In Association With

Learning work book to contribute to the achievement of the underpinning knowledge for unit: HSC028

Handle Information in Health and Social Care Settings

Credit value 1

Version 1- 01/10/10

Learner's Name: _____

Learner's Signature:
(Please sign inside the box)

Employer's Name: _____

Employer's Address: _____

Start Date: _____

Anticipated End Date: _____

College Provider: _____

Learner's Enrolment Number: _____

Mentor's Name: _____

Assessor's Name: _____

Internal Verifier's Name: _____

I V's Sampling Date: _____

INTRODUCTION

This workbook provides the learning you need to help you to achieve a unit towards your qualification. Your qualification on the Qualification and Credit Framework (QCF) is made up of units, each with their own credit value; some units might be worth 3 credits, some might have 6 credits, and so on. Each credit represents 10 hours of learning and so gives you an idea of how long the unit will take to achieve.

Qualification rules state how many credits you need to achieve and at what levels, but your assessor or tutor will help you with this.

Awarding Organisation rules state that you need to gather evidence from a range of sources. This means that, in addition to completing this workbook, you should also find other ways to gather evidence for your tutor/assessor such as observed activity; again, your assessor will help you to plan this.

To pass your qualification, you need to achieve all of the learning outcomes and/or performance criteria for each unit. Your qualification may contain essential units and optional units. You'll need to complete a certain amount of units with the correct credit value to achieve your qualification. Your tutor/assessor can talk to you more about this if you're worried and they'll let you know how you're doing as you progress.

This workbook has been provided to your learning provider under licence by The Learning Company Ltd; your training provider is responsible for assessing this qualification. Both your provider and your Awarding Organisation are then responsible for validating it.

THE STUDY PROGRAMME

This unit is designed for individuals who are working in or wish to pursue a career in their chosen sector. It will provide a valuable, detailed and informative insight into that sector and is an interesting and enjoyable way to learn.

Your study programme will increase your knowledge, understanding and abilities in your industry and help you to become more confident, by underpinning any practical experience you may have with sound theoretical knowledge.

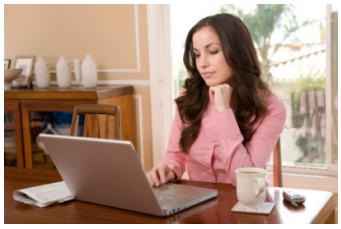
Where To Study

The best way to complete this workbook is on your computer. That way you can type in your responses to each activity and go back and change it if you want to. Remember, you can study at home, work, your local library or wherever you have access to the internet. You can also print out this workbook and read through it in paper form if you prefer. If you choose to do this, you'll have to type up your answers onto the version saved on your computer before you send it to your tutor/assessor (or handwrite them and post the pages).

When To Study

It's best to study when you know you have time to yourself. Your tutor/assessor will help you to set some realistic targets for you to finish each unit, so you don't have to worry about rushing anything. Your tutor/assessor will also let you know when they'll next be visiting or assessing you. It's really important that you stick to the deadlines you've agreed so that you can achieve your qualification on time.

How To Study



Your tutor/assessor will agree with you the order for the workbooks to be completed; this should match up with the other assessments you are having. Your tutor/assessor will discuss each workbook with you before you start working on it, they will explain the book's content and how they will assess your workbook once you have completed it.

Your Assessor will also advise you of the sort of evidence they will be expecting from you and how this will map to the knowledge and understanding of your chosen qualification. You may also have a mentor appointed to you. This will normally be a line manager who can support you in your tutor/assessor's absence; they will also confirm and sign off your evidence.

You should be happy that you have enough information, advice and guidance from your tutor/assessor before beginning a workbook. If you are experienced within your job and familiar with the qualification process, your tutor/assessor may agree that you can attempt workbooks without the detailed information, advice and guidance.

THE UNITS

We'll start by introducing the unit and clearly explaining the learning outcomes you'll have achieved by the end of the unit.

There is a learner details page at the front of each workbook. Please ensure you fill all of the details in as this will help when your workbooks go through the verification process and ensure that they are returned to you safely. If you do not have all of the information, e.g. your learner number, ask your tutor/assessor.

