Medico-legal aspects of record-keeping and documentation

HSE
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Documentation and Record Keeping

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Medical Records

- What is a Medical Record?
- What are Medical Records for?

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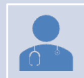
What is a Medical Record?



What are Medical Records for?

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Why Keep good records?

- On-going Patient care & quality
- Clinical audit
- Trust
- Defence of litigation

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On-going

Patient care

& quality

"…poor quality (completeness, readability and adequacy) of the available patient information was associated with higher rates of AEs [adverse events]. The quality of the recorded information in patient records seems to be a predictor of the quality of care. Better registration of patient information could contribute to better patient outcomes and safer healthcare."

Zegers et al.
BMJ Qual Saf 2011;20:314-318

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Hughes v. Staunton, Collins, Daly

(HC, Unrep., Lynch J., 16/2/90, case dismissed)

- Plaintiff suffering from Sub Acute Sclerosing Panencephalitis (SSPE)
- 1st Def: Consultant Neurologist – allegation that he advised 3rd Def to prescribe Largactil which was unsuitable and failed to advise on dosage and excessive dosage
- 2 & 3rd Defs: GPs: they both prescribed an unsuitable drug, an excessive dose and failed to monitor its effect
- Did Largactil worsen condition? – NO – case dismissed.
- GPs Notes were criticised – not relevant in this case to liability - but:

"The primary duty of a doctor is to treat the patient. Included in that will be the keeping of such records as are necessary for the continued treatment of the patient on a properly informed basis. ***It is not a duty to the Plaintiff but a council of wisdom in his own interests that the doctor should also keep sufficient notes of his dealings with his patient to enable him to refresh his memory therefrom and thus be in a position to state positively and precisely if required in the future what he did***."

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Armstrong v. Eastern Health Board

(HC, unreported, 5/10/90)

- Plaintiff had history of psychiatric admissions to other institutions
- Plaintiff wished to be admitted but was told by the defendant to get a GP's referral letter. This was done with the GP expressing the view that he agreed that the patient ought to be admitted since she had suicidal ideas
- However, on the second attendance to the defendant's hospital, a duty doctor, who had never seen the patient before, nor had read the medical records, discharged her concluding that she was not clinically depressed nor suicidal, and was only suffering from simple schizophrenia
- The plaintiff threw herself over a balcony sustaining serious injury
- The High Court found the defendant ***negligent in failing to consider the referral letter and medical records***, which if read would have lead to an admission thus preventing the injury
- Egan J., stated that:

"I do not hold that clinical notes or entries in log books must always be read in all circumstances. There must be many occasions when there is simply not sufficient time and an emergency decision is required. ***Notes, however, are made for a purpose and should be read in the ordinary course.***"

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Your obligation in respect of records

- **Medical Council guidelines:**

  You must keep accurate and up-to-date patient records either on paper or in electronic form. Records must be legible and clear and include the author, date and, where appropriate, the time of the entry, using the 24-hour clock.

- **HIQA Standards and Standard 8.3:**

  You can expect that people working in your healthcare service will record information about you accurately

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Clinical Audit

"...a healthcare record which is structured, facilitates the monitoring of standards, audit, quality assurance and the investigation of complaints."

HSE Standards and Recommended Practices for Healthcare Records Management (HSE, 2011).

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Medico-legal purposes

"However inconvenient and burdensome it may be to write up medical records accurately, such records constitute a vital safeguard for both medical practitioners and patients alike in any situation where it later becomes necessary to conduct any form of investigation as to what transpired during the course of a patient's treatment. Every practitioner must be taken as knowing that records may later be used in court proceedings or other investigations or inquiries and hence their importance is self-evident."

McManus v. Medical Council [2012] IEHC 350
Kearns P at p30

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Purposes of Medical Records, Reports, Audit?

