LEVEL 2 DIPLOMA

IN

HEALTH AND SOCIAL CARE

Candidate Name…….....

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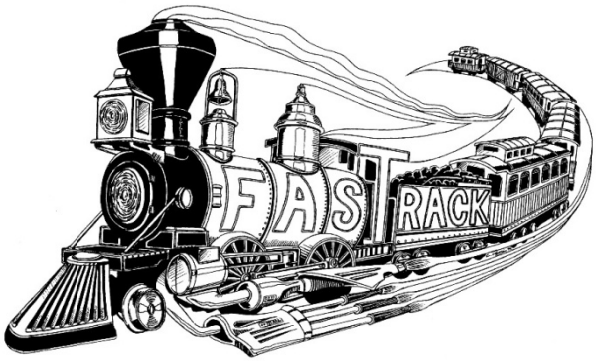

The Name of the Game is to Train

FOREWARD

The Jet Qualification and Credit Framework Modules are designed to Inform, Educate and Probe the Candidates Knowledge and Understanding of the subject matter to confirm their competence on the subject

This programme module is designed to help the candidate in several ways.

- To aid the understanding of what the criteria is asking for
- To give advice and guidance as to what is required
- To gain definitions to help the candidate understand the wording that underpins the criteria
- To give relevant answers to the specific questioning
- Information has been collected from previous NVQ training which still has validity as specific training needs and is specific to the subject matter.

I wish you well with your training.

John Eaton RMN, RGN, RN (New York) DipRSA D32/33/34/36

QUALIFICATIONS AND CREDIT FRAMEWORK

QCF Health and Social Care

Level 2 Diploma in HSC (adults) Mandatory Group A

HSC 028 HANDLE INFORMATION IN HEALTH AND SOCIAL CARE SETTINGS

Level 2 **Credit value 1**

Learning outcomes are the black on white overview statements that '*The learner will:'*

The **Assessment criteria (1.1 et al)is what after the assessment '***The learner can:'*

!. UNDERSTAND THE NEED FOR SECURE HANDLING OF INFORMATION IN HEALTH AND SOCIAL CARE SETTINGS

1.1 Identify the legislation that relates to the recording, storage and sharing of information in health and social care

The **Data Protection Act 1998** is a United Kingdom Act of Parliament which defines UK law on the processing of data on identifiable living people. It is the *main* piece of legislation that governs the protection of personal data in the UK. Although the Act itself does not mention privacy, it was enacted to bring UK law into line with the European Directive of 1995 which required Member States to protect people's fundamental rights and freedoms and in particular their right to privacy with respect to the processing of personal data. In practice it provides a way for individuals to control information about themselves. Most of the Act does not apply to domestic use,[1] for example keeping a personal address book. Anyone holding personal data for other purposes is legally obliged to comply with this Act, subject to some exemptions. The Act defines eight **data protection principles**. It also requires companies and individuals to keep personal information to themselves.

History

The 1998 Act replaced and consolidated earlier legislation such as the Data Protection Act 1984 and the Access to Personal Files Act 1987. At the same time it aimed to implement the European Data Protection Directive. In some aspects, notably electronic communication and marketing, it has been refined by subsequent legislation for legal reasons. The Privacy and Electronic Communications (EC Directive) Regulations 2003 altered the consent requirement for most electronic marketing to "positive consent" such as an opt in box. Exemptions remain for the marketing of "similar products and services" to existing customers and enquirers, which can still be permissioned on an opt out basis.

The Key Principles themselves are discussed below in the context of their definition in law.

- Data may only be used for the specific purposes for which it was collected.
- Data must not be disclosed to other parties without the consent of the individual whom it is about, unless there is legislation or other overriding legitimate reason to share the information (for example, the prevention or detection of crime). It is an offence for Other Parties to obtain this personal data without authorisation.
- Individuals have a right of access to the information held about them, subject to certain exceptions (for example, information held for the prevention or detection of crime).