To begin with, just read through the workbook. You'll come across different activities for you to try. These activities won't count towards your qualification but they'll help you to check your learning.

You'll also see small sections of text called "did you know?" These are short, interesting facts to keep you interested and to help you enjoy the workbook and your learning.

At the end of this workbook you'll find a section called 'assessments'. This section is for you to fill in so that you can prove you've got the knowledge and evidence for your chosen qualification. They're designed to assess your learning, knowledge and understanding of the unit and will prove that you can complete all of the learning outcomes.

Each Unit should take you about 3 to 4 hours to complete, although some will take longer than others. The important thing is that you understand, learn and work at your own pace.

YOU WILL RECEIVE HELP AND SUPPORT

If you find that you need a bit of help and guidance with your learning, then please get in touch with your tutor/assessor.
If you know anyone else doing the same programme as you, then you might find it very useful to talk to them too.

Certification

When you complete your workbook, your tutor/assessor will check your work. They will then sign off each unit before you move on to the next one.

When you've completed all of the required workbooks and associated evidence for each unit, your assessor will submit your work to the Internal Verifier for validation. If it is validated, your training provider will then apply for your certificate. Your centre will send your certificate to you when they receive it from your awarding organisation. Your tutor/assessor will be able to tell you how long this might take.

Unit HSC 028: Handle information in health and social care settings

About this unit

This unit is aimed at those who work in health and social care settings. It provides the learner with the knowledge and skills required for good practice in recording, storing and sharing information.

Learning outcomes

There are three learning outcomes to this unit. The learner will be able to:

1. Understand the need for secure handling of information in health and social care settings
2. Know how to access support for handling information
3. Be able to handle information in accordance with agreed ways of working

Principles of good record keeping

Care plans, needs assessments, case reviews and day files are required as legal records and the keeping of certain confidential notes and records relating to individual service users are an essential part of the communication and day-to-day running of a setting.

According to the NHS Confidentiality Code of Practice care records should:

1. Be factual, consistent and accurate i.e. they should be:

   - Written as soon as possible after an event has occurred, providing current information on the care and condition of the service user
   - Written clearly, legibly and in such a manner that they cannot be erased
   - Written in such a manner that any alterations or additions are dated, timed and signed in such a way that the original entry can still be read clearly

- Accurately dated, timed and signed or otherwise identified, with the name of the author being printed alongside the first entry
- Readable on any photocopies i.e. Care records should be written in black ink
- Written, wherever applicable, with the involvement of the service user
- Clear, unambiguous, concise and written in terms that the service user can understand and
- Written so as to be compliant with the race relations act and the disability discrimination act

2. Be relevant and useful i.e. they should:

- Identify problems that have arisen and the action taken to rectify them
- Provide evidence of the care planned, the decisions made, the care delivered and the information shared
- Provide evidence of actions agreed with the service user, including consent to care and/or consent to disclose information

3. Records should **not** include:

- Unnecessary abbreviations or jargon
- Meaningless phrases, irrelevant speculation or offensive subjective statements
- Irrelevant personal opinions regarding the service user

Legislation and record keeping

The rules governing the recording and use of service user information has been laid down by the Caldicott Report. The key requirements of this report are that the care worker must:

1. Justify a purpose for recording and using service user information
2. Only record and use information when it is absolutely necessary
3. Use only the minimum information required
4. Only access information on a strict 'need to know' basis.
5. Be aware of his or her responsibilities concerning the recording and use of service user information
6. Understand and comply with the law e.g. the Data Protection Act

The Data Protection Act 1998

The Data Protection Act 1998 (DPA) sets standards governing the storage and processing of personal data held in manual records and on computers. The Act works in two ways — giving individuals (data subjects) certain rights, whilst requiring those who record and use personal information (data controllers) to be open about their use of that information and to follow sound and proper practices (the Data Protection Principles). All residential or nursing care homes that hold manual or computerised service user or employee records are covered by the DPA. According to The DPA, there are eight main principles under which personal data should be kept and collected. Personal data should:

- Be obtained fairly and lawfully
- Be held for specified and lawful purposes
- Be processed in accordance with the person's rights under the DPA
- Be adequate, relevant and not excessive in relation to that purpose
- Be kept accurate and up to date
- Not be kept for longer than is necessary for its given purpose and
- Be subject to appropriate safeguards against unauthorised use, loss or damage

One of the most important aspects of the DPA is that personal data may be processed only if the service user has given their consent. All files kept about residents or staff should be confidential and, according to the DPA service users should know what records are being kept about them and why they are being kept.

