



FlexiLearnHub

Knowledge Hub

Professional Resources for Care, Catering & Hospitality

FREE PROFESSIONAL RESOURCE

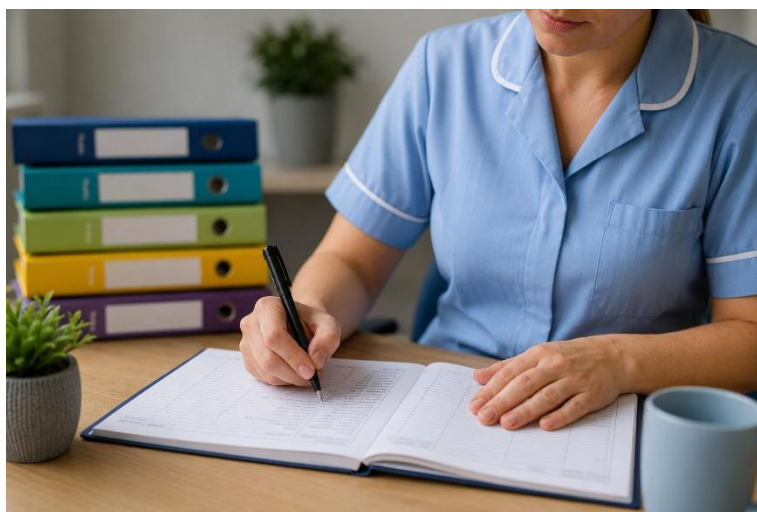
Record Keeping & Care Documentation

A Professional Awareness Guide for Care Staff

Knowledge Hub Resource 026

Version 1.0

First Published: August 2026



www.flexilearnhub.com

Part of the FlexiLearnHub Professional Knowledge Lib

About This Resource

Purpose

Accurate record keeping is an essential part of providing safe, effective and person-centred care. Every entry made in a care record contributes to the ongoing support, wellbeing and safety of the individuals receiving care. Clear documentation helps ensure that important information is shared appropriately between members of the care team and provides an accurate record of care delivered.

This resource explains the importance of good record keeping, introduces the principles of professional documentation and highlights how accurate records support continuity of care, accountability and regulatory compliance.

Suitable For

This guide is suitable for:

- Residential Care Homes
 - Nursing Homes
 - Home Care Services
 - Supported Living Services
 - Healthcare Assistants
 - Senior Care Staff
 - Team Leaders
 - New Care Workers
 - Anyone responsible for recording or documenting care
-

Learning Objectives

After reading this resource, you should understand:

- Why accurate record keeping is important in care settings.
 - The principles of clear, factual and professional documentation.
 - The difference between factual observations and personal opinions.
 - Why records should be completed promptly and accurately.
 - Common documentation mistakes and how to avoid them.
 - How good record keeping supports safe, person-centred care and effective communication.
-

Important Information

This resource provides professional awareness only and should always be used alongside your employer's policies, agreed ways of working, care plans, documentation procedures and current legislation.

Care records should always be completed in accordance with your organisation's documentation standards, confidentiality requirements and data protection responsibilities.

Why Good Record Keeping Matters

Accurate record keeping is one of the most important responsibilities of every care worker. Care records provide a clear history of the care and support an individual has received, helping to ensure that everyone involved understands their current needs, preferences and any changes in their condition.

Good documentation supports continuity of care by allowing staff to communicate effectively across different shifts and between members of the care team. It also demonstrates that appropriate care has been provided and helps protect both the individual receiving care and the staff responsible for delivering it.

Professional record keeping is an essential part of providing safe, effective and person-centred care.

The Principles of Good Record Keeping

Good care records should always be:

Accurate

Record information exactly as it happened. Ensure names, dates, times and details are correct before completing documentation.

Clear

Use straightforward, professional language that can easily be understood by colleagues and other authorised professionals.

Factual

Record what you saw, heard or did. Avoid assumptions, opinions or personal judgements.

Timely

Complete records as soon as possible after providing care so that information remains accurate and up to date.

Legible

If handwritten records are used, ensure they can be easily read by others. Electronic records should also be completed carefully and accurately.

Confidential

Care records contain sensitive personal information and must always be handled securely in accordance with your organisation's confidentiality policies and data protection requirements.

Facts vs Opinions

Professional documentation should always record **facts**, not personal opinions.

Good Example

"Mrs Taylor ate approximately half of her lunch and stated that she felt tired afterwards."

This records exactly what was observed and what the individual communicated.

Poor Example

"Mrs Taylor wasn't trying very hard to eat today."

This is a personal opinion and should not be included in professional care records.

