Local Government & Social Care
OMBUDSMAN

Good record keeping

Guide for care providers

February 2023

Introduction

The Local Government and Social Care Ombudsman regularly receives complaints about residential and domiciliary care, where at least part of the complaint hinges on the information kept by the care provider. Among the complaints we uphold, the common things we see going wrong are:

- not keeping comprehensive records
- not ensuring records are accurate, and
- not retaining relevant information for action.

At times these failures cause serious consequences.

We have developed this guide to share the learning from our investigations. By highlighting some errors in real scenarios, we want to stress to care providers that not only does maintaining accurate records ensure compliance with the regulations – more importantly, it also saves people from real distress.

What do the regulations require?

The regulations (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) say providers 'must maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided.'

The Care Quality Commission (CQC) - with whom we share our investigation decisions - gives guidance for providers on complying with the regulations to ensure the records kept are 'fit for purpose', which the CQC summarises as 'complete, legible, indelible, accurate and up to date'.

Our approach

Examining care provider records is a key part of our investigations. The daily care notes, together with (where appropriate) risk assessments, accident reports, food and fluid and medication charts, are one of the first things we ask a care provider for when we start investigating a complaint. They form vital contemporaneous evidence and enable us to gain insight into how a care provider responded to a resident's needs, how staff took necessary action where patterns of increased need developed (for example weight loss), and how relatives' concerns were monitored.

Care providers compiling accurate records enables us to reach robust findings. However, if there are gaps in recording or a conflict of evidence, we can make findings based on the balance of probabilities. This means we will weigh up the available relevant evidence and base our findings on what we think was more likely to have happened.

"We are likely to find a care provider at fault where records are illegible or have clearly been changed after the event, where they are inadequate for their purpose, or where they omit essential information or include misleading information."

Digital Records

We may not state in our complaint decisions whether the records considered in an investigation were electronic or paper-based, unless it is relevant. But the use of digital records is a factor in some of our cases.

In some, providers have moved to, or are in the process of moving to, electronic systems of record keeping. And in others, providers have reflected on our investigation and said they planned to invest in electronic systems that promise to support more secure and robust processes.

We do not prescribe a particular system of record keeping. But it is important to note that electronic systems do not automatically mean records are of a high quality.

In some investigations, the electronic system has encouraged a formulaic data response and the opportunity, for example, of a free text commentary has not been used. Regardless of the system, the same requirements apply that records should be accurate, complete and contemporaneous.

The National Care Forum has pointed to a number of resources for care providers on making the move to digital records systems, which can be found on the Digital Social Care website.

Examples of poor practice in record keeping

False or inaccurate records caused distress and lack of trust
Case refs: 19 009 394 and 19 001 354

Arthur and Harriet's stories

A care provider was commissioned by a council to provide home care for Arthur after he left hospital. A carer visited Arthur one morning and wrote in her notes that she had seen him and given care before she left.

Later that day Arthur's neighbour called the emergency services when they found Arthur dead at home. He had died during the night, before the carer's visit.

The care provider investigated and found the carer had falsified her notes. When the complaint came to us, our investigation found the carer's actions caused Arthur's daughter "severe and avoidable" distress.

As a result of the complaint the care provider agreed to deliver urgent training to its staff on the requirement for honesty and accuracy (in line with CQC regulations), and to remind them of the seriousness of falsifying records.

In another complaint, we found a care home had two versions of the care charts for Harriet, a resident nearing the end of her life. The original version said staff called 999 at 3.35pm, the other said 4.35pm.

The original version described Harriet as "sleepy" between 4:30 and 5pm and notes a 5pm check. Both versions show half hourly checks. The second version did not include the 5pm check and described Harriet as "quite chatty and responsive up until 4:30pm".

The care provider had amended its records, to provide a better picture of Harriet's care, after it received a complaint from her daughter.

The existence of two sets of records with discrepancies between them put into question the integrity of all the care provider's records and was also a breach of the CQC regulations.

We found it likely Harriet had not been checked as often as the care provider said, and that her care was inadequate.

Poor record-keeping caused physical harm

Case ref: 18 010 137

Lily's story

A domiciliary care provider used such a confusing record-keeping system for both its nutrition/hydration and medication records that it was difficult for carers to know what to record.

This had harmful consequences for Lily who it was providing care to. Our investigation found a carer failed to give Lily her medication but recorded she had done so (another carer found the tablets in the lid of the medication dispenser).

Another carer recorded she had given Lily "cheese on toast, sausage rolls, a cup of tea, juice" at lunch but a CCTV recording showed she was only given water.

Lily was found dazed and confused the next day and admitted to hospital. A safeguarding investigation found "no clarity" in between visits of what food was left from the previous evening and what was eaten the next day.

It also found that fluid and nutritional charts went missing. There were days when Lily received no food, drink or medication.