Also, service users should be given access to what is said about them in any personal records maintained by the home and information should be withheld only in exceptional circumstances. All data, and particularly sensitive or confidential data, must be stored securely. Manual records such as personnel files and resident care files should be kept in locked filing cabinets, preferably within an office that is locked when unattended. Care must be taken when working on confidential files that they are put away securely and not left out on a desk when people could walk by and see them. Where data is stored electronically on a computer the following steps should be considered:

- Check regularly on the accuracy of data being entered (remember that a home may be liable for inaccurate or erroneous data)
- Ensure that the computer system is secure by checking that it has a backup system, that lost data can be recovered and that backups are stored in a safe and secure place

- Ensure that all staff who need to use the computer system are thoroughly trained in its use
- Ensure that passwords are being used for access to different parts of the system, that these are regularly changed and not abused by being passed on to people who should not have them
- Use screen blanking to ensure that personal data is not left on screen when not in use by authorised staff
- Review the terminal positions to ensure that unauthorised staff or service users cannot casually view personal data on screen
- Ensure that confidential or private print-outs are stored securely and safely and that they are collected immediately if printed onto a networked printer

Access to Medical Reports Act 1988

This Act gives guidelines covering requests from employers or insurance companies wanting medical reports on individuals. For example, the individual's specific consent has to be given before a medical report can be written for employment or insurance purposes. The individual also has the right to see the report before it is passed to the employer or insurance company, they can then request alterations to be made and refuse permission for the report to be sent.

For example, a GP could not give information about an individual's medical history to an insurance company without a consent form signed by the individual staying that they agree to their personal information being given. The consent form would include a statement saying that the individual did or did not want to see the report before it is sent to the insurance company.

Other relevant legislation may include:

- Crime and Disorder Act 1998
- Criminal Procedures and Investigations Act
- Human Right Act 1998

- Freedom of Information Act 2000
- Children Act 2004

DID YOU KNOW?	
There was no soap in the ancient Mediterranean world. Olive oil was used to wash the body in addition to cooking.	

ACTIVITY ONE

Circle the words or phrases you would associate with legislation

Apple	**Act**	**Reports**
Access	**Pears**	**Rights**
Information	**Consent**	**Oranges**

The Caldicott Principles

All information that is recorded and reported about individuals should only be required in order to meet their specific needs. Information that is not relevant should not be recorded at all, for example financial information would not be relevant to a patient who has been admitted to hospital for an operation, however, it may be needed to determine an individual's ability to pay for adult social care services. Information describing personal characteristics such as age, gender, disability, ethnicity, religion and sexual orientation should only be used to support the provision of high quality care to meet individual needs. This information can be used to meet the requirements of legislation, regulations, policies and to demonstrate good practice.

The Caldicott Principles were developed for the NHS in relation to the recording and sharing of personal information. These principles can easily be applied to any organisation or setting. The Caldicott Standards are based on the Data Protection Act 1998 principles and again are set out in the form of Principles.

1. *Justify the purpose(s) of using confidential information*
Every proposed use or transfer of patient-identifiable information within or from an organisation should be clearly defined and scrutinised, with continuing uses regularly reviewed, by an appropriate guardian.

2. *Do not use patient-identifiable information unless it is absolutely necessary*
Patient-identifiable information items should not be included unless it is essential for the specified purpose(s) of that flow. The need for patients to be identified should be considered at each stage of satisfying the purpose(s).

3. *Use the minimum necessary patient-identifiable information that is required*
Where use of the patient-identifiable is considered to be essential, the inclusion of each individual item of information should be considered and justified so that the minimum amount of identifiable information is transferred or accessible as is necessary for a given function to be carried out.

4. *Access to patient-identifiable information should be on a strict need-to-know basis*
Only those individuals who need access to patient-identifiable information should have access to it, and they should only have access to the information items that they need to see. This may mean introducing access controls or splitting information flows where one information flow is used for several purposes.

