Support Records and Record Keeping Policy

Supportive Bridge Ltd | Community Support and Healthcare Staffing | Bradford, England

POLICY AT A GLANCE

- **Write it at the visit:** record what you did before you leave the home, not hours later or at the end of the week.
- **Facts, not opinions:** write what you saw, heard and did, in plain English. No jargon, no guessing, no judgements about the person.
- **Sign, date and time everything,** using the 24-hour clock and your full name.
- **Never rewrite history:** to correct a paper entry, draw one line through it, write the correction, then sign and date it. Never use correction fluid, never scribble out, never change someone else's entry.
- **The support record stays in the person's home;** anything that identifies them must never be shared, photographed or posted, and never discussed where others can hear.
- **Never take photographs** of a person, their home or their records on a personal phone.
- **People can see their own records** and are involved in writing them. Requests for copies go to the Registered Manager.
- **Records are kept for 8 years** after the service ends, then securely destroyed.

SERVICE DETAILS (fill in before issuing)

Registered Manager	Iffrah Ishtiaq
Nominated Individual	Iffrah Ishtiaq
Data Protection lead (and ICO registration no.)	ZC010224
Support records system used (paper and/or software name)	Paper based and Supportive Bridge own secure online system
Office phone	07448 266215
Date issued	01-10-2026
Next review date	

This summary is a quick guide only. All staff must read and follow the full policy on the following pages.

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1. PURPOSE

1.1 This policy explains how Supportive Bridge Ltd ("Supportive Bridge", "we", "us") creates, writes, stores, shares, keeps and destroys the records we hold about the people we support in their own homes.

1.2 Good records are not paperwork for its own sake. They are how the next support worker knows what happened, how we spot that someone is becoming unwell, how we show that care was given safely, and how we protect both the person and our staff if something is ever questioned.

1.3 It supports Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, which requires an accurate, complete and contemporaneous record for each person, and Regulation 9 (Person-centred care). It also sets out how we meet the UK GDPR and the Data Protection Act 2018.

2. SCOPE

2.1 Supportive Bridge Ltd operates two arms, and this policy applies to both: our **healthcare staffing service**, supplying care and support workers to care homes, hospitals and other providers; and our **community support service**, where our own support workers visit adults and older people in their own homes, including council housing, on morning and evening shifts, to support them with daily living.

2.2 Supportive Bridge does **not** provide personal care. Personal care is a regulated activity under the Health and Social Care Act 2008 and we will provide it only if and when we are registered with the Care Quality Commission. Our support workers provide non-personal support such as companionship, meal preparation, shopping, domestic help, prompting, and support to get out and about. This policy is written to meet both local authority provider assurance requirements and the standards we will be assessed against at CQC registration.

2.3 It applies to all Supportive Bridge staff, including support workers, agency-supplied workers, field supervisors, office staff, managers and bank staff.

2.4 It covers every record about a person we support, in any form:

- the support record kept in the person's home: the support plan, risk assessments, daily notes, medication administration record (MAR) chart and any monitoring charts;
- office records: assessments, reviews, correspondence, consent forms, complaints and incident records;
- electronic records, including any care management or electronic call monitoring system we use;
- messages and notes: emails, text messages and handover notes that contain information about a person;
- anything else that identifies a person we support, in writing, on a screen, or in an image.

2.5 Records about staff are covered by our Staff Records and Data Protection policies.

2.6 Failure to follow this policy may lead to action under our Disciplinary Policy. Deliberately falsifying a support record is treated as gross misconduct and may also be a safeguarding matter and a criminal offence.

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3. WHAT RECORDS WE KEEP FOR EACH PERSON

Record	What it is and where it is kept
Support plan	How the person wants to be supported, agreed with them, with their goals, routines, preferences and the tasks at each visit. Kept in the home, with a copy held securely in the office.
Risk assessments	Risks to the person and to staff (for example moving and handling, the home environment, pets, medication, lone working), and how they are managed.
Daily notes	A short, factual entry for every visit: the time in and out, what support was given, how the person seemed, anything refused, and anything reported to the office.
MAR chart	The record of medicines prompted, assisted with or administered, completed at the time (see our Medication Policy).
Monitoring charts	Only where the support plan requires them, for example food and fluid records, repositioning charts, or blood pressure and blood glucose readings.
Consents	Consent to care, to share information, and any mental capacity assessments or best interests decisions.
Communication record	Contacts with the GP, district nurse, social worker, family and others, with the date, who was spoken to and what was agreed.
Reviews	Records of care reviews and any changes made.

