H&H Care SA Pty Ltd	**Form08.** Case Notes Handover and Client Record Management **Australian Government Support at Home Program**	
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Policy and procedure 8
H&H Care SA Pty Ltd | Support at Home services

This policy sets out how H&H Care SA creates accurate case notes, communicates essential information at handover and manages client records securely throughout their lifecycle. It supports safe care, client rights, professional accountability and evidence of services delivered.

Document control	Details
Policy number	HH SAH RECORD 008
Version and status	1.0 — Draft for Director approval
Prepared	24 October 2026
Policy owner	Director and Service Coordinator
Approved by	Huy Le, Director — signature: _____
Effective date	24 October 2026
Next review	12 months after approval, or earlier following relevant change
Applies to	All managers, nurses, workers, administration staff and approved contractors creating, accessing or sharing client records

1 Purpose and scope

Records must show what was planned, what actually occurred, how the client responded, what changed and who will follow up. Documentation must be timely, factual, respectful, relevant and attributable to its author. An urgent concern requires direct escalation as well as a written record.

This policy applies to electronic and paper notes, charts, care plans, messages, referrals, handovers, photographs, correspondence and service evidence for Support at Home delivery on behalf of The Fig Trees and other approved registered providers. It operates with Policy 3 on consent, privacy and information sharing and does not itself authorise disclosure or clinical treatment.

2 Responsibilities

Workers record their own care and observations and communicate urgent changes directly. Nurses meet applicable professional documentation standards and maintain required clinical charts. The Coordinator checks record completeness, follows up gaps and controls care plan versions. The Clinical Lead RN reviews clinical documentation and escalation. Administration reconciles service evidence without creating clinical observations on behalf of workers.

The Director appoints a records custodian and Privacy Officer, approves systems, access, retention and audit arrangements, and agrees secure record exchange with the registered provider. Delegated functions must be recorded; accountability is not removed by using a software supplier or another provider’s template.

Writing accurate case notes

3 Timing authorship and identity

Confirm the correct client record using at least two suitable identifiers before entry. Record the service date, actual visit times, entry date and time, author and role. Make notes as soon as practicable after care, ordinarily before the shift ends, without delaying urgent treatment or escalation. Never pre-document care as completed.

Use an individual login or legible signature and role. Record only what you performed, observed or were reliably told, identifying the source. Do not sign for another person. A joint visit may have an agreed lead narrative, but each worker remains accountable for their contribution and any required individual clinical or attendance record.

4 Minimum content for each visit

- Authorised tasks delivered and relevant assistance provided, including what the client did independently. Identify incomplete tasks, changed arrangements or non-attendance accurately.
- Client consent, preferences, refusals and choices relevant to the visit, including any communication support or material concerns.
- Objective observations and changes from the usual condition, including measurements only where actually taken with an appropriate method and within competence.
- Client response, progress relevant to agreed goals and any significant symptoms or concerns reported, with the source identified.
- Action taken, advice sought, person contacted, time, instructions received and outcome. Identify outstanding actions, responsible person and required timing.
- Relevant links to charts, incident reports, care plan versions or referrals without replacing required records with a vague cross-reference.

5 Language and professional boundaries

Use plain, specific language and approved abbreviations. Distinguish facts from interpretation. Write the client's relevant words in quotation marks where helpful. Avoid judgemental labels such as difficult, lazy or non-compliant; describe the action, stated reason and response. Do not record irrelevant family matters, speculation or personal criticism.

Support workers must not invent diagnoses or document clinical assessments outside competence. A reported diagnosis should identify its source. If recording a behaviour, describe what happened, context, support offered and outcome rather than assuming intent. Use respectful language and remember that clients may request access to their records.

Do not copy yesterday's note or use a template that asserts observations not made. A checklist may support recording but must allow relevant individual details. Entries must describe that visit; a generic statement such as all good is insufficient when it hides unmet care, risk or required observations.

