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## CARE DOCUMENTATION

### Overview

This course is designed both for care and nursing staff, within any organisation. It will emphasise the legal and regulation standards of responsibility within any care setting. The importance of quality communication throughout the service, and best practices which support inspection and LHB expectations.

**Duration** - 2 ½ - 3 Hours

The course will explore and extend participants' knowledge about what is necessary for legal purposes and the need of 'detail' statements during their daily duties. Participants will discuss their own experiences and current methods in an aim to improve/develop new practices, which can be followed comfortably within their work environment.

### Aim

The aim of the course is to provide participants with the opportunity to examine the wider issues and implications of good quality practice, and develop stronger more robust strategies, within its prevention and management.

### Course objectives

Having completed the course, participants will/should be able to:

1. Understand why documentation is so important.
2. Identify features of it and reasons behind it.
3. Identify possible triggers of poor standards.
4. Develop stronger more clinical strategies.
5. Identify the main legal implications.

Each participant will gain a more confidence and competency during their role of care. They will have better understanding of the liability and responsibility of their work, understanding the need of clinical evidence, and implementations of their actions. Promote a more proactive workforce, and stronger team ethos.

The course is supported by an informative handout, a question & answer session and accompanying discussions. On completion of the session, the participant will receive a Mind Consultancy certificate of attendance, outlining the NVQ & new QCF CMH 301 learning outcomes. Each training session would be designed specific to the work/care environment.