3.1 A support record is set up before the first visit, from the initial assessment, and is in the home when care starts. The office keeps a matching file, and the two are kept in step.

4. HOW TO WRITE A GOOD RECORD

4.1 Every entry, whether on paper or on a screen, must be:

- **Contemporaneous:** written at the visit, before the support worker leaves the home, not later from memory;
- **Factual:** what was seen, heard and done. Write "ate half a bowl of soup and drank 200 ml of tea", not "ate well". Write "said her hip was hurting when she stood up", not "seemed uncomfortable";
- **Complete:** including anything the person refused, anything not done and why, and anything reported to the office;
- **Clear:** plain English, legible, no jargon, no abbreviations unless they are in everyday use and unambiguous;
- **Respectful:** written as though the person and their family will read it, because they may. Never use words that judge or label, such as "difficult", "attention seeking", "non-compliant" or "pleasantly confused";
- **Signed:** with the support worker's full name printed, their signature, the date and the time in 24-hour format;
- **Accurate about others:** only include information about family members or other people where it is relevant to the person's care.

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Words to use instead

Instead of	Write
"Ate well" / "Poor intake"	"Ate all of a cheese sandwich and a yoghurt." / "Ate two spoonfuls of porridge and refused the rest."
"Refused care, non-compliant"	"Said she did not want a shower today and would prefer a wash at the sink. Supported with a wash. Explained the shower can be offered again tomorrow."
"Was aggressive"	"Raised his voice and pushed my hand away when I tried to help with his socks. I stepped back and waited. He settled after a few minutes and let me help."
"Seemed off today"	"Was more drowsy than usual and did not finish her drink. Skin warm to touch. Rang the office at 10:20 and they said they would contact the GP."

Correcting a mistake

4.2 On paper: draw a single thin line through the entry so it can still be read, write the correct information, and sign, date and time the correction. Never use correction fluid, never black anything out, and never write over an entry.

4.3 On an electronic system: use the system's own correction or amendment function, which keeps a record of the change.

4.4 Never alter or add to an entry made by another member of staff. If a support worker believes someone else's entry is wrong, they should make their own dated entry explaining what they know, and tell the office.

Late entries

4.5 If an entry genuinely could not be made at the time, write it as soon as possible, mark it clearly as a "late entry", give the date and time of the event as well as the date and time of writing, and never make it look as though it was written earlier. Late entries should be rare.

5. RECORDS IN PEOPLE'S HOMES

5.1 Support records kept in the home are the person's own record of their care. They are kept in a folder in a place agreed with the person, tidy and out of casual view of visitors, but easy for the person, their family and visiting professionals to find.

5.2 Support workers must:

- read the support plan and recent notes at the start of a visit, especially the first visit or after time away;
- keep the folder complete and in order, and report to the office if pages are missing, damaged or full;
- never remove the folder from the home except when the office asks for completed sheets to be returned;
- never leave the folder, a MAR chart or any loose paperwork in a car, a bag or another person's home.

5.3 Completed sheets, such as finished daily note pages and MAR charts, are returned to the office at the end of each month (or sooner if the care ends), checked by the office and filed securely. Fresh sheets are supplied before the old ones run out.

5.4 Support records must not contain complaint or safeguarding investigation papers, or notes about other people; those are held in the office (see our Complaints and Safeguarding policies).

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6. ELECTRONIC RECORDS AND DEVICES

6.1 Where we use an electronic care system or an electronic call monitoring app, the same rules about accuracy, timing and respectful language apply.

