UNISON

West Midlands Ambulance Branch

Clinical Documentation – Why is it important?

- **If it's not documented it's not done!**
- **Protect your patients**
- **Protect yourselves**
- **Protect the Trust**
- **Standard 10 HPC Standards of Conduct, Performance and Ethics.**

You Must Keep Accurate Records

Making and keeping records is an essential part of care and you must keep records for everyone you treat or who asks for your advice or services. You must complete all records promptly. If you are using paper-based records, they must be clearly written and easy to read, and you should write, sign and date all entries. You have a duty to make sure, as far as possible, that records completed by students under your supervision are clearly written, accurate and appropriate.

Whenever you review records, you should update them and include a record of any arrangements you have made for the continuing care of the service user. You must protect information in records from being lost, damaged, accessed by someone without appropriate authority, or tampered with. If you update a record, you must not delete information that was previously there, or make that information difficult to read. Instead, you must mark it in some way (for example, by drawing a line through the old information).

Fit to Practice

When we say someone is 'fit to practise', we mean that they have the skills, knowledge, character and health to practise their profession safely and effectively. We consider complaints about registrants from members of the public, employers, professionals, the police and other people and take action to protect the public. This can include cautioning a registrant, placing conditions on their registration, suspending them from practice or, in the most serious cases, removing them from the Register.
When we consider a complaint about a registrant, we take account of whether the standards have been met when we decide whether we need to take any action to protect the public. We will also take account of any guidance or codes of practice produced by professional bodies. www.hpc.uk.org

The following is a quotation from a real court case that highlights the important of good note keeping in the ambulance service.

Leeds crown court 'Edwards's v Yorkshire Ambulance Service'.

This case revolves around the care provided to a patient with a placental abruption which subsequently resulted in the baby suffering significant cerebral hypoxia. Only one set of observations were poorly recorded on the patient report form with incorrect times documented for a patient journey of 25 minutes.

The judge said to the paramedic is this a true and accurate record of clinical events that took place in the ambulance? To which the paramedic replied no. I carried out other tasks such as taking a blood pressure, gave oxygen etc but did not write it down as I did not consider it necessary. My main concern was looking after the patient not writing things down. The solicitor for the patient then stated, in view of the poor quality of note keeping by the paramedic the creditability of his care is called into question due to a negligent approach in keeping critical patient records.

As the case progressed this solicitor challenged every statement from the paramedic, each time referring him back to the patient report form and a perceived breach duty of care.

The ambulance trust lost the case and multimillion pound compensation was awarded against the NHS.

Learning point; due to the poor quality of documentation on the patient report form, the paramedic was unable to demonstrate a satisfactory level of pre hospital care. Once this poor documentation had been established in open court, it gave the solicitor ammunition to challenge anything and everything the paramedic had done or not done.
Had the paramedic recorded the full set observations with the correct times on the PRF it would more than likely have satisfied the court that the duty of care was not breeched. The solicitor's task of proving the paramedic was negligent would have been made so much more difficult.

Could this happen to our patients? Our staff? Our Trust?

Yes, staff from our trust have been reported to the HPC and a hearing has been undertaken by the HPC for poor record keeping and non documentation of clinical findings.

A monthly clinical audit of records is carried out at WMAS which shows that we have poor compliance with recording the following areas:

- ✓ Mental capacity
- ✓ Name of the hospital staff member who the patient was handed over to
- ✓ Onset of symptoms times
- ✓ All of the above could lead to difficulty in justifying your actions in court.

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