Critical And Ethical Responsibility Of Phlebotomist

The biggest reason for keeping and maintain records is to ensure that the client will get continuing care as accurate as possible. Record keeping is actual communication between health care workers and clients, where it includes care planning, quality assurance of care for clients, legal documents. Record keeping is very important for care workers as they are updated every day and any changes are passed from shift to shift and when they finish they work. Those records must be kept from reach of the different clients and their families, friends and actually anyone who is not responsible for clients (Residents) wellbeing from physical to emotional side.

Record keeping of the care assistant are usually made by Nurses with admission of the client (Patient) this is already made in front as they usually have forms ready to go which are premade for care assistant staff. Record keeping of nurses and care assistants is as well proof that the client (patient) did get appropriate care which he/she needs as well as they are proof in legal cases where they are used as an evidence and there for they must be as much accurate as they can.

The records should have relevant information's such as relevant clinical findings, where doctors can diagnose and continue with treatment of the client where there is also decision made and relevant action appropriate to clinical findings and who is actually making the decision and who is agreeing with it as well, which should be signed with both parties. Another is the information given to the client and any drugs which are prescribed to the client (patient) or other findings and investigations which will help the client with his/hers recovery or treatment and of course who is making the record and when and what time and date it was last updated as for future treatments, consultations or tests necessary for future treatments and as well clients progress, findings on examinations (tests), monitoring and follow up arrangements with client where the details of the client contacts are included in the records for future consultations in person or on phone, where all of them must be recorded, even if the client refuse future consultations where the reason must be recorded as well. Those records might be anything from Text message or emails up to written notes.

The records of the health care assistant are different as they don't possess that many information's as medical or nursing records and are differently orientated. As example the records in the nursing home are orientated more on caring part of the client and not his/hers diagnosis or treatment.

There are stating the name of the client, the date, time and year when he/she was first time admitted to the facility or nursing home. If the client have the room then the room number is included in those records, as to know where the client will spend his night. Other information's such as if the person needs assistance to go to the bed or him/her-self are independent, if they have the call bell, which will call care assistant in needs, or if they are using a floor alarm which will inform the care assistant if they are out of the bed. Those are used in cases of high risk falls and if the person is confused to the point where he/she don't know where they are and need some insurance that they are in the right place. The next might be the personal hygiene as there is some the cases where the person might need assistance with daily washing, or bath or shower or mouth hygiene which the care assistant is able to provide, where of course the dignity

and respect Must take a place at all times. As it goes with hygiene the next Colom might be the transfer where it is depending on the clients condition, as he/she might be independent or using the wheel chair or they are bed bound. The transfer might be non or with assistance of one or two or the hoist where the care assistants will use them in appropriate and right way as they have been trained and make sure that they won't do any harm to the client or them-self's by doing so. Next part is about the mobility of the clients as not all can move freely by themselves there might use the walking aid or need assistance by one of the carers or by only supervised or they might use the wheel chair for transfer longer distances. This might not look like it but many clients (patients, residents) might use wheel chairs especially elderly or clients with disability. In some of the records there might be Colum for the sleep patterns as not all of the clients might sleep the same and that goes especially for the clients with mental dysfunctions, or disability's. As the rest it might be accordance with the room of the clients. The example might be that the pillow cases have been changed, where it goes for the linens as well, or the duvet covers, or if the client have clean clothes on him/her or if they are properly groomed, etc. next it usually is the bladder and bowel movement as not all clients are independent and need assistance with toileting but even so with established trust between the client and care taker the carer might also ask the client if there was any movement where those are most likely monitored ourly.

Where confidentiality must be in place as the client's privacy must be protected all the time. All clients information such as written, any kind of records or only kept in the memory of care worker is confidential and must stay this way until the client will agree otherwise.

This Includes:

- Any diagnosis and treatment;
- Pictures, photographs, video and audio of the client;
- Who is the patient's doctor, what department/s they have been attending and when;
- Or anything what can actually identify client directly or indirectly.

Confidentiality is very important as it establishes the trust between the client and care worker and can actually talk about the worries and problems which sometimes they might think that they are embarrassing or trivial in the point of view. If the confidentiality is broken the clients (Patients) might even stop looking for medical or professional help and it might/will affect their health or mental wellbeing. That is the reason why confidentiality has an enormous impact on security, freedom, self-respect, and freedom for clients.

As it is all collected data (information) about the client (patient) in confidence must stay confidential and can be used only in the sense which they were originally collected unless there is a legitimate legal reason for disclosure. The information is staying confidential even after the death of the client (patient). As it is the staff is as well only on a need-to-know basis with the client's information as to complete the purpose of their work only.

As for clients, the care worker should always shove dignity and respect for the client as those are the basics of first contact and communication between them, the care worker should never discriminate the client (Patient) directly or indirectly against their gender, family status, age, disability, sexual orientation, religion, race, color, nationality or ethics or etc... As it happens before in Ireland and there are many cases of discrimination, where the prohibition might be in place in some cases and the client is now protected by law. The care worker should not as well take any money or other different things as payment as it might or will affect the professional

judgment of the carer and be expecting even more in the future as it might affect the relationship with the client. This might even go as far as theft or neglect.

If we look at it from our point of view the carer's records are not the same as the records of the nurses or medical records of any kind and so it is only on must to know basis. Even so, those documents are protected by confidentiality, and not all personal can access them as they will for their own information knowledge or to pass the information to a third party. The confidentiality of that information is protected by law and that is the reason why they should not be breached by any circumstances at any time even if there is a requirement for them at the present. As for the phlebotomist, those information’s are not even on a must-know basis, where when their ask for them there might be an ethical dilemma or issue which can contradict the studies of the care assistants, and then the care assistant should go back to the basics and ask for the contents of the client if he/she is allowed to provide those information’s and by which occasion and if they are necessary for the particular procedure required on this occasion, as well as to ask for written consent of the client to make sure that they are protected if any confidential information is lost or given to another party.