- each member of staff has their own username and password, which they must never share or write down, and must not let anyone else use;
- devices are locked with a PIN, passcode or biometrics, and locked whenever they are put down;
- screens must not be visible to anyone who should not see them;
- care information must never be sent through personal email, WhatsApp or other personal messaging apps;
- staff must not take photographs of a person, their home, their records or a screen on a personal phone or camera. Where a photograph is genuinely needed, for example of a pressure sore or an injury, this is only done with consent (or a best interests decision) on a company device, at the Registered Manager's direction;
- if a phone, tablet or paperwork is lost or stolen, or information is sent to the wrong person, staff must tell the Registered Manager **immediately**, at any hour, so that a possible data breach can be assessed (section 10).

6.2 If the electronic system is unavailable, staff keep paper records and enter them into the system as soon as it is working again, as set out in our Business Continuity Plan.

7. CONFIDENTIALITY AND SHARING INFORMATION

7.1 Information about a person is confidential. Staff must not discuss the people we support with anyone who does not need to know, including their own family and friends, or in places where they can be overheard, such as a doorstep, a bus or a supermarket. Nothing about a person or their home may be posted on social media (see our Social Media Policy).

7.2 We share information when the person has agreed to it, or when the law allows or requires it. In practice this means:

- sharing with other professionals involved in the person's care, such as their GP, district nurse or social worker, where it is needed for their care;
- sharing in an emergency, for example telling paramedics about a person's conditions and medicines;
- sharing to protect someone from harm under our Safeguarding Adults Policy, which does not need the person's consent;
- sharing with the person's family or representative only to the extent the person has agreed, or, if they lack capacity, where it is in their best interests.

7.3 We follow the Caldicott principles: only share confidential information when there is a clear purpose, share the minimum needed, tell people how their information is used, and remember that the duty to share can be as important as the duty to protect.

7.4 Every share is recorded: what was shared, with whom, when and why.

8. PEOPLE'S RIGHT TO SEE THEIR RECORDS

8.1 People have the right to read their own support records at any time, and to be involved in writing them. Support workers should write with the person, and read entries back to them where this helps.

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8.2 A person, or someone acting for them with their authority, can also ask for a copy of everything we hold about them. This is a subject access request. It can be made in any way, including verbally.

- Any request is passed to the Registered Manager on the same day.
- We respond within one calendar month, free of charge.
- We confirm the person's identity, and check what information about other people may need to be removed first.
- If a request is made on someone's behalf, we check their authority and, where the person has capacity, their consent.

8.3 People also have rights to have inaccurate information corrected, and to be told how we use their information, which is explained in our Privacy Notice and Service User Guide. Further detail is in our Data Protection Policy.

9. STORAGE, SECURITY AND RETENTION

9.1 Office records are kept in locked cabinets in a secure office, or on password-protected systems with regular backups. Only staff who need access have it. Paperwork is never left in a car overnight or taken home.

9.2 We keep the records of an adult receiving social care for **eight years** after the care ends (or, if the person dies, eight years after their death), in line with the NHS Records Management Code of Practice. Some records are kept longer, for example where there is an ongoing investigation, complaint, inquest or legal claim, and safeguarding records may be kept for longer where the local authority requires it.

9.3 When the retention period ends, paper records are destroyed by cross-cut shredding or a confidential waste service, and electronic records are securely deleted. The Registered Manager records what was destroyed, when and how.

9.4 When a person moves to another provider or into hospital, we share what is needed for their continuing care with their consent, and keep our own record for the retention period. We do not hand over our original records except where the law requires it.

10. DATA BREACHES

10.1 A data breach is any loss of, unauthorised access to, or wrongful sharing of personal information. Examples include a lost care folder or phone, an email sent to the wrong address, a record left in a car, or a conversation overheard.

10.2 Staff must report any actual or suspected breach to the Registered Manager immediately. The Registered Manager records it, takes steps to limit the harm, and decides whether it must be reported to the Information Commissioner's Office (ICO). A reportable breach must reach the ICO **within 72 hours** of us becoming aware of it. Where the breach is likely to cause a high risk to the person, we tell them too. Serious breaches may also require a CQC notification and a safeguarding referral.