Clinical records corrections and examples

6 Clinical charts and escalation

Record medication support in the required medication record according to the medication policy, including refusal or omission. Do not retrospectively sign administration not verified or imply prompting was administration. Maintain wound, bowel, fluid, observations and other charts only as indicated by the individual plan and professional directions.

Describe symptoms, actual findings and actions within role. Clinical decisions, delegation and treatment changes require authorised practitioners. Record the professional contacted, advice, verification or read-back where appropriate, implementation and response. Verbal directions must be handled under the relevant clinical policy and confirmed in the required form.

Call emergency services for an emergency and directly contact the responsible manager or RN as appropriate. A case note, app alert or email is not proof a clinician received urgent information. If no response is obtained, use the escalation pathway and record attempts. Complete incident reporting separately when required; a case note does not replace an incident report.

7 Late entries and corrections

Make a late entry using the current entry date and time, label it clearly and state the original event date/time, reason for delay and reliable source. Do not backdate, guess missing observations or recreate a note as though it was contemporaneous. Escalate significant documentation gaps, especially where safety or billing may be affected.

Correct electronic records using the approved amendment or addendum function that preserves the original entry, author, date and reason. For paper, draw a single line through the error so it remains readable, add the correct information and date and sign the correction. Do not erase, use correction fluid, delete an incident or silently change service times.

If information was placed in the wrong client file, immediately notify the Coordinator and Privacy Officer. Restrict inappropriate exposure, use the controlled correction process and preserve the audit trail. Assess both care impact and privacy risk. Notify relevant recipients of corrected information when required or appropriate and lawful.

8 Documentation examples

Illustrative example only: “09:00–10:00. Client agreed to shower assistance. Prepared bathroom as set out in current plan and assisted with lower-body washing; client washed upper body independently. Client declined hair washing, saying, ‘I washed it yesterday.’ No substitute task requested. Client reported new left knee pain while standing. Stopped planned walk and phoned Coordinator at 09:35; RN callback arranged. Client seated comfortably. RN to review before the next mobility session; Coordinator tracking callback.”

This example does not prescribe a response to knee pain. Follow the actual client’s clinical plan and urgency. Avoid replacing it with “shower done, client fine” or copying the example into a real record. Record only actual actions and observations.

Safe handover and transfer of care

9 When handover is required

Provide handover between workers where care continues, when another person must act, after significant changes or incidents, when a new worker takes over complex care, and on transfer, hospital attendance, discharge or service exit. Routine low-risk information may use the approved record system if the next worker can reliably access and acknowledge it. Urgent or high-risk matters require direct contact and confirmation.

10 Structured handover procedure

- Identify yourself, the client and the intended recipient using trusted contacts. Confirm the recipient has an authorised role and can accept the handover. Use an approved secure and private channel.
- Describe the current situation and urgency, the person's present location and relevant care need. State immediate safety concerns first.
- Give only relevant background: usual function, current plan, allergies, clinical instructions, equipment and communication needs.
- Describe actual observations, changes, care already given, refusals and advice received. Distinguish your observations from others' reports and avoid unsupported clinical conclusions.
- State the required action, timing and responsible role. Explain what remains unresolved and what to do if the condition worsens or the action cannot be completed.
- Ask the recipient to confirm key information and acceptance of responsibility; use read-back for critical details where appropriate. Record recipient, time, agreed action and acknowledgement.
- If the intended recipient is unavailable or cannot act, escalate to the backup or responsible manager. Do not treat an unanswered message as completed handover.

11 Coordination with The Fig Trees and other services

Agree the routine reporting method, frequency, recipients and urgent escalation contacts with The Fig Trees. Share relevant delivery records, changes, incidents and outstanding needs on an established lawful basis. The brokerage agreement permits record access for oversight but does not authorise unrestricted access to unrelated clients or unnecessary information.

For hospital transfer or another provider, supply a concise current summary and relevant plan or charts, including last verified medication information where required and within role. Identify the source and date of clinical information; do not compile a medication list from memory. Confirm who received the information and how ongoing care will be covered.

