Documentation

Purpose

Documenting policies and procedures is crucial for maintaining transparency, accountability, and quality in a homecare organization supporting the elderly and people with disabilities in Australia.

Scope

This policy applies to all staff members, clients and contractors related to Coastal Care.

Policy Statement

Coastal Care (CC) is dedicated to delivering high-quality homecare services to the ageing and people with disabilities in Australia. This policy outlines our commitment to maintaining accurate, complete, and confidential documentation to support the delivery of safe, effective, and person-centered care.

Procedure

Documentation Standards

- Documentation serves as a critical tool for communication, decision-making, continuity of care, and compliance with legal and regulatory requirements.
- CC will use standardised electronic or paper-based formats for documentation, ensuring consistency and clarity.
- Documentation will be in plain language and free from jargon, ensuring it is easily understood by all stakeholders.

Responsibility and Training

- Trained staff members will be responsible for completing and maintaining client records, ensuring accuracy, timeliness, and compliance with this policy.
- Staff will receive training on documentation procedures, including data privacy and security requirements.

Types of Documentation

- Detailed records will be maintained for each client, including assessments, care plans, progress notes, and any significant changes in the client's condition or care plan.

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- Any incidents, accidents, or adverse events will be documented, including the circumstances, actions taken, and follow-up.
- Medication administration, adherence, and any medication-related incidents will be meticulously documented.

Documenting Client Information

- Initial assessments will capture a client's demographic information, medical history, preferences, goals, and support needs.
- Individualised care plans will be documented, specifying the services to be provided, goals, timelines, and the responsible caregivers.
- Regular progress notes will document the care provided, any changes in the client's condition, and any concerns or achievements.
- Records of informed consent for care and services will be maintained in accordance with legal requirements.

Data Privacy and Security

- CC will strictly adhere to data privacy regulations, safeguarding client information from unauthorised access or disclosure.
- Records will be retained for the period required by law and then securely destroyed or archived.

Review and Quality Assurance

Records will be regularly reviewed for accuracy, completeness, and compliance with

CC will implement quality assurance measures to ensure the accuracy and effectiveness of documentation.

Accessibility

- Client records will be accessible to authorised staff members for the purpose of providing care and services.
- Clients or their authorised representatives may request access to their records in accordance with legal requirements.

Continuous Improvement

Feedback from clients, staff, and stakeholders will be used to improve the efficiency and quality of documentation processes.

This Documentation Policy and Procedure demonstrate that CC is committed to maintaining accurate and confidential documentation to support the delivery of safe, effective, and person-centered homecare services in Australia.

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VARIATIONS

Coastal Care reserves the right to vary, replace or terminate this policy from time to time.

RELATED DOCUMENTS

- Workplace Health and Safety
- Managing Challenging Behaviours
- Critical Incidence Management
- Incident Reporting
- External Referral
- Record Keeping

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