10.3 No member of staff will be treated unfairly for reporting a breach promptly and honestly.

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11. ROLES AND RESPONSIBILITIES

Role	Responsibilities
Nominated Individual	Makes sure the service has safe, lawful record keeping and the systems and resources to support it, and reviews audit findings and any breaches at least quarterly.
Registered Manager	Overall responsibility for support records: makes sure records are set up, accurate and secure; audits them monthly; handles access requests and breaches; arranges training; and oversees retention and destruction.
Data Protection lead	The named person (the Registered Manager unless someone else is named on page 1) responsible for the company's ICO registration, privacy notice, and advice on data protection questions.
Field Supervisor / Care Coordinator	Checks records in people's homes during spot checks and reviews, collects completed sheets, and reports gaps or poor-quality entries.
Support workers	Complete accurate records at each visit, keep them secure and confidential, and report anything missing, wrong or lost.

12. TRAINING

12.1 All staff receive training on record keeping, confidentiality and data protection during induction (linked to the Care Certificate), before they work alone. This is refreshed at least every year and whenever our systems or forms change.

12.2 New support workers have their first records checked by a supervisor, and record keeping is looked at in every spot check and supervision.

13. MONITORING AND REVIEW

13.1 The Registered Manager audits a sample of support records every month, checking that entries are timely, factual, signed, legible, respectful and complete, that MAR charts have no gaps, and that support plans are up to date. Findings are fed back to individual staff and to the team, with an action plan where needed.

13.2 The Nominated Individual reviews a summary at least quarterly. This policy is reviewed every year, or sooner if the law or guidance changes, or if an audit, complaint or breach shows it needs to change.

14. LEGISLATION AND GUIDANCE

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, especially Regulation 9, Regulation 17 (good governance) and Regulation 20 (duty of candour)
- Care Quality Commission (Registration) Regulations 2009
- UK General Data Protection Regulation and Data Protection Act 2018
- Common law duty of confidentiality and the Caldicott principles
- NHS Records Management Code of Practice (retention schedule)
- Mental Capacity Act 2005
- Care Act 2014
- Information Commissioner's Office guidance on subject access requests and personal data breaches
- NICE guideline NG21: Home care

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15. RELATED POLICIES AND FORMS

Related policies: Data Protection and Confidentiality; Support Planning and Risk Assessment; Medication; Consent and Mental Capacity; Safeguarding Adults; Complaints, Concerns and Compliments; Incident and Accident Reporting; Social Media and Mobile Phones; Business Continuity; Quality Assurance and Audit.

Forms: Support Plan; Risk Assessment; Daily Notes sheet; MAR chart; Communication Record; Consent to Share Information; Care Record Audit tool (Appendix A); Subject Access Request log; Data Breach Record.

16. DOCUMENT CONTROL

Version	Date	Approved by	Role	Reason
1.0			Nominated Individual	New policy for local authority assurance and CQC registration

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APPENDIX A: MONTHLY SUPPORT RECORD AUDIT

Complete one per person audited. Aim to audit every person's records at least twice a year, and all new packages in the first month.

Person: _____ Audited by: _____ Date: _____

Check	Yes / No / N/A	Comments and action
Support plan is in the home, signed and dated, and matches the person's current needs		
Support plan has been reviewed in the last six months		
Risk assessments are present, current and match the support plan		
Daily notes are complete for every visit, with no missing days		
Entries are timed (24-hour clock), dated and signed with printed names		
Entries are factual and specific, not vague ("ate well", "all fine")		
Language is respectful, with no judgements or labels		
Corrections are made properly (single line, signed and dated); no correction fluid		
Refusals, missed tasks and anything reported to the office are recorded		
MAR chart is complete with no gaps or unexplained codes		
Any monitoring charts required by the support plan are being completed		
Consent and any capacity or best interests records are in place		
Contacts with GP, family and professionals are recorded		
Records are stored appropriately and contain nothing about other people		

Action taken / feedback given: _____

Re-check due: _____ Signed (Registered Manager): _____

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