DIMOND'S LEGAL ASPECTS OF NURSING

A definitive guide to law for nurses

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Richard Griffith
and Iwan Dowie

Pearson

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Chapter 9

Record keeping, statements and evidence in court

This chapter discusses

- Record keeping
- Statements
- Evidence in court
- Defamation
- Internet

Introduction

Good standards of record keeping are an essential part of professional practice and the duty of care owed to the patient. This chapter provides guidance on record keeping and advice on statement and report writing and giving evidence in court.

Record keeping

General principles

The NMC considers record keeping a crucial aspect of a nurse's professional duty. Failing to meet the standard for record keeping remains an instance that can lead to one's name being removed from the professional register.

Standard 10 of the Code[1] imposes a duty on district nurses to keep clear and accurate records relevant to their practice. The Code makes clear that the standard applies to all records relevant to a nurse's practice and not just patient records. To achieve the standard, district nurses must be able to show that they:

- complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event;
- identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need;
- complete all records accurately and without any falsification, taking immediate and appropriate action if they become aware that someone has not kept to these requirements;

- attribute any entries they make in any paper or electronic records to themselves, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation;
- take all steps to make sure that all records are kept securely; and
- collect, treat and store all data and research findings appropriately.

Failure, therefore, to maintain reasonable standards of record keeping could be evidence of unprofessional behaviour and subject to fitness to practice proceedings.

Guidance on record keeping is also provided by NHS Digital.[2] The Audit Commission made recommendations to improve the standard of record keeping in hospitals in 1995.[3] It reviewed the situation in 1999 and concluded that, although progress had been made, there was still scope for further improvements.[4] The Clinical Negligence Scheme for Trusts monitors standards of record keeping and risk management by NHS organisations as part of its work in setting levels for membership of the NHS pool for sharing liability for compensation claims (see chapter 6). The standards set by the NHS Resolution include in their criteria principles relating to documentation. For example, criterion 8 for the governance standard relates to health records management. This states that chief executives and senior managers of all NHS organisations are personally accountable for records management within their organisation. Records are now kept of the many assessments which have to be carried out, including risk assessment, manual handling assessment, tissue viability assessment, social care, nutrition, and many others.

Increasingly, the records include a care pathway tracked out for that particular patient and nurses would be expected to identify the progress of the patient along that pathway.

CQC Fundamental Standards

Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires that NHS care providers maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.

Box 9.1 sets out the Care Quality Commission (CQC) requirements for meeting that regulation.

Box 9.1 CQC requirements for records that are fit for purpose

Records relating to the care and treatment of each person using the service must be kept and be fit for purpose. Fit for purpose means they must:

- be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence and changes to care plans following medical advice.
- include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. This includes consent records and advance decisions to refuse treatment. Consent records include when consent changes, why the person changed consent and alternatives offered.
- be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This applies both internally and externally to other organisations.
- be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance.
- be kept secure at all times and only accessed, amended, or securely destroyed by authorised people.

Both paper and electronic records can be held securely providing they meet the requirements of the General Data Protection Regulation (GDPR) and Data Protection Act 2018.

Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act 2005 or, where relevant, the Mental Health Act 1983, and their associated Codes of Practice.

Information in all formats must be managed in line with current legislation and guidance.

Systems and processes must support the confidentiality of people using the service and not contravene the GDPR and Data Protection Act 2018.

Common errors noted in record keeping

These are listed in Box 9.2 and are the most common errors in record keeping.

Box 9.2 Common errors in record keeping

Times omitted
Illegible handwriting
Lack of entry in the record when an abortive call has been made
Abbreviations were ambiguous
Record of phone call (e.g. to social services) that omitted the name of the recipient (e.g. social worker)
Use of Tippex and covering up of errors
No signature
Absence of information about the child
Inaccuracies, especially of the date
Omission of date of medical check-up and hearing test and records for immunisation
Delay in completing the record; sometimes more than 24 hours elapsed before the records were completed
Record completed by someone who did not make visit
Inaccuracies of name, date of birth and address
Unprofessional terminology, e.g. 'dull as a doorstep'
Meaningless phrases, e.g. 'lovely child'
Opinion mixed up with facts
Reliance on information from neighbours without identifying the source
Subjective not objective comments, e.g. 'normal development'

The errors shown in Box 9.2 are not of course exhaustive and each practitioner could add others they have noticed to the list. However high a standard of record keeping is maintained, this is of little value if the records are not read. An inquest heard in 2010 that a diabetic patient died in hospital because the nurses had failed to read the records and to ensure that she received her insulin.[5] The CQC criticised Manchester Royal Infirmary in its inspection in December 2013 because notes were illegible which meant that records were incomplete and increased the chance of patients failing to get the treatment they needed. In its report the Manchester Children's Hospital was told that 'we found that many entries in the medical notes were illegible'. In a news item in May 2014 it was reported that the wrong notes were used for a patient with the same name. An arm operation was carried out based on the records of another patient with the same name at Westmorland General Hospital Cumbria.[6]