- Record of treatment of Patient
- Informs of the 'standards of care' at time of care in relation to diagnosis and treatment of patient
- May be evidence of practice in existence at the time – which may be informative in relation to whether a practice was or was not practiced as stated:

Case 1:

- **Plaintiff claims he contracted MRSA during a procedure whilst a patient at the Hospital**
- **Claims negligence for breach of duty for exposing plaintiff to risk of injury and failure to adhere to infection control policy**
- **Here – audits and records of infection control policy and practice may be important in the Defence**

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Rhodes v. Spokes & Farbridge

[1996, UK]

- Pl visited her GP complaining of headaches over period of 3 years;
- His notes contained certain derogatory remarks;
- GP eventually referred PL to neurologist after a blackout but indicated issues of marital discord, family illness but that he was sure symptoms were ***'stress headaches'*** and that ***"She is now convinced that she has a brain tumour, although neurological examination is normal. I would be most grateful for your help with this patient";***
- GP omitted to mention that patient had a shunt inserted 26 years earlier – even though a note was in his records;
- 2nd Def Neurologist – reassured by letter – did not notice the operation scar on patient's head;
- GP negligent – in failing to have mentioned the Shunt which would have resulted in earlier resolution of the issue
- Court critical also of record keeping

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- 1959 – plaintiff suffered from Hydrocephalus at age 11 – relieved by insertion of intracranial shunt
- In 1984 Pl began suffering headaches and saw GP (2nd Def) in 1985
- He diagnosed stress and prescribed tranquilisers
- In 1986, plaintiff consulted GP between February – November 1986 on 7 occasions complaining of headache: prescribed various tranquilisers
- Attended again in February, When the GP wrote ***"as a hypochondriacal as ever"*** and March 1987 when she complained that the headaches were getting worse, with double vision, slurred speech and deafness in one ear loss of balance, sleepiness and vomiting and some visual disturbance
- GP did not record these complaints. Records noted as follows: "migraine over 6 weeks; ***usual list of neurotic symptoms***. Try sanomigram 1.5 daily"
- Again visited GP in April, and May on 2 occasions after a blackout. GP referred plaintiff to a neurologist on the impression of some sort of optical imbalance
- Referral letter made no reference to past history but contained strong expression of opinion that plaintiff's headaches were caused by stress
- June: plaintiff suffered second blackout and attended neurologist (1st def)
- Neurologist did not discover past history and concluded plaintiff was suffering from nerves and anxiety prescribing a new drug regime. No referral for CT scan
- On further consultation in July, plaintiff referred for a CT scan as a tumour was a remote possibility

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- August: CT scan revealed grossly enlarged lateral ventricles
- Dr. who examined scan suspected tumour but also identified what looked like a shunt
- His investigation of the hospital records revealed the past history and after a second CT scan plaintiff was then seen by the neurosurgeon who had been involved in her treatment in 1959
- In September, her raised intracranial pressure was relieved by fitting of a ventricular abdominal shunt, which was effective and relieved her symptoms
- GP stated that he had plaintiff's shunt in mind at all times and considered blockage as a differential diagnosis – this was rejected and he was held to be negligent for misdiagnosis and failure to refer the plaintiff onwards at an earlier stage
- In evidence, the plaintiff was a poor historian and the court found that she was liable to exaggerate
- However, the case is a cautionary tale for medical practitioners!

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"A doctor's contemporaneous record of a consultation should form a reliable evidential base…I regret to say that Dr. Farbridge's notes of the plaintiff's attendances do not provide any such firm foundation. They are scanty in the extreme. He rarely recorded her complaints or symptoms; he rarely recorded any observation; usually he noted only the drug he prescribed. These brief entries were sometimes accompanied by a cryptic or occasionally even derogatory comment as to the genuineness of the plaintiff's complaints. ***The failure to take a proper note is not evidence of a doctor's negligence or of the inadequacy of treatment. But a doctor who fails to keep an adequate note of a consultation lays himself open to a finding that his recollection is faulty and someone else's is correct***. After all, a patient has only to remember his or her own case, whereas the doctor has to remember one case out of hundreds which occupied his mind at the material time "

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O'Neill v Rawluk

[2013] IEHC 461

- the procedure had been performed 12 years prior to trial;
- the relevance and assistance of written records was noted by the court, Moriarty J stated:

"The unique experience of the plaintiff is likely to be more indelible than the recollection of one of many procedures undertaken by a busy neurological surgeon, with a clinical case load exceeding, on the defendant's own evidence, 350 patients per year.

However, the defendant's practice of maintaining handwritten notes also gives a more reliable picture."