- Personal information may be kept for no longer than is necessary and must be kept up to date.
- Personal information may not be sent outside the European Economic Area unless the individual whom it is about has consented or adequate protection is in place, for example by the use of a prescribed form of contract to govern the transmission of the data.
- Subject to some exceptions for organisations that only do very simple processing, and for domestic use, all entities that process personal information must register with the Information Commissioner's Office.
- Entities holding personal information are required to have adequate security measures in place. Those include technical measures (such as firewalls) and organisational measures (such as staff training).
- Subjects have the right to have *factually incorrect* information corrected (note: this does not extend to matters of *opinion*)

The Act covers any data about a living and identifiable individual. Anonymised or aggregated data is not regulated by the Act, providing the anonymisation or aggregation has not been done in a reversible way. Individuals can be identified by various means including their name and address, telephone number or Email address. The Act applies only to data which is held, or intended to be held, on computers ('equipment operating automatically in response to instructions given for that purpose'), or held in a 'relevant filing system'.

In some cases even a paper address book can be classified as a 'relevant filing system', for example diaries used to support commercial activities such as a salesperson's diary.

Subject rights

The Data Protection Act creates rights for those who have their data stored, and responsibilities for those who store, process or The person who has their data processed has the right to[2]

- View the data an organisation holds on them, for a small fee, known as 'subject access fee'[3]
- Request that incorrect information be corrected. If the company ignores the request, a court can order the data to be corrected or destroyed, and in some cases compensation can be awarded.[4]
- Require that data is not used in any way that may potentially cause damage or distress.[5]
- Require that their data is not used for direct marketing.[6]

Data protection principles

1. Personal data shall be processed fairly and lawfully and, in particular, shall not be processed unless-
    1. at least one of the conditions in Schedule 2 is met, and
    2. in the case of sensitive personal data, at least one of the conditions in Schedule 3 is also met.
2. Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
3. Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
4. Personal data shall be accurate and, where necessary, kept up to date.
5. Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes.
6. Personal data shall be processed in accordance with the rights of data subjects under this Act.
7. Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.

8. Personal data shall not be transferred to a country or territory outside the European Economic Area unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Conditions relevant to the first principle

Personal data should only be processed fairly and lawfully. In order for data to be classed as 'fairly processed', at least one of these six conditions must be applicable to that data (Schedule 2).

1. The data subject (the person whose data is stored) has consented ("given their permission") to the processing;
2. Processing is necessary for the performance of, or commencing, a contract;
3. Processing is required under a legal obligation (other than one stated in the contract);
4. Processing is necessary to protect the vital interests of the data subject;
5. Processing is necessary to carry out any public functions;
6. Processing is necessary in order to pursue the legitimate interests of the "data controller" or "third parties" (unless it could unjustifiably prejudice the interests of the data subject

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

1. **Why is Information Security Important?**

Information on Care Home clients and in house information is valuable and critical to the business of the Home. We all rely on information to store and process information, so it is essential that we maintain Information Security.

The purpose of information security policies is to preserve: -

Confidentiality data is only accessed by those with the right to view the information.
Integrity information can be relied upon to be accurate and processed correctly.
Availability information can be accessed when needed.

Insecure information can lead to:

- Violation of an individual's human and civil rights; action or deliberate inaction that results in neglect and/or physical, sexual, emotional or financial harm. Abuse can be perpetrated by one or more people (either known or not known to the victim) or can take the form of institutional abuse within an organisation; it can be a single or a repeated act.

- The extent to which people are able to receive the information, services or care they need and are not discouraged from seeking help. Issues involved include distance of travel; physical access (e.g. premises suitable for wheelchairs); communication (e.g. information in Braille/large print and other formats); and the provision of culturally appropriate services.

Accountability, staff have to take:

Responsibility for one's own actions and explaining them to managers and others who have regard to secure systems for recording and storing information.

