Record keeping, litigation and the clinician

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Anne Reed is a medico-legal consultant and has worked with PCTs and hospital trusts across the UK. Here, Anne discusses the interaction between the day-to-day practice of clinicians and the legal and professional frameworks that govern their activities. Anne highlights the risks associated with poor record keeping and answers some questions posed by *The Diabetic Foot Journal*.

All too often, clinicians' records fail to provide evidence of their careful decision making and skilled delivery of care to patients. All too often, clinicians fail to heed the legislation and local policies that govern their everyday practice. These failures leave clinicians vulnerable to legal or professional conduct actions.

Making your own case

To demonstrate that one is a professional, in any field, evidence of skill and aptitude in carrying out their duties is required. Unlike in other legal proceedings, clinicians are rarely afforded the luxury of evidence in the form of objects, CCTV footage or the like. Rather, a clinician's actions and omissions are preserved almost solely in a single, key document: the patient's clinical record. Yet, in my visits to trusts all over the UK, I do not see the importance of these documents reflected in daily practice.

Often record keeping is considered a "chore", "a thing we have to do". Clinicians have told me: "if only we could just do the care it would be alright", "we spend so much of our time writing we don't have time to deliver care to the patient". Ultimately, maintenance of accurate and comprehensive records is a part of delivering care and a requirement of the role – a requirement enforced, not least, by the various professional bodies.

Record keeping: A learned skill

I firmly believe that record keeping is a skill – a skill that cannot be assumed or bestowed, but must be learnt. A skill, as I see it, that trusts have a responsibility to ensure their staff are trained in, and updated on. The written word can be open to interpretation and unless the writing of clinical records is concise and unambiguous, they could be subject to misinterpretation.

Documents that give guidance on writing and maintaining patient records are available from trusts and the relevant professional body, of which clinicians will be members. These documents should be known to, and used by, clinicians. Beyond these, aspects of the *Data Protection Act* (1998) are also relevant.

When it is too late

Possible outcomes of failure to maintain thorough, clear and up-to-date patient

records are serious and manifold. Failure to maintain patient records in accordance with the requirements of the appropriate professional body or the clinician's individual contract could result in a professional conduct hearing or a disciplinary hearing. Furthermore, poor records will make defence difficult should a civil or criminal action be brought. Despite the possible sanctions – striking-off from professional registers, dismissal, prosecution – I continue to witness poor record keeping among healthcare professionals.

It is also worth bearing in mind that, since the *Access to Health Records Act* (1990), people have the right to read their clinical records. Records can be requested for disclosure under the *Data Protection Act* (1998; for people still living), or through the *Access to Health Records Act* (1990; for deceased people). The *Freedom of Information Act* (2000) has also increased access to information held by public bodies – including the NHS. In addition to individual clinical records, information on audits, policies, minutes of meetings and the like can be requested by patients or their families – and used by their legal representatives.

No records, no defence

It is essential that clinicians keep thorough patient records, according to their professional codes of conduct, that detail their clinical decisions, treatments and outcomes for all their patients. The adage of "poor records, poor defence" is truer still for "no records, no defence". ■

Medico-legal Q&A session

Anne Reed [AR] answers some medico-legal questions for *The Diabetic Foot Journal* [TDFJ].

TDFJ: When assessing a patient, what should clinicians keep in mind in terms of possible future litigation?

AR: Clinicians should be recording evidence of their assessment of the patients' level of risk in multifactorial dimensions. This might include pressure sore risk assessments (e.g. Waterlow or Braden scores), moving and handling scores, skin blanching times (upon which repositioning schedules would be devised and recorded), pain and dependency scores and so on. Furthermore, the record should demonstrate that care planning for the appropriate management of the identified risks has been undertaken. Outcomes, and treatment adjustments as necessary, should be recorded at every assessment.

Clinicians should also be identifying potential complications and treatment limitations. Patient choices and requests should also be recorded.

TDFJ: Were you representing a wound care clinician, what would you hope to see in the patient record pertinent to that case?

AR: Clarity and objectivity. Entries in the record should be coherent, succinct and grammatically correct. Also, I would hope not to see simply a list of tasks performed. In the area of wound care, patient records can be supplemented with photographs, wound maps, measurements, wound and infection grades, appropriate referrals, wound assessment charts, care plans and evidence of multidisciplinary team input.

Progression to healing, or deterioration, of the wound should be recorded and I would also hope to see revision of care plans based

on progress. Evidence of patient education and involvement in the care planning process would also be positive.

TDFJ: What is valid consent?