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O’Sullivan v Anor & Bon Secours

(Unrep. HC, O’ Neill J. 2/4/04)
(finding for Plaintiff, TD: €256,766.02)

O’Neill J. in relation to the recording in the notes in 1996 of the McRoberts manouvre:

“The first named defendant’s evidence was that it was not the practise to note the particular manoeuvre used and he went on to say that he had been trained to make short notes rather than long notes on the basis that shorter ones are more likely to be read and that in a hospital which wasn’t a teaching historical shorter notes of the kind made here were the norm. He acknowledged that in a teaching hospital there was tendency to write essays.

In my view the universal desirability of brevity simply fails to explain an omission such as this from this note. A single short additional sentence was all that was required, to say that shoulder dystocia had been encountered and was overcome by the McRoberts manoeuvre in the left lateral position with supra pubic pressure.

The contents of this note tends to persuade me that the parents of the plaintiff are right in their recollection that Ms. O’Mahoney was not changed into the left lateral position nor was supra pubic pressure applied.”

“I would be of the opinion therefore that the use of the left lateral position for the purposes of the McRoberts manoeuvre is an acceptable professional practice for an obstetrician when confronted with shoulder dystocia…”

Lesson: record all procedures in notes for evidential purposes

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Records in Evidence

- Medical records, in and of themselves, are not proof of the contents of those records.
- They will become evidence in proceedings:
  - (i) if the parties agree to admit the medical records to trial without formal proof (in which case the author of the record will not be required to give evidence in relation to the content of the record) or
  - (ii) the author of the record is called to give oral evidence and therefore prove the content of the record.
- Therefore, where there is a dispute in relation to the alleged facts which are stated in the medical record, then, the author of that record must be called.
- This is so the patient/plaintiff can give evidence and be cross-examined in relation to their version of events, and that the same can take place with the author of the record.
- Otherwise, the notes in question cannot be regarded as evidence which can be proved, as they cannot be appropriately tested in cross-examination.
- ***The better the record, the easier it will be for the author of that record to stand over it and give evidence in relation to it where its content is disputed.***

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'Good' Record Keeping: the Basics

- **legible**
- **dated**
- **times**
- **signature + name - identifiable**
- **abbreviations**
- **Omit irrelevant patient/colleague remarks**
- **Keep records factual**
  - **E.g. drug name, dose, time given, specific procedures used**
- **Record consent clearly and fully: *disclosure and discussion of risks***
- **When a 'seminal' event of importance occurs – document in detail**

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'Good' Record Keeping: Other Issues I

- The record should be ***contemporaneous***
- The medical record should be written/recorded at the time of the relevant event or immediately thereafter
- Longer the gap between the care transaction and its writing – more open to scrutiny is the entry
- If called away – the note should be written as soon as possible thereafter and, the fact that it is being written on a non-contemporaneous / retrospective basis should be recorded: Note the time of patient interaction and the time of entry of the record
- A medical ***record cannot be retrospectively altered*** for any improper purpose
- If a genuine mistake occurs on a medical record, or where a further entry is required in the note on a retrospective basis, any mistake should be clearly struck through with a line and this should be signed/initialled and dated

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‘Good’ Record Keeping: Other Issues II

- The record should be ***consistent***
- A consistently kept record will act in favour of a Defendant in the case of a dispute:
- In ***Rossiter v. Donlon* [2019] IEHC 105,** Barr J stated:

"I prefer the evidence of the defendant. In particular, I attach significance to the fact there is no reference to any such concern [of breast cancer] in the defendant's contemporaneous notes. She had recorded the concern on the part of the plaintiff in relation to a possible lump in her left armpit. There was absolutely no reason why the defendant would have recorded that concern which was expressed to her by the plaintiff, but would not have recorded any other concern was also expressed to her by the plaintiff. Accordingly, I am satisfied that the absence of any reference in her notes to the plaintiff been [sic] concerned about the possibility of having breast cancer, or been [sic] concerned about breast cancer generally, it is persuasive that no such concern was expressed by the plaintiff to the defendant on that occasion…"

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Freeney v HSE [2020] IEHC 286

Involved an allegation against a radiographer:

