records so that patients may get appropriate medical treatment. Keeping the manual record in a safe locker or maintaining electronic records with safety procedures is essential for fulfilling the obligation under the requirements. It is under the legal or regulatory requirement to ensure the safety of the record. However, it is an internal requirement to report different concerns linked with the record-keeping in the setting. Different concerns about recording may link with information storing and sharing. In case of any concern, it is essential to report to the concerned manager so that he can provide assistance or guidance (Wright, 2013).

Review of Technology Use:

The use of technology in the context of the care setting is very useful because technology enables record-keeping efficient and perfect. In the given scenario, it is to develop a training program for new staff on the use of technology sot that new staff can become trained to use. It is also the objective of the program to use technology so that the obligation to report and record services in a care setting may take place professionally and effectively. However, in so doing, the new staff has to take national and local policies and guidelines into account so that they may come under the regulating the process of using the technology.

The new staff has to understand the use and effectiveness of technology at the broader level so that they can employ it in their setting. According to World Health Organization, health technology is the application that contains all the knowledge and skills in different forms, including medicines, vaccines, systems, and procedures so that health problems may solve and the quality of patients improves. The national and local policy guidelines are important in this

regard because it is part of the long term plan by NHS to focus on technology. The body would pursue the policy that prioritizes technology in the setting (Cowan and Haslam, 2006).

It is worthwhile to consider and discuss some different types of technologies used in the healthcare setting. In a given scenario where the new staff has to get the knowledge to use technology, they can use it for reporting and recording services in a care setting. Several applications serve the purpose of the NHS, including health management applications and the Fitbit app. The use of computers, iPads, and tablets along with other devices, is very effective. Various diagnostic technologies make the treatment convenient and easy that include Computerized Tomography CT scans, Electroencephalogram or EEG, and other such technologies help report and record data. The use of relevant websites and access to them, the use of different software like RIO and Compass care, and Digital medicine are examples of the effectiveness of technology for the purpose (Lipley, 2014). The use of wireless sensors through Telecare and monitoring technology pieces of equipment are all examples through which local and national guidelines for technology embracement may meet (Meeks et al., 2014).

The new staff has to know that there are many options at hand to use technology for their job in a care setting. For instance, they may utilize NHS e-Referral service, image archive, electronic patient record, writing a clinical letter, and the use of voice recognition and other forms of technology may help new staff in their performance in a care setting. It is quite inspiring to know that policies and guidelines at the local and national levels favor the use of technology in a care setting (IGA, 2016).

Application of Law and Policy with Regulatory and Ethical Requirements:

Keeping and maintaining the record in the care setting should be consistent with national requirements, along with the employer's guidelines. Two main and important considerations in

this regard, those ethical and regulatory aspects are there in the care setting. Ethical considerations and application of law and policy help to be moral and ethically empowered. Regulatory requirements ensure that a lack of compliance may lead to punishment. Therefore, it is useful to maintain this requirement in record-keeping and to maintain it. In the given scenario, a Care Home Staff team requires briefing after receiving the poor CQC report. The reason for the poor report was the lack of perfect record-keeping by the staff team. The care provider seeking guidance should look into the ethical and regulatory context of record-keeping so that perfect record-keeping may take place (Care Quality Commission , 2010).

Record keeping complies with the principles of the Nursing and Midwifery Council (2008), and the implementation takes place along with the local policy of the employer (Duffy and Gillies, 2018). In the record-keeping activities, it is better to consider some important aspects related to legal, communication, accountability, negligence, and investigations cases. Legal issues in record-keeping are the most important. Record-keeping by nurses must follow legal issues so that they can present them in any court of law. For instance, in the case of healthcare litigation, the role of clinical records is very important. A meticulous record-keeping practice may help them in a court of law so that they can defend their clinical records. Due to the importance of clinical record keeping, lawyers are guiding nurses to write them so that they can present them before the court. As a result, the nursing staff gives attention to records objectively and they do not consider the practice merely for meeting the job requirement. Communication, accountability, investigations, and negligence are other tools that are protected under the law and policy of the care setting (Wright, 2013).

Ethical considerations of record-keeping have a link with maintaining ethical practices and confidentiality in maintaining and keeping a record (Crook, 2003). In so doing, the record is

available for use only for a given objective, and it does not compromise one's secrets and information. Here, personal experiences are also important; those may emphasize the security and confidentiality of records of patients in a care setting. It is better to keep and maintain the record in manual and electronic forms and that should be available to concerned members of the care setting. The record-keeping and different forms of it have been mentioned in the above sections in this report. It is the central objective of record-keeping that this practice should follow regulatory and ethical provisions so that the policy may be perfect (IGA, 2016).

Conclusion:

The report concludes that record-keeping, maintaining, and reporting is effective in the health and social care setting. The report has followed some scenarios and informed about steps in light of regulatory, policy, and ethical guidelines to follow. Requirements for legal and regulatory domains related to record-keeping are very crucial and are of central importance. The report notes that considering different regulatory requirements may make record-keeping practice more perfect and error-free. Moreover, requirements associated with internal and external factors are also important in a care setting so that record keeping practice is equipped with all important aspects of information. The use of technology and considering the national and local policies for record-keeping can open ways for exploiting new opportunities. As a result, any unpleasant event may not occur due to a lack of proper reporting, keeping, and maintaining the record. The report recommends taking serious attention to record-keeping and maintaining in social and healthcare sectors.

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