On discharge or return home, obtain current instructions and resolve discrepancies before affected tasks resume. Never assume the pre-admission plan or medication directions remain unchanged. Record the review and notify allocated workers. At service exit, coordinate secure transfer and outstanding follow-up without destroying records that must be retained.

Record systems retention and quality controls

12 Organise the client record

Use a controlled record or linked set of records with a clear index: identity and contacts; rights, consent and authority; assessments and risks; current care plan and authorisations; clinical instructions and charts; visit notes and attendance; handovers and correspondence; incidents and complaints; reviews, referrals and exit documents. Keep active alerts concise and current, with a source and review date.

Assign document titles, dates, author and version. Make the current plan readily available to authorised workers and archive superseded versions without removing history. Avoid conflicting instructions in informal notebooks or personal messages. If a home communication book is agreed, specify its purpose, readers, privacy controls and how material information reaches the formal record; do not treat it as a replacement for essential records.

13 Security access and downtime

Use approved systems such as ShiftCare with role-based access, individual credentials and appropriate security controls under Policy 3. Do not use personal messaging, email or unapproved AI and transcription tools for identifiable client information. Any approved drafting aid requires privacy assessment and author verification of every fact before the entry is finalised; it must never invent observations or sign for staff.

Protect paper files in locked storage and transport only what is necessary. Keep records out of public view and secure home-held records with the client's agreement. Remove access promptly when roles change or engagement ends. Report lost documents, wrong-recipient messages or unauthorised access immediately through the privacy breach pathway.

During outages, use controlled downtime forms, record actual events and author, safeguard the paper record and arrange direct urgent communication. When systems return, reconcile and upload or transcribe once, identify the downtime source and preserve originals according to the retention schedule. Avoid duplicate or contradictory entries. Verify backup restoration arrangements and test them at least annually as an internal control.

14 Access correction retention and disposal

Refer client access and correction requests to the Privacy Officer under Policy 3; family or supporter status alone does not authorise all record access. Provide accessible responses, preserve lawful refusal reasons and maintain the audit trail. An unresolved disagreement may require an associated statement rather than deletion of a professional record.

Apply a documented retention schedule based on law, professional requirements, insurance and contract. The Fig Trees agreement requires records during the term and for seven years afterwards unless otherwise notified, and contains return/destruction provisions. Resolve conflicting instructions before disposal. Do not treat a request for return or deletion as overriding a legal duty or legal hold.

Suspend disposal for complaints, incidents, investigations, claims and other legal holds. When lawful retention ends, approve secure destruction or de-identification and record what, why, when, method and authority, including supplier and backup arrangements. Do not keep records indefinitely without a valid basis.

Case note template

RECORD F01 | Use for each visit or an equivalent approved electronic entry. Complete promptly and record facts only. A separate clinical chart or incident form may also be required.

Client name and identifier: _____
Service date: _____ Actual start and finish: _____
Entry date and time: _____ Author and role: _____
Current plan or authorisation reference: _____

Care delivered and client participation

Consent and relevant preferences: _____
_____
Tasks and assistance provided: _____
_____
_____
Client independence and response: _____
_____
Goals supported and relevant progress: _____
_____

Observations changes and incomplete care

Observed facts and actual measurements where required: _____
_____
_____
Client or other person's report with source: _____
_____
Refused or incomplete tasks and stated reason: _____
_____
Immediate safety concern and action: _____
_____

Escalation and follow up

Person contacted role date and time: _____
Advice received and action taken: _____
_____
Client outcome or response: _____
Outstanding action owner and required time: _____
Recipient acknowledgement or escalation if no response: _____
Linked chart incident or handover reference: _____
Author signature or electronic authentication: _____

For a late entry, label it and record the event date/time, current entry date/time, reason for delay and source. Never backdate or sign for another worker.

