

# Introduction to health records

In its 2008 annual report, the National Health Service Litigation Authority (NHSLA) estimated that as at 31 March 2008, its total liabilities of outstanding claims for clinical negligence was £11.9 billion.<sup>1</sup> This includes legal costs and the costs of compensation that was paid out. It does not include the cost of staff and management time in dealing with those complaints, or the additional costs of bed space, which means that the true cost is far higher. The vast majority of clinical accidents arise as a result of a breakdown in communication through poor systems and poor documentation.

Record keeping is a fundamental part of healthcare. Health professionals have both a legal and professional obligation to maintain a reasonable standard of health records. If they fail to do so they will be held accountable. It is therefore important for health professionals to understand their legal and professional obligations, how they apply in practice and what the consequences are of getting them wrong.

If a health professional fails to maintain a reasonable standard of record keeping their accountability will impact in four distinct areas: (i) their patient; (ii) their professional body; (iii) their employer; and (iv) society. This is discussed in detail in Chapter 3.

Health professionals are often concerned about whether their records will stand up to legal scrutiny. In order to put this into context, this book firstly explores the law, accountability and then the records in context. It also specifically covers the courts' view of records.

A good standard of record keeping is the sign of a safe practitioner and helps to protect the welfare of patients. Good records promote high standards

of clinical care, continuity of care and better communication between members of the healthcare team. They provide an accurate account of treatment, care planning and delivery and the ability to detect problems at an early stage, such as changes in the patient's condition.

Poor record keeping compromises patient care and often reflects a wider underlying problem with the individual's practice. This makes health professionals vulnerable to legal and professional problems and increases workloads. The vast majority of clinical accidents arising from poor recording keeping and the resulting breakdown of communication and system failures cost the NHS approximately 10% of their annual budget in legal claims.

### **EXAMPLE OF SYSTEM FAILURE**

This was an unreported case involving Mrs S, a 28-year-old woman who was admitted for routine surgery for a prolapsed disc. She was the third patient on the theatre list. The first patient had been operated on and the instruments were being sterilised. The same instruments were required for patient number two and, rather than wait for those instruments to come out of the steriliser, the surgeon swapped the list around. Mrs S then became patient number two. Part-way through the procedure they realised they had forgotten to swap the blood bags over and had administered a wrong blood type transfusion. The patient died on the theatre table.

At the inquest the anaesthetist who had failed to check the wristband with the blood bag explained, 'I am new to the Trust; I trained and worked abroad and we did things differently there'.

The surgeon said, 'Next time I swap the list around I will tell people'.

This is very reassuring! This is a classic example of a system failure and a breakdown of communication. The surgeon tells the theatre nurse, the nurse goes on coffee break and tells someone else, etc., etc., and it then becomes Chinese whispers resulting in a breakdown of communication – in this case with tragic consequences.

Litigation is increasing in relation to consent issues. Sadly, this is not necessarily because valid consent has not been obtained, but rather there is no evidence that valid consent has been obtained. This is because the records are either insufficient in detail or there is nothing recorded. Issues in question often concern what advice was given or risks explained. Consent

is a complex area in itself and there is often confusion as to when consent issues should be recorded and how they are recorded. This is explored in more detail in Chapter 7.

There are many reasons why litigation in respect of clinical care has risen in recent years. There have been changes in the law. The Human Rights Act 1998,<sup>2</sup> Data Protection Act 1998<sup>3</sup> and Freedom of Information Act 2000<sup>4</sup> have all impacted on the rights and expectations of the patient. Patients are no longer passive and are much more aware of their rights. They have wider access to information, particularly via the internet. 'No win no fee' arrangements in relation to the legal costs of pursuing a claim are widely publicised. The first thing patients see when they enter a healthcare setting is a leaflet entitled 'How to Complain', which encourages patients to come forward.

Health professionals must be familiar with the law and must uphold the patient's rights. They must also be aware of the issues of consent and confidentiality, amongst other things, and that they are accountable for their actions.

## REFERENCES

- 1 National Health Service Litigation Authority. *Report and Accounts: fact sheet 2, financial information*. London: National Health Service Litigation Authority; 2008.
- 2 The Human Rights Act 1998.
- 3 Data Protection Act 1998.
- 4 Freedom of Information Act 2000.