Faculty of
Health

BIRMINGHAM CITY University

Your Records in Court

"when you chose nursing you also chose law"

The standard of record keeping in health services in general have been criticised by public bodies and official enquiries into deficiencies of care. Records remain the most tangible evidence of a professionals' practice and, in an increasingly litigious environment, the means by which it may be judged. The record is the practitioner's main defence if assessments or decisions are ever scrutinised. Record keeping is a non-negotiable clinical skill (NMC2009) that all registered nurses must be competent at. Poor record keeping means that organisations are unable to defend themselves in cases of litigation, as it is this documentation that is examined in court. In many cases of litigation, the Claimant can win compensation amounting to thousands of pounds because documentation was not up to acceptable standards. Nurses are frequently struck off the NMC register for poor record keeping and increasingly held to account for their record keeping, resulting in litigious action against them and/or their employers.

Nurses' Record Keeping CD ROM

The CD shows a practitioner being cross-examined by a lawyer in the witness box of a Coroner's Court about her records. The CD is supported by additional resources showing an example of a 'good' set of notes and a 'bad' set of notes. Students will be able to compare and contrast the two sets of notes and see for themselves how much easier it is to rebut allegations using the 'good' notes in a legal setting. Although this CD was produced to be used within the primary care module it lends itself to a generic audience both pre and post registration in the teaching of good record keeping.

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Scenario

A patient in the care of the nurse has died unexpectedly. This has led to the death being investigated. The notes have been sealed and removed from the setting where the patient was being cared for (e.g. hospital, nursing home, community clinic, patient's home environment). The nurses involved have been called to appear as witnesses in the Court to answer questions about their care of the patient. The nurse is sworn into the witness box and questioned on the care delivered to the patient. The only records available for the practitioner to refer are the notes recorded at the time of the care episode. The practitioner experiences trying to give evidence about the care and treatment delivered, under oath, when the only evidence of this care is poorly recorded. The practitioner then has the opportunity to give evidence using good records.

The Notes

These are the written evaluations of the District Nurse's visit to Mr Dave Harris. These notes are to be used in conjunction with the Coroner's Court hearing video.

Poor Notes - Entry 6th October 2009

6th Oct 09
Dave appears upset this morning and was reluctant to have his dressing changed. Dave complaining of a temperature and advised to take 2 paracetamol (500mgs) every 4 hours. Wound swab taken. Next visit for 7th October 2009 at 10.00

Signed:
A.C.Davies. *A. C. Davies* (Sister/Team Leader)

Good Notes - Entry 6th October 2009

6th Oct 2009. Arrive 10.25 Depart 11.15
Dave appears upset this morning. He put his head in his hands and said "I am so fed up my arse is killing me'. He reported that he was eating better but his bum was still sore. He said he was 'cold all night and now I feel hot and bothered'. He also reported that the physiotherapist cancelled her appointment with him. He said 'you lot are all the same – you just don't care'. It was explained to Dave that his symptoms could indicate that he has an infection and he was persuaded to let me look at his pressure ulcer. On examination the pressure ulcer had an increased level of offensive exudate and the wound edges were inflamed. Dave's temperature was recorded aurally at 40°C and his pulse was 100bpm. With Dave's consent a wound swab was taken and sent to identify the correct anti-biotic to treat the infection. Meanwhile Dave was advised to take 2 x 500mgs paracetamol tablets every 4 hours to reduce his temperature. He was also advised to drink at least 8 glasses of cold fluids throughout the day. Due to the infected wound, visits will now be daily. Next visit arranged for 7th Oct 2009 between 10.00 and 10.30

Signed:
A.C.Davies. *A. C. Davies* (Sister/Team Leader)

Student Feedback/Comments

"I've been qualified for 15 years and have never been taught this level of detailed record keeping training before – excellent!"
Qualified RN – District Nurse

"Really enjoyed the Record Keeping sessions within the module – very informative and interactive – makes you think"
2nd Year Diploma Nursing Student – Adult Branch

"These sessions were both scary and instructive – I will really pay attention to Numbers, Names, Dates and Times in my records from now on!"
Graduate Diploma Nursing Student – Adult Branch

"As a qualified Midwife Record Keeping has always been taught as a key element of our nursing care and given high priority. This session reaffirmed our knowledge base and the method of delivery made it enjoyable and relevant to practice. An excellently taught session – thank you"
Qualified Midwife