

GDPR (General Data Protection Regulations) & Handling Information

Knowledge Paper Answers

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1. Give three examples of records that carers contribute to.

- MAR charts (medicine administration records)
- Care plans
- Accident books
- Daily incident logs
- Fluid monitoring charts
- Urine input / output
- Bowel movement records

2. How can computer records be protected?

By using passwords for protection (each carer should have their own)

3. Which regulation was introduced on the 25th May 2018 to protect personal data?

GDPR General Data Protection Regulations

4. What colour ink should you use when you fill in forms?

Black

5. Why is it important that you complete records with a correctly coloured pen?

So that it is legible, photocopy or scannable and will not get rubbed out or fade away

6. What's wrong with the following record?

'Got Mr Brown out of bed this morning; he was a bit dodgy but said he'd be ok in a bit.'

Opinion not fact, doesn't really tell us anything. What does dodgy mean?

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7. Give two reasons why you would only record facts about clients and not opinions.

- So that records are factual, accurate and correct
- To avoid causing offence – clients can see records when they want
- To avoid misunderstandings

8. Why must you make sure that any abbreviations you use are agreed with your employer?

So that you know that you are using abbreviations that everyone will understand

9. Why is it important to complete records as soon as possible after carrying out tasks? (e.g. giving medication)

To ensure that they are as accurate and complete as possible; so that things aren't forgotten

10. Give an example of a way in which poor record keeping could result in harm to a client.

- Extra medication given because first dose not recorded
- Accident not recorded so reoccurs
- No maintenance records for equipment
- Appointments missed
- Poor communication between health care staff
- No information about allergies

11. Give an example of a way in which good record keeping protects clients from harm.

Any information that demonstrates good communication of things that should be known to keep individuals safe

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12. How does good record keeping contribute to person-centred care?

- Individuals and their loved ones are encouraged to contribute and see what is agreed about their care
- Everyone knows how to care for the individual appropriately
- Records are factual and nonjudgmental / discriminatory
- Personal information is taken care of

13. Give two reasons why carers' standards of record keeping may be poor.

- Workload pressures resulting in lack of time to complete the records
- Staff may not consider record keeping such a high priority compared to the individual care
- Staff view writing records as a chore
- Too many distractions and unexpected events
- Lack of staff training, supervision
- Staff may be afraid of making mistakes, punishment, breaching individuals rights, possible litigation
- IT system breakdowns

14. Who is responsible for the quality of the entries you make in clients' records?

The carer is (although managers should ensure everyone is up to standard)

15. What should be done to ensure that it's possible to identify who made an entry in a record and when they did so?

Should be signed and dated

16. If you make a mistake how should you correct it?

Do not use correcting fluid, cross through errors with a single line, sign and date

17. Why is it bad practice to use correcting fluid in clients' records?

It hides what has been done

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18. What would you do if a colleague asked you to remove or change an entry they had made in an individual's care plan?

Refuse to

19. What's wrong with the following record?

'Mrs Carter said she had a headache so I gave her a couple of tablets. LR 19.4.2012'

- Not specific about medication
- Not signed – only initialed
- No time given

In essence we don't know what Mrs Carter was given, when or by whom

20. Why should an individual's records be stored for a length of time after they are made, even if the individual is no longer in your care?

- It's a requirement in case they are needed for legal reasons to provide evidence of care given, medications etc
- In case the individual or their family wish to look at them