Confidentiality

Client's have the right to:

- privacy and confidentiality of your personal and clinical records which reflect accommodations, medical treatment, written and telephone communications, personal care, associations and communications with people of your choice, visits and meetings of family and resident groups;
- private meeting space for you and your family;
- approve or refuse the release of personal and clinical records to any individual outside the facility except when you are transferred to another health care facility or when record release is required by law or health insurance company contract;
- privacy in written communications, including the right to send and receive unopened mail promptly;
- access to stationery, postage and writing implements (at your own expense);
- regular access to the use of a telephone where calls can be made without being overheard and which is wheelchair accessible and usable by residents who are visually and hearing impaired.

Care Home Responsibility

The Care home must:

- ensure that you have privacy in accommodations, medical treatment, personal care, visits and meetings of family, friends and resident groups;
- ensure that your mail is delivered to you unopened and that it is sent out unopened;
- provide you, upon your request, with stationery, postage and writing materials (to be paid for by you) and assist you in reading or writing mail if you so request;
- provide you, upon your request, with access to a telephone (and assist you in its use) that is private and, if necessary, wheelchair accessible and equipped for the hearing impaired or the visually impaired;
- instruct all staff and assure that all staff adhere to its instructions to fully honor and maintain your right to approve or refuse to approve release of your personal and clinical records to any outside individual;
- instruct all staff involved in your care to maintain your personal and clinical record in the strictest privacy. Staff must restrict discussion of your medical, mental and psychosocial problems to appropriate forums only, for example, at facility interdisciplinary care team conferences or unit conferences. Staff must not discuss or otherwise divulge your medical, mental and psychosocial problems with any other resident, even though discussion may be initiated by the other resident.

2. KNOW HOW TO ACCESS SUPPORT FOR HANDLING INFORMATION

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

Job Description

A **job description** is a list that a person might use for general tasks, or functions, and responsibilities of a position. It may often include to whom the position reports, specifications such as the qualifications or skills needed by the person in the job, or a salary range. Job descriptions are usually narrative,[1] but some may instead comprise a simple list of competencies; for instance, strategic human resource planning methodologies may be used to develop a

competency architecture for an organization, from which job descriptions are built as a shortlist of competencies.

Roles and responsibilities

A job description may include relationships with other people in the organization: Supervisory level, managerial requirements, and relationships with other colleagues.

Goals

A job description need not be limited to explaining the current situation, or work that is currently expected; it may also set out goals for what might be achieved in future.

Limitations

Prescriptive job descriptions may be seen as a hindrance in certain circumstances:[2]

- Job descriptions may not be suitable for some senior managers as they should have the freedom to take the initiative and find fruitful new directions;
- Job descriptions may be too inflexible in a rapidly-changing organisation, for instance in an area subject to rapid technological change;
- Other changes in job content may lead to the job description being out of date;
- The process that an organisation uses to create job descriptions may not be optimal.

Care Plan

Everyone with a long-term condition can have a care plan if they want one.

A care plan is an agreement between the individual and the individual's health professional (and/or social services) to help the individual manage the individual's health day-to-day. It can be a written document or something recorded in the individual's patient notes.

Everyone who has a long-term condition can take part in making their care plan. It helps to assess what care the individual need and how it will be provided.

If the individual think a care plan could help the individual, talk to the individual's GP, nurse or social worker about the support the individual need to help manage the individual's condition better. Mention things that are important to the individual and any goals the individual want to work towards. These can range from losing weight or stopping smoking, to going out more or going back to work.

Also, try to talk about anything that might be worrying the individual. For example, some people want to talk about how they feel lonely or anxious.

By talking about the individual's care plan with the GP, nurse or social worker, the individual can say how the individual want the individual's health to be looked after and choose what's best for the individual. The care plan will be based on what the individual want, so that the individual is in control.

The care plan is to help the individual, rather than the GP and other healthcare workers that look after the individual. It will cover areas including:

- The goals the individual want to work towards, such as getting out of the house more, returning to work, or starting a hobby.
- The support services the individual want, who is in charge of providing these services, what the support services have agreed to do and when they will do it.
- Emergency numbers, such as who the individual should contact if the individual become very unwell and the individual's doctor's surgery is closed.
- Medicines.
- An eating plan.
- An exercise plan.