"A separate case is made against the radiographer…who carried out the mammogram on the plaintiff on 17 June 2015. The allegation against her is a straightforward one; that in drawing up the Note for the radiologists to consider, she failed to fully and accurately record her conversation with the plaintiff …"

The issue was what the radiographer recorded in the Notes and her approach to patient information, she stated:

"In relation to a possible different approach depending on whether a lump or a cyst is identified by a patient, when asked whether she [radiographer] saw a difference between a woman saying to her that she had a lump or a cyst, explained that she was not a doctor, not a physician, just an imaging professional, so that when a patient tells her something, that is what she writes down…[she] went on to explain, when asked again why she had written down "lady feels a cyst in her R breast", that the patient had told her this, that she had to document it for the radiologists so that the radiologists would know it, and that whatever the patient tells her she has to put it down for the radiologist. In relation to her approach when writing a note, under cross examination, on being asked whether she had to exercise a certain amount of professional judgment in what she writes, she replied that she can only write what the patient tells her and can't interpret it or make it her own way and that she writes down all relevant information…"

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Freeney v HSE [2020] IEHC 286

Court found:

I conclude that her practice was to report accurately what the patient told her and that it is very likely that the account of her interaction with the plaintiff was an accurate reflection of the contents of same.

- **No negligence**
- **Lesson:** ***record accurately what a patient tells you***

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No records = no defence ?

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Mordel v Royal Berkshire NHS Foundation Trust

[2019] EWHC 2591 (QB)

- This was a claim for 'wrongful birth'
- Ms. Mordel, whose first language was Polish although she spoke good English, became pregnant in 2014 and had her booking appointment with a community midwife at her GP's surgery on 23 June.
- She agreed to undergo all six of the standard screening tests, including those for Down's syndrome during the first trimester. However she was recorded as being "unsure" about any invasive tests (namely diagnostic testing in the event that initial screening indicates more than a 1:150 risk of Down's).
- Initial screening consists of ultrasound testing of the foetal neck (the nuchal translucency test) and a blood serum test of the mother. Ms. Mordel saw a sonographer on 22 July for these tests, the latter asking "Do you want the screening for Down's syndrome?", to which she answered "no".
- Accordingly, those tests were not performed and the sonographer only undertook a maternal ultrasound for dating purposes. She noted in the records "Down's screening declined".
- Throughout the remaining course of the pregnancy, no Down's tests were undertaken and the claimant gave birth to a child with Down's on 25 January 2015.

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- She was extremely upset at this and sued the trust, maintaining that if she had she known that her child possessed this condition, she would have had a termination.
- The trust's defence was that Ms. Mordel unequivocally informed the sonographer that she did not want Down's testing and that a patient's wishes must be respected.
- Mr. Justice Jay found in favour of the claimant.
- He decided that the sonographer should have satisfied herself that the patient understood "the essential elements and purposes of scanning for Down's syndrome". He thought the sonographer's first question was "somewhat abrupt" and that she should have "done more to lay the ground properly".

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"… it is the sonographer's duty to satisfy herself that the patient is consenting to the procedure… before it is undertaken on the basis of proper information; and that her consent is informed. This in my view logically mandates:

(i) checking that there has been a discussion between patient and midwife
(ii) checking that the patient has been supplied with the NHS booklet, and
(iii) ascertaining by brief questioning that the patient understands the essential elements and purposes of scanning for Down's syndrome."

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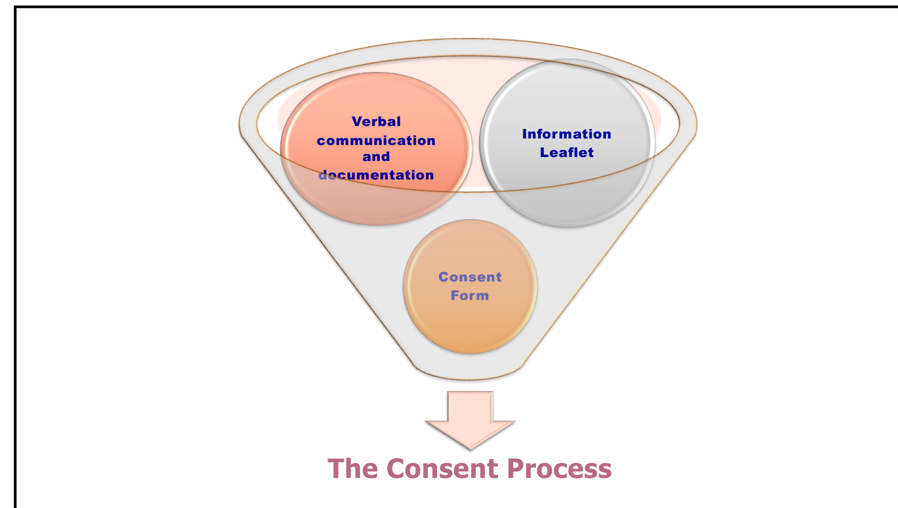

