About this course
Keeping clear and accurate records is perhaps one of the most important skills a healthcare professional can possess. It’s absolutely essential that good records are available for a variety of situations, such as an accurate reflection of care that has been delivered, to provide a solid defence in the event of a clinical negligence case and for audits.

This training course will provide participants with the knowledge to identify good record keeping from poor record keeping and ensure they understand how to attain audit standards. They will also be taught how to properly store records safely and be appraised of the data protection laws that govern the responsibility of confidentiality for medical records.

Throughout the duration of this course we will use actual cases and documentation to clearly demonstrate the importance of good record keeping, as well as providing assessment process skills and information on the correct use of assessment tools.

Course content
- Good documentation
- Poor documentation
- Principles of record keeping
- Communication
- Confidentiality
- Access to records
- Data protection
- Audit
- Contemporaneous records

Learning outcomes
- Explore the legal aspects of record keeping using actual cases and documentation.
- Know what the documentation audit policy requires.
- Understand the benefits of documentation, audit to the professional, client and organization.
- Assessment process skills.