5. *Everyone with access to patient-identifiable information should be aware of their responsibilities*
Action should be taken to ensure that those handling patient-identifiable information – both clinical and non-clinical staff – are made fully aware of their responsibilities and obligations to respect patient confidentiality.

6. *Understand and comply with the law*
Every use of patient-identifiable information must be lawful. Someone in each organisation handling patient information should be responsible for ensuring that the organisation complies with the legal requirements.

Caldicott Guardians are senior staff in the NHS and social services appointed to protect patient information to ensure that it is used for the purposes intended, meeting the individual needs of the patients in their care.

With regard to the use of service user records the NHS Confidentiality Code of Practice for record keeping states that the care worker should ensure that records are:

- Formally booked out from their normal filing system
- Tracked if transferred, with a note made or sent to the filing location of the transfer
- Returned to the filing location as soon as possible after use
- Stored securely within the clinic or office, arranged so that the record can be found easily if needed urgently.
- Stored closed when not in use so that contents are not seen accidentally
- Inaccessible to members of the public and not left even for short periods where they might be looked at by unauthorised persons
- Held in secure storage with clear labelling. Protective 'wrappers' indicating sensitivity – though not indicating the reason for sensitivity – and permitted access, and the availability of secure means of destruction, e.g. shredding, are essential

With regard to electronic records, the NHS Confidentiality Code of Practice states that care staff must:

- Always log-out of any computer system or application when work on it is finished.
- Not leave a terminal unattended and logged-in.
- Not share logins with other people.
- Not reveal passwords to others.
- Change passwords at regular intervals to prevent anyone else using them.
- Avoid using short passwords, or using names or words that are known to be associated with them (e.g. children's or pet's names or birthdays).
- Always clear the screen of a previous patient's information before seeing another.
- Use a password-protected screen-saver to prevent casual viewing of patient information by others.

PLEASE REMEMBER!

- Accurate and timely record-keeping is essential to good care practice
- Care records e.g. observation charts, records of daily activities, risk assessment charts and care plans etc. are all legal documents. You must complete them in a clear, accurate and objective way

- You must be familiar with and always follow your Employers policies and procedures on what, where, when and how to complete individual care records
- Observing the rules concerning the appropriate storage, security and disclosure of care records will ensure that service user information will remain confidential

The approach to record keeping that courts of law adopt tends to be that 'if it is not recorded, it has not been done'. Workers across the sectors have both a professional and a legal duty of care. Their record keeping should therefore be able to demonstrate:

- A full account of their assessment and the care that has been planned and provided
- Relevant information about the condition of the patient/ client at any given time
- The measures taken by the worker to respond to their needs
- Evidence that the worker has understood and honoured their duty of care, that all
- Reasonable steps have been taken to care for the patient/client and that any actions or omissions on the part of the worker have not compromised their safety in any way
- A record of any arrangements that have been made for the continuing care of a patient/client

DID YOU KNOW?	
Absolute pure gold is so soft that it can be moulded with the hands.	

ACTIVITY TWO

Circle the words or phrases you would associate with record keeping

Omissions	**Seaside**	**Measures**
Rules	**Storage**	**Skiing**
City break	**Confidential**	**Safety**

Organisational policies

All organisations have their own individual policies and procedures regarding recording and reporting of information to make sure that all practitioners observe the regulations that apply to them. Confidentiality is an essential component of an accessible service. Some users of services bring issues with them and they provide personal details in order for them to be assisted. By providing an assurance of the manner in which their information is going to be recorded, stored and shared individuals can be enabled to disclose a problem that they previously may not have been happy to discuss. Some people feel intimidated by, or reluctant to talk about their issues. Young people, refugees and offenders, for example, may feel especially vulnerable. Users of services need reassurance that they will not be judged, and that anything they tell workers will not be shared with others without their knowing and giving consent. The few exceptions to this are usually outlined in the policies the organisation follows. In order for policies to operate successfully there needs to be commitment from the all staff.