AR: For consent to be valid, it must be given voluntarily by an appropriately informed person (the patient, or someone with parental responsibility for an individual under 18 years of age) who has the capacity to consent to the proposed intervention. That is, the three elements of consent are:

1. Voluntariness.
2. Provision of appropriate information.
3. Patient capacity.

Where there is any doubt regarding the person's capacity, it is important to establish both that they have the capacity to consent to the intervention and that they have received enough information to enable valid consent to be given. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

It is worth noting that consent is decision specific; each and every treatment should be consented to by the individual.

TDFJ: What is informed consent?

AR: People must be given sufficient information, in a way that they can understand, to make a balanced judgment on the proposed intervention. This includes them understanding (i) the nature of the proposed treatment, (ii) possible alternative treatments and (iii) any significant risks, particular to that patient's circumstances, posed by the treatment.

All these elements must be explained, given individual circumstances, in an appropriate setting by appropriately trained staff. The person's representative or family should be involved if indicated by the individual.

TDFJ: Where and when is it necessary to obtain informed consent?

AR: The seeking and giving of consent is usually a process, rather than a one-off event. For major interventions (e.g. radical surgical debridement), it is good practice to seek the individual's consent well in advance of the scheduled date of the procedure. This allows time for questions to be asked and additional information provided. Clinicians should then check again, before undertaking the procedure, that the person still consents.

If the person is not asked for their consent until just before the procedure is due to start – a time when they may be feeling vulnerable – there may be doubt as to its validity. Under no circumstances should people be given preopertaive medications before being asked for consent to proceed with the treatment.

TDFJ: When is written consent necessary? In legal terms, is verbal consent ever truly received?

AR: The validity of consent does not depend on the form – written, physical or verbal – in which it is given. Written consent merely serves as tangible evidence of consent. Ultimately, a signature on a form will not make the consent valid if the elements of consent (i.e. voluntariness, provision of appropriate information, patient capacity) have not been satisfied.

Although written consent is, in most cases, not a legal requirement (exceptions include certain sections of the *Mental Health Act* [2007, updating the *Mental Health Act* {1983}] and the *Human Fertilisation and Embryology Act* [1990]), the use of such forms is good practice when a major intervention is to be undertaken, or when an individual participates in a research project or a video recording.

If the person has the capacity but is illiterate, they may make their mark on the form to indicate consent. It is good practice for the mark to be witnessed by a person other than the clinician seeking consent, and for the fact that the individual has

chosen to make their mark in this way to be recorded in the case notes. Similarly, if the person has the capacity and wishes to give consent, but is physically unable to make their mark, this fact should be recorded in the notes. Consent in such circumstances may also be expressed non-verbally (i.e. physically). After receiving appropriate information, a person may be asked to hold up their hand to indicate consent.

TDFJ: What role does poor practitioner–patient communication play in cases that end in litigation?

AR: Practitioners are required by their requisite professional codes of conduct to ensure that they effectively communicate with their patients and failure to do so represents a breach of the code. Clinician–patient discussions should be evidenced and recorded in the case notes.

What is under-recorded are conversations between clinicians. Telephone conversations, emails, video conferences and so on are often not considered for inclusion in the case notes, yet the information exchanged in these communications may be central to clinical decision making.

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TDFJ: When faced with litigation, what should the practitioner keep in mind?

AR: Reality. What did and did not happen. The clinician needs to ensure they are well versed in the events (be they good or bad), their statement and the clinical record of the person in question.

Appearing in court can be an intimidating and frightening ordeal, and preparation for the court room should be sought. Clinicians facing litigation should ensure that their trust's legal team has briefed them so that they are able to present their position in a competent and professional manner.

TDFJ: What are the top three things our readers can do in their day-to-day practice to better guard themselves against litigation?

AR: The top three would be:

1. Invest time in gaining a thorough knowledge of the legislation, policies and professional standards with which you, as a clinician, must comply.
2. Maintain accurate and up-to-date records for all patients.
3. Appreciate the necessity of identifying, assessing, measuring and effectively managing elements of *risk* specific for every person and every intervention. ■

Access to Health Records Act 1990 (c. 23) HMSO, London
Data Protection Act 1998 (c. 29) HMSO, London
Freedom of Information Act 2000 (c. 36) HMSO, London
Human Fertilisation and Embryology Act 1990 (c. 37) HMSO, London
Mental Health Act 2007 (c. 12) HMSO, London [updating the *Mental Health Act* {1983}]

If your organisation would like to contact Anne regarding the provision of training, please do so on 018 2261 0303 or email annereed@medeagle.co.uk