Make sure the individual say what's important to the individual and that the individual're happy with any decisions that are put into the plan. Unless health and social care workers know what the individual want, they can't put it in.

Usually the individual's care plan will be printed on paper for the individual to take home. If the individual're not given a paper copy, ask for one. The individual's care plan may also be stored in the individual's GP's computer.

All the information in the care plan is private, seen only by the individual and the people who give the individual care or support. If the individual want someone else to be allowed to see the care plan, the individual can say so.

The individual's plan will be looked over at fixed times (a care plan review). You can have a care plan review at least once a year. If you feel the care plan isn't working or other things in your life change, you may ask for a care plan review

Data Protection Act

The Data Protection Act 1998 came into force in March 2000. Its purpose is to protect the right of the individual to privacy with respect to the processing of personal data. The Act laid down eight data protection principles:

1. Data must be processed fairly and lawfully.
2. Personal data shall be obtained only for one or more specific and lawful purposes.
3. Personal data shall be adequate, relevant and not excessive in relation to the purpose(s) for which they are processed.
4. Personal data shall be accurate and where necessary kept up to date.
5. Personal data processed for any purpose(s) shall not be kept for longer than is necessary for that purpose.
6. Personal data shall be processed in accordance with the rights of data subjects under the 1998 Data Protection Act.
7. Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.
8. Personal data shall not be transferred to a country outside the EEA, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Policy and Procedure

With guidance and interpretation of the National Minimum Standards for Older People, the policies and procedures have been designed to help meet the care standards requirements and prepare the home for inspection. Plus it also contains best practice information on health and safety and human resource issues.

Contents include:

Care home management:

- Management of the home
- Management of residents
- Procedures for new residents
- Care management and good practice
- Health and Ageing

Human resources:

- Recruitment and selection
- Staff management
- Working time, pay and benefits

Health and safety:

- Management responsibilities
- Work activities
- Premises and equipment safety
- Workplace hazards
- Workplace environment
- Occupational health

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

Information recorded in a patient's records is confidential under both common law and the Data Protection Act 1998, and must be protected by health and social care staff. Systems for the safe storage of records must be in place, and no-one should have access to the records or the information contained therein unless they are directly involved in the care of the client, or the client has given permission. Under the Data Protection Act clients can have access to their records, subject to a situation where disclosure is likely to cause serious harm to the physical or mental health or condition of the client or any other person.

If you find out about activities that harm clients of the Home, colleagues working for the Home, or the Home itself. These may include:

- Illegal activities
- Miscarriages of justice
- Risks to health and safety
- Damage to the environment
- Misuse of public funds
- Fraud and corruption
- Abuse of clients
- Other wrongdoing, (including attempts to cover up wrongdoing)

For example, you could raise a serious concern about service provision, the actions of managers, or the actions of others acting on behalf of the Home, which:

- Fall below the Home's standards of practice, including the Home's Code of Conduct for Employees
- Are against the Home's Standing Orders and policies
- Amount to improper conduct

Firstly, I would make my concerns to my immediate manager, and seek resolution. If this was not satisfactorily dealt with I would seek a meeting with the Registered manager and/or Owners.

If dissatisfied with the answers, I would contact the Registering Authority and/ or the police in cases of immediate danger or harm. I may also contact my Member of Parliament if is is felt appropriate

What is the Public Interest Disclosure Act?

The Public Interest Disclosure Act provides workers with protection from dismissal or other damage as a result of making a disclosure of information in the public interest about wrongdoing at work. Such disclosures are protected if they are done according to the Act's provisions. Disclosures may be made to the employer, prescribed regulatory bodies or on a wider basis to the Police. The Act's protection is strongest where workers raise matters with their employers.