References are made to responsibility in relation to recording and reporting of information in many different organisational policies including:

- Confidentiality Policies
- Health and Well-being Policies
- Information Governance Policies
- Health and Safety Policies
- Child Protection Polices

- Assessment, Recording and Reporting Policies
- Codes of Conduct and National Standards Frameworks relating to practitioners across the sectors which also apply within organisations

Across the sectors there are different procedures and practices which may be expected to be followed within each organisation.
Every organisation must have a policy which explains the procedures to be followed for sharing information. The policy should clearly state:

- Which senior managers have the responsibility to decide about disclosing information
- What to do when action is required urgently
- How to make sure that information will only be used for the purpose for which it is required
- Procedures to be followed to obtain manual records
- Procedures to be followed to access computer records
- Arrangements for reviewing the procedures

Maintaining confidentiality

Confidentiality means that personal and private information obtained from or about an individual must only be shared with others on a 'need to know basis'. Information given to a worker should not be disclosed without the person's informed permission having been given. Maintaining confidentiality is a very important aspect of building trust between a person and a worker. Without trust communication is less likely to progress between two or more people. This involves honouring commitments and declaring conflicts of interest. It also means making sure that the policy which relates to ways of communicating with people is followed.

The right to confidentiality means that person's notes must not be left lying around or stored in an insecure manner (such as left in a car). On the computer, anything relating to the person should only be accessed by those who have been given the authority to do so, which means that a password should have been given to authorised staff. When being spoken to, the conversation with the person should not be so loud that others can hear and, if the content of the conversation is personal, the interaction should be in a room where others are not present and where the door is closed.

People have the right not to be gossiped about or to be spoken about in a way in which they can be identified. There are occasions when a worker may have to break confidentiality. Such situations arise when:

- A person is likely to harm themselves
- When a person is likely to harm others
- When a child or vulnerable adult has suffered, or is at risk of suffering significant harm
- When a person has been, or is likely to be, involved in a serious crime

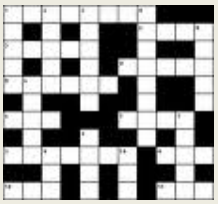
It must also be remembered that other professional workers will need to have specific information on a 'need to know' basis and in these circumstances information may have to be passed to others.

Confidentiality means, for example:

- Safe storage of information so that people who should not see the information cannot gain access to it
- The use of passwords for computer log on
- Only giving information on a need to know basis
- Not passing on information without the relevant permission
- Only using the information for the intended and agreed purpose
- Adhering to relevant legislation relating to data protection and accessing personal files.

The most common ways in which confidentiality can be breached are:

- Notes left in an unattended area
- Failure to ask whether information may be disclosed to others
- Discussions about users of services in public areas
- Failure to log off the computer system
- Allowing others to know and use your password
- Leaving information on a VDU screen which can be seen by the public
- Failure to establish a person's identity before giving them information
- Holding conversations, including on the telephone in a public area
- Leaving personal and private information in a car

DID YOU KNOW? "Asthma" and "isthmi" are the only six-letter words that begin and end with a vowel and have no other vowels between.	

ACTIVITY THREE

Circle the words or phrases you would associate with confidentiality

Securely	**Snowdrop**	**Closed**
Storage	**Daffodil**	**Safely**
Tulip	**Filing**	**Tracked**

UNIT HSC 028: SIGN-OFF

Assessor's Name: _____

Assessor's Signature:_____**Date:**_____

Learner's Name: _____

Learner's Signature:_____**Date:**_____

Mentor's Name: _____

Mentor's Signature: _____**Date:**_____

UNIT HSC 028: ASSESSMENT

ASSESSMENT ONE

Explain how you would identify the legislation that relates to the recording, storage and sharing of information in health and social care

ASSESSMENT TWO

Explain why it is important to have secure systems for recording and storing information in a health and social care setting

ASSESSMENT THREE

Describe how to access guidance, information and advice about handling information

ASSESSMENT FOUR

Explain what actions you would take when there are concerns over the recording, storing or sharing of information

ASSESSMENT FIVE

Explain how to keep records that are up to date, complete, accurate and legible

ASSESSMENT SIX

Explain how to follow agreed ways of working for:

- **recording information**

- **storing information**

UNIT HSC 028: ASSESSMENT SIGN-OFF

Assessor's Name: _____

Assessor's Signature:_____Date:_____

Learner's Name: _____

Learner's Signature:_____Date:_____

Mentor's Name: _____

Mentor's Signature:_____Date:_____

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