Objective, factual documentation helps ensure that care records remain accurate, reliable and useful for everyone involved in supporting the individual.

Why It Matters

Good record keeping helps to:

- Promote safe and consistent care.
- Support effective communication between staff.
- Provide an accurate record of care delivered.
- Identify changes in an individual's condition.
- Support continuity of care across different shifts.
- Demonstrate professional accountability.
- Meet legal, regulatory and organisational requirements.

Every entry made in a care record contributes to the overall quality and safety of the care provided.

Best Practice Checklist

Good record keeping supports safe, effective and person-centred care. Following these simple principles helps ensure that care records remain accurate, reliable and useful for everyone involved in an individual's care.

Always remember to:

- ✓ Complete records as soon as possible after providing care.
 - ✓ Record information accurately and honestly.
 - ✓ Write only factual observations and actions taken.
 - ✓ Use clear, professional and respectful language.
 - ✓ Record significant changes in an individual's condition promptly.
 - ✓ Follow your organisation's documentation procedures.
 - ✓ Report concerns through the appropriate reporting process.
 - ✓ Sign or authenticate all entries in accordance with workplace procedures.
 - ✓ Maintain confidentiality when handling care records.
 - ✓ Store paper and electronic records securely.
-

Common Mistakes to Avoid

Avoid the following common documentation errors:

- ✗ Recording personal opinions instead of factual observations.
- ✗ Guessing or estimating information that has not been observed.
- ✗ Leaving blank sections or incomplete records without explanation.
- ✗ Waiting until the end of a shift to complete documentation.
- ✗ Using unclear handwriting or inappropriate abbreviations.
- ✗ Altering records incorrectly or attempting to erase information.
- ✗ Forgetting to record important changes in an individual's condition.
- ✗ Sharing confidential information with unauthorised people.
- ✗ Recording information in the wrong person's care record.
- ✗ Failing to report concerns that require immediate attention.

Remember

Every care record may be relied upon by colleagues, healthcare professionals, inspectors or others involved in an individual's care.

Good documentation helps ensure that important information is communicated accurately, supports continuity of care and demonstrates the professionalism of those providing care.

Taking a few extra moments to complete records correctly can make a significant difference to the safety, wellbeing and quality of care experienced by the individual.

Professional Standards Checklist

Professional record keeping is a key responsibility for everyone working in care. High-quality documentation helps ensure safe, effective and person-centred care while supporting communication, accountability and regulatory compliance.

Use this checklist to reflect on your own practice:

- ☐ I record information accurately and truthfully.
 - ☐ I complete documentation as soon as possible after providing care.
 - ☐ I only record facts, observations and actions taken.
 - ☐ I use clear, respectful and professional language.
 - ☐ I follow my organisation's documentation policies and procedures.
 - ☐ I maintain confidentiality when handling care records.
 - ☐ I report concerns promptly using the correct reporting procedures.
 - ☐ I understand that care records are legal and professional documents.
-

Key Messages

- Accurate records support safe, high-quality care.
 - Good documentation helps ensure continuity of care between staff and services.
 - Records should always be factual, clear, timely and professional.
 - Confidential information must be handled securely at all times.
 - Every care worker has a personal responsibility to maintain accurate care records.
-

Final Reminder

Good record keeping is far more than an administrative task—it is an essential part of delivering safe, compassionate and professional care. Every entry contributes to a clearer understanding of an individual's needs, supports effective communication within the care team and helps demonstrate that appropriate care has been provided.

By following good documentation practices every day, care staff help protect the people they support, their colleagues and themselves while contributing to a culture of accountability, professionalism and continuous improvement.

Continue Your Professional Development

FlexiLearnHub provides a growing library of professional online training courses and free Knowledge Hub resources to support continuing professional development across the care, catering and hospitality sectors.

Visit www.flexilearnhub.com to explore our latest courses, professional guidance and downloadable resources.

Document Information

Resource Title: Record Keeping & Care Documentation – A Professional Awareness Guide for Care Staff

Resource Number: 026

Version: 1.0

First Published: July 2026

Prepared by: FlexiLearnHub

Website: www.flexilearnhub.com



Copyright & Disclaimer

© 2026 FlexiLearnHub. All rights reserved.

This resource has been produced by FlexiLearnHub to support professional awareness and continuing professional development within care settings. It may be downloaded, printed and shared in its original, unaltered format for personal, educational and workplace training purposes. It must not be modified, reproduced for commercial gain, sold or republished without the prior written permission of FlexiLearnHub.

Information within this guide is intended as general awareness and should always be used alongside current legislation, organisational policies, professional guidance and individual care plans where applicable.