Telling other people confidential information

Giving out information about third parties to whom the Home owes a duty of confidence may not be protected under the Public Interest Disclosure Act. This may lead to disciplinary action. If you are in any doubt you should seek advice from your manager, union, lawyer or Public Concern at Work

3. BE ABLE TO HANDLE INFORMATION IN ACCORDANCE WITH AGREED WAYS OF WORKING

3.1 Keep records that are up to date, complete, accurate and legible

THE REASONS FOR KEEPING RECORDS

Records should provide objective, accurate, current, comprehensive and concise information concerning the condition and care of the client.

We keep records:

- To record client details. Some will remain the same such as date of birth, others will change and require updating
- to provide a full assessment of the client's needs and identify any factors that may affect or have affected the client's progress.
- to provide a record of any problems that arise and the action taken in response to them.
- to provide evidence of the care required, the intervention by professional practitioners and client responses.
- to provide the chronology of events and the reasons for any decisions made.
- to provide a baseline record against which improvement or deterioration may be judged.
- to enable all members of the multi-disciplinary team to care for the client, the records being an important means of communication within the team and for the purpose of risk assessment, regardless of what stage they have reached in the care process.

KEEPING EFFECTIVE RECORDS

Effective record keeping by health and social care staff is a means of:

- ensuring a high standard of health and social care
- organising communication by disseminating information among members of the team providing care for a client, and describing what has been observed or done and what needs to be observed and done.
- ensuring a cohesive approach to client care
- detecting problems or changes in the client's condition, at an early stage and taking swift, appropriate action
- demonstrating the chronology of events, the care implemented and the responses to care and treatment.
- demonstrating the properly considered health and social care decisions relating to client care.
- demonstrating that staff have exercised their professional accountability and fulfilled their legal and professional duty of care

Remember! In law ' if it hasn't been written down….it hasn't happened'!

Protect your client and yourself by keeping accurate records of the actions you have taken and the care you have given.

STANDARDS FOR RECORD KEEPING

All assessment tools and every continuation sheet should be clearly labelled with the name and date of birth of the client/service user as a bare minimum. This is to ensure that, should a page become detached from the notes that they are easily identifiable.

In order to be effective, accurate and safe, records must be made as soon as possible after the events to which they relate, providing current information on the care and condition of the client. All records must be written up as soon as possible after the event, interview or incident has occurred, no later than the end of the shift on in-client units, and no later than 24 hours after the event in community care. Records must be an accurate record of what took place. The time and date that the entry is being made must be clearly documented in the margin. The time and date that the event, interview or incident occurred must be clearly documented in the content of the entry, so that there is no doubt exactly when the event being documented occurred.

Should it be necessary to document an event in a record other than the client's notes, such as a Seclusion book or a Group Activity Book, the record must also be made in the client's own notes, ensuring contemporaneous records at all times. It is not acceptable that a record be made about the client in a document other than their individual notes and not be reflected in those individual notes.

Records must also:

- be factual and consecutive, in chronological order
- not include any abbreviations except those approved by the Trust (see below), jargon, meaningless phrases, irrelevant speculation and offensive, subjective statements.
- identify problems that have arisen, and the action taken to rectify them
- provide clear evidence of the care planned, the decisions made, the care delivered and the information shared.

- be accurately dated, timed and signed, with the writer's name printed alongside the first entry on the page. Further entries on that page will not require a printed name (this is to ensure the writer can be identified, which may not be possible from a signature).
- be timed using the 24 hour clock to prevent any confusion regarding the timing of an entry
- be written, wherever possible with the involvement of the client
- be written in terms that the client will be able to understand.
- be written clearly and in such a manner that the text cannot be erased, and no space is left between the entries. Under no circumstances must a blank space be left in the notes so that entries can be made at a later date. Any gaps made in error should be scored through with two lines across the space.
- be written in black ink/biro
- be 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.
- be written in such a manner that deletions are made by crossing the entry through with a single line, and are signed, dated and timed. Tippex must not be used.