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Practice Tips:

- Fill in consent forms properly and correctly;
- Ensure that discussion of risks is documented – whether in notes or consent form;
- Non-documentation of risks discussed can lead to allegations that a discussion never took place

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Lessons from Litigation

- ***Listen*** to your patient – essential for a careful history: law expects high standards in treatment and diagnosis
- Careful and proper communication with medical team and patient
- ***Communicate*** with patients and other professionals
- Give patient and other professionals clear instructions and document these
- ***Careful and clear Documentation*** of reports and records
- When you have ANY doubts about care – seek clarification – inter-professionally

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Lessons from litigation: Reflections on your Medical Records

Therefore, it is advisable for healthcare providers to reflect on any potential anomalies in relation to the record keeping process:

- Are you keeping any record of the patient outside of what might be considered the formal clinical record 'bundle' e.g. a diary, a logbook, a notepad etc.?
- Is clinical information relevant to the treatment, diagnosis and care of the patient being recorded by secretarial staff?
- What is your record-keeping practice in relation to an outpatient appointment?
- Do you keep a written record of your transaction and consultation with the patient, or do you simply dictate a follow-up letter in relation to your consultation to the patient's GP?
- If so, is the dictation of such a GP follow-up letter appropriately recording the full extent of your consultation with the patient and is it properly contemporaneous?
- In relation to the consent process, if you have discussed the material risks of a procedure with the patient at their outpatient clinic, have you documented the discussion of these risks in the medical record?
- If a material risk discussed subsequently and unfortunately transpires, are you able to convincingly provide evidence that such risk was actually discussed, as opposed to having to rely on the narrative that "it is my practice to always discuss the risks, and I would invariably have discussed this risk…"
- Are you recording sufficient details of your consultation with your patient in the written/electronic record?
- This should include information in relation to your "safety netting" e.g. telling a patient that they should return/contact you or the accident and emergency department (depending on what is appropriate), should the symptoms worsen.
- Are you recording what is done when you receive any sort of laboratory report on foot of any test ordered by you?
- For example, what is your practice in relation to contacting the patient on the receipt of the test result – do you contact the patient in all circumstances or only if the result is negative?
- Do you tell the patient "I will only contact you if the result is negative", and then do you record the fact of this communication with the patient?
- Do you record all follow-up instructions and information, including any request that the patient should follow-up with you at a certain time?
- Do you record information received by individuals other than the patient e.g. information received from a relative on foot of a telephone call revealing potentially relevant clinical information/a symptom?
- Do you ensure the use of standard and appropriate abbreviations in your clinical records which could be expected to be understood by any other practitioner?
- Do you appropriately date, time and sign all entries?
- Do you ensure that your records are kept objective and factual and free from unnecessary subjective entries?
- Would you be happy for an independent expert to review/audit your records and which audit would conclude that the records provide a clear, accurate, chronological, consistent and complete picture of the care of your patients, such that you would be happy to stand over such a record before a court or tribunal and/or that such a record would assist you in your ongoing care of the patient and assist you in providing a proper and accurate history to deliver such care?

Ask Yourselves….

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Checklist: Things to Think about

- ❑ **What is a 'medical record"?**
  - ❑ **What does it contain?**
- ❑ **What is the purpose of a medical record?**
- ❑ **What is the importance of keeping a medical record?**
- ❑ **How should medical records be kept and for how long?**
- ❑ **What is their importance for legal issues?**

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