Handover and record audit templates

Structured handover record

RECORD F02 | For significant changes, ongoing care tasks or transfers. Record acknowledgement; urgent action requires direct communication.

Client name and identifier: _____
Handover date and time: _____
Sender name and role: _____
Recipient name role and verified contact: _____
Method and lawful sharing basis: _____

Handover component	Relevant information
Situation and urgency	_____ _____
Relevant background and plan	_____ _____
Observations care and response	_____ _____
Required actions and timing	_____ _____
Owner acceptance and contingency	_____ _____

Key details confirmed or read back: _____
Recipient acknowledgement and time: _____
If no acknowledgement escalation and outcome: _____
Current records sent or referenced: _____
Follow-up verified by and date/time: _____

Record audit checklist

RECORD F03 | Auditor: _____ Date: _____ File sample: _____

- Correct client, actual service times, identifiable author and timely entry.
- Tasks, consent, response and incomplete care accurately documented.
- Changes and urgent concerns directly escalated with outcomes or assigned follow-up.
- Clinical charts and incident reports complete where required.
- Handover acknowledged; current plan and authorisation available.
- Corrections traceable; no unsupported copied text or inappropriate access.

Gap risk and immediate action: _____
Action owner and due date: _____
Evidence of correction and effectiveness: _____

Implementation monitoring and references

15 Supervision and audit

Train workers before unsupervised documentation on objective writing, consent, clinical role limits, direct escalation, late entries, corrections and confidentiality. Use realistic scenarios and check an initial sample of their entries. Offer coaching and accessible language support without writing observations that the author did not make.

As internal controls, the Coordinator checks urgent alerts and missing notes each service day, assigns follow-up and hands over unresolved matters. Management reviews recurring gaps and privacy or documentation incidents monthly and audits a risk-based sample of case notes, handovers and linked invoices quarterly. Use RECORD F03 or an equivalent audit record. Review high-risk failures immediately rather than waiting for the routine audit.

Address errors with timely correction, client safety review and proportionate support or workforce action. Investigate suspected falsification or deliberate concealment fairly and preserve evidence. A manager must never direct a worker to remove an accurate account to avoid a complaint, liability or payment issue.

16 Implementation checklist

- Confirm the records custodian, Privacy Officer and clinical review roles.
- Agree The Fig Trees' reporting access, handover, urgent contacts and record transfer arrangements.
- Approve templates, chart requirements, record index, version control and retention schedule.
- Set individual user access, downtime processes and escalation of unacknowledged messages.
- Train staff and verify the first records and handovers meet the policy.
- Record approval, effective date, audit schedule and annual review date.

17 Related policies and references

Related documents: Policies 1 to 7; incident management and SIRS; complaints and open disclosure; safeguarding; clinical governance and medication; workforce conduct; business continuity and invoicing.

- Aged Care Act 2024 and Aged Care Rules 2025, including the Statement of Rights and Aged Care Code of Conduct; applicable strengthened Quality Standards.
- Aged Care Quality and Safety Commission — Outcome 2.7 Information management. https://www.agedcarequality.gov.au/strengthened-quality-standards/organisation/information-management
- Aged Care Quality and Safety Commission — Standard 3 The care and services. https://www.agedcarequality.gov.au/strengthened-quality-standards/care-and-services
- OAIC — Guide to health privacy, including access and correction. https://www.oaic.gov.au/privacy/privacy-guidance-for-organisations-and-government-agencies/health-service-providers/guide-to-health-privacy
- Privacy Act 1988 and Australian Privacy Principles; applicable professional documentation standards and South Australian legal requirements; The Fig Trees agreement dated 10 March 2026 and current approved variations.

Official guidance checked on 24 October 2026. Apply requirements relevant to the services and registered provider categories. Internal audit intervals do not replace shorter clinical or legal obligations.

Director approval: _____ Effective date: _____
Next review: _____

Version 1.0 — Initial draft prepared 24 October 2026. Approval and implementation remain to be completed.