If rough notes are made during an initial assessment or appointment, guidance from the Nursing and Midwifery Home and the General Medical Home advises that these do not have to be kept once the notes are accurately written up in the client's notes, although there are exceptions to this rule (please see below) The records must be written up from the rough notes
as soon as possible after the event and no later than 24 hours afterwards. The entry must make it clear the exact date and time the assessment or appointment took place. Staff must dispose of the rough note properly by shredding it.

The rough note must be kept in the following circumstances:

- If the transcription took place more than 24 hours after the assessment or appointment
- If the rough note contained any information that might be needed in court, or in criminal proceedings for example if there was reference to an assault or other criminal activity having taken place.
- If the rough note contained any information related to child protection or protection of vulnerable adults.
- If the rough note relates to a Serious Untoward Incident at level 3, 4 or 5.

If a member of staff is not sure whether to keep a rough note, this must be discussed with their line manager and further advice sought if necessary from the Trust's Senior Nurse Adviser or Risk Manager. If the note is being kept it will still be necessary to transcribe the record into the notes to ensure there is a formal and neatly written record that other staff can read and understand.

If the rough note is being retained it must be placed in the client's notes in a white care file envelope which must be secured in the page the transcription of the event has been made. The transcription must refer to the retention of the rough note. The envelope containing the rough note must be clearly marked with the details of what is in the envelope, the date and time the note was made and the signature of the staff member who made the rough record.

All written records, i.e. the client's notes, any charts, observation forms and any contemporaneous notes written when assessing or interviewing the client must be considered as evidence and must be gathered together and taken into safe keeping by the Service Manager. In the event of a client death contemporaneous notes/aide memoires related to the client must not be destroyed, even if these have been transcribed into the client notes.

3.2 Follow agreed ways of working for:

- **recording information**

Record keeping will be central to the processes of assessment, decision making, service planning and delivery and is an integral part of the service to service users and carers.

It is recognised that good recording supports good practice in a number of ways:-

- Supports effective partnerships with users and carers
- Assisting continuity when workers are unavailable or change
- Provides documented evidence and account of the department's involvement with an individual service user
- Providing evidence for planning and allocating resources at an individual and strategic level
- Facilitating reflection, analysis and planning
- Supporting the formulation of risk assessments and risk management plans
- Supporting supervision and professional development
- Recording that the practitioner and agency have met the expected standards of social care

General Principles of Recording

Information and case records that are held on those who are referred, assessed, and receive services provided by Community Services should meet the following principles:-

- Records will clearly show the nature of involvement with service users, what decisions have been taken, by whom and on what basis
- Service users and carers are helped to understand the purpose and content of their case record and are invited to contribute to it.
- Service users and carers are informed about decisions and outcomes of requests for services, receive written copies of their assessment and care plans, as well as being kept informed at all stages.
- Case records will be kept in accordance with Department of Health guidance and legal requirements.
- The use of abbreviations, symbols or language that is not clearly understood by service users should not be used
- Service users and carers are informed of their right of access to their case record and the procedures for doing so. Users are encouraged access to their personal records, if this is their wish, supported in reading their records, correcting errors and omissions and recording personal statements, including any dissent
- Case records should identify issues arising from ethnicity, race, culture, gender, age, religion, language, communication, sensory impairment, disability, sexuality and how these have been taken into account.

- **storing information**

Care Plans that are taken to outpatient appointments with a client must be related to the client having the Out Patient Appointment, and no one else.

The Care Plans and the client must get to the outpatient appointment at the notified time of appointment.

CD-ROM's, other computer software, videotape and / or Cassette Tape may be insured for loss or damage. Many documents have to be signed by an appropriate person, dated to confirm that they have been received

Any written comment in those records must reflect accurately the situation and at each stage of inputting information and should be legible, signed and dated.

Some bloods and medications need monitoring by the local hospital, often bloods are taken and have to be with the hospital by a specific time, otherwise the test done are inaccurate, it is very important to send bloods to get to the hospital on time.

All documents are stored according to legal, organisational and ethical standards. Some information, i.e. Menus, can be stored and displayed in a kitchen or dining area.

Any individual accidental or deliberate leaving of confidential information in an uncontrolled area will be reported to the Person in Charge and may be subjected to the Homes Disciplinary Policy or legal sanction. Documentation, such as care plans, medication sheets, employee files need to be stored in locked cupboards in locked rooms to deny access to those who have no right to the information.

- **sharing information**

The Home has a general duty in common law to safeguard the confidentiality of personal information; because of the personal and sensitive nature of information required by WBC in order to provide these services, our work and recording must conform to the standards set out in the Data Protection Act.
The Home has a clear policy on Data Protection, which staff should adhere to.

Staff should pay particular attention to ensuring consent to share information is clearly recorded on file. Where it has been necessary to share information without consent then the justification should be recorded and authorised by line manager

CONFIDENTIALITY POLICY

All information regarding clients or other parties must be recorded in the appropriate place, i.e. Care Notes, Staff Files, Diary, Computer Files. No information should be left unattended or in a place where others can view the information. Any Computer Files should be consistent with the Data Protection Act.
All records must be current, accurate, legible and appropriate at the time of writing or recording.

Only those who have a right to access information should be able to view it. Any unauthorised viewing is contrary to policy and a disciplinary offence. Any outside agency or internal employee must identify who they are and the reasons for their interest in the information

Any statement, verbal, written, sign language must be consistent with the need of that information and information should not be given outside of that need. All staff should be aware of the need for confidentiality and be sensitive to whom and why the information is given

Where information is given which is relevant outside of inter-personal communication, the individual giving the information to the other person must be made aware of the fact that the information will be given to any appropriate individual or organisation.

All records that carry confidential information should be stored securely and where appropriate, locked in a room or cupboard which has access only to those whom have authority to hold a key or enter that area.

Sharing Information with Other Agencies

This confidentiality Agreement covers access by staff of agencies and organisations external to records kept at The Home.

1. Introduction

1.1 The Home collects records and processes information on individuals as part of its routine business in order to provide clients with an effective service.

The Home aims to ensure that:

- All data collected on clients is reliable, up to date and conforms with its Equal Opportunities policy
- All data is reviewed at regular intervals
- Information provided about or by its clients is treated as confidential and only disclosed to third parties with the client's permission, or where there is a duty to pass on the information
- Data is handled in a way which is consistent with the legislation set down in the Data Protection Act 1998.

1.2 The Home recognises that the principles of social inclusion are not best served by unnecessary secrecy and bureaucracy.

1.3 The Home also recognises that in order to serve the best interests of the client it is important to encourage 'joined up' working between professionals which may include, with the client's consent, sharing of confidential information about the client.

2. Conditions of Access

2.1 Access to The Home s client databases and tracking systems is granted only to its recognised partner agencies and organisations.

2.2 Access to client records will be granted only to named staff of those agencies and organisations who are working directly with the client(s) concerned.

2.3 Staff from partner agencies and organisation's must agree to and sign this Confidentiality Agreement prior to being granted access to client records held by The Home

2.4 Information gleaned from The Home s records remains the property of The Home and must not be published in any format or disclosed to any other person without the express written permission of The Home and the client or his/her nominated representative.

3. Procedures

3.1 Workers from partner agencies and organisation's who wish to access The Home client records should, prior to their first access of these records, sign this document and return it to the appropriate member of The Home Staff.

3.2 Partners will have web access from anywhere to client records where the client permission allows it. Where there is no partner access to the web it may be possible to arrange to access client records via The Home 's staff member's laptop in another mutually acceptable and secure venue.

3.3 Before access to individual The Home client records can be granted express permission for this must be obtained from the client(s) concerned. This permission may be obtained by the worker from the partner agency or The Home ’s Key Worker or Manager

3.4 Workers from partner agencies and organisations using The Home ’s databases are expected to access only the records for clients that they are directly working with and who have given permission for their records to be accessed in this way.