We alerted the CQC to the complaint: the council which commissioned the care addressed the inadequate record-keeping and poor practice with the care provider.

Failing to complete incident report records led to late intervention

Case ref: 19 008 791

Manjit's story

Manjit lived in a care home and had dementia and difficulty communicating. She had a pressure mat next to her bed.

A carer found Manjit in pain one morning with her right leg hanging over the edge of the bed. She was admitted to hospital and found to have a fractured hip as the result of a fall.

The home's records showed her pressure mat had been activated twice during the night. On both occasions the electronic call bell records showed it was turned off from inside Manjit's room.

There was no record of who attended those calls or any action they took. None of the night staff admitted to turning off the call bell. It meant a serious injury did not receive attention it should have and Manjit suffered for longer than necessary. Her family was left with the distressing thought of their mother in significant pain.

As a result of the local council's safeguarding investigation the care provider carried out a safeguarding plan reminding staff of the importance of accurate and timely recording.

It agreed to our recommendation to pay the family an amount to recognise the distress they suffered.

Failure to record care in care plan led to pain and infection
Case ref: 20 005 052

Jan's story

Jan needed his catheter bag emptying every night and changing weekly. However, the weekly change was not written into the care provider's plan.

Our investigation found carers failed to carry out the weekly change even after the District Nurse left a note in their logbook. As a result, Jan suffered frequent UTIs which caused him considerable pain and distress, and led to hospital admissions more than once.

The carers also failed to keep accurate records about the extent of a pressure wound caused by not emptying the bag properly. Had they done so, Jan could have received treatment before it worsened.

They also did not always record applying the prescribed cream to the wound and there were doubts they had done so.

We shared our investigation decision with the CQC, and the council which commissioned the care agreed to our recommendation to pay an amount to Jan's estate and his family, in recognition of their avoidable distress and anxiety.

Key messages for care providers

Care providers should ensure:

- all care records are accurate, honest and comprehensive
- all staff are familiar with the recording system used
- records are updated with new information in a timely way

Any gaps in records cast doubt on the integrity of the whole care provider record. This may lead us to criticise the provider and make recommendations for apologies, training and practice changes.

Appendix

The **Care Quality Commission (CQC)** guidance for providers on complying with the regulations:

Records relating to the care and treatment of each person using the service must be kept and be fit for purpose.

Fit for purpose means they must:

- Be complete, legible, indelible, accurate and up to date, with no undue delays in adding and filing information, as far as is reasonable. This includes results of diagnostic tests, correspondence and changes to care plans following medical advice
- Include an accurate record of all decisions taken in relation to care and treatment and make reference to discussions with people who use the service, their carers and those lawfully acting on their behalf. This includes consent records and advance decisions to refuse treatment. Consent records include when consent changes, why the person changed consent and alternatives offered
- Be accessible to authorised people as necessary in order to deliver people's care and treatment in a way that meets their needs and keeps them safe. This applies both internally and externally to other organisations
- Be created, amended, stored and destroyed in line with current legislation and nationally recognised guidance
- Be kept secure at all times and only accessed, amended, or securely destroyed by authorised people
- Both paper and electronic records can be held securely providing they meet the requirements of the Data Protection Act 1998
- Decisions made on behalf of a person who lacks capacity must be recorded and provide evidence that these have been taken in line with the requirements of the Mental Capacity Act 2005 or, where relevant, the Mental Health Act 1983, and their associated Codes of Practice
- Information in all formats must be managed in line with current legislation and guidance
- Systems and processes must support the confidentiality of people using the service and not contravene the Data Protection Act 1998

NICE (the National Institute for Health and Care Excellence) also issues guidance on the record-keeping for medications in care homes. It says:

Care homes should keep records of all medicines that are taken by residents. A common type of record used in care homes is called the 'medicines administration record'. Records should include:

- the person's name, date of birth and weight (if under 16 years or frail)
- the names of the medicines being prescribed
- the strength of the medicines and the amount of the medicine or dose
- how the medicines should be taken or used and how often
- other information that might be important, such as whether the medicine should be taken with, before or after food
- whether any medicines need to be monitored and when they should be reviewed
- any support needed to help the person continue to take their medicines
- information about any allergies to medicines or their ingredients or reasons why the person has been unable to take any medicines in the past

Care homes should make sure the information in these records is accurate and up-to-date. They may need help from health professionals prescribing the medicines and the pharmacies supplying the medicines

Records must be filled in as soon as possible after a person takes their medicine, including the date and time the medicine is taken

The Nursing and Midwifery Council (NMC) produces a Code of conduct for its members, which says:

Keep clear and accurate records relevant to your practice (section 10).

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- complete all records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- complete all records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
- take all steps to make sure that all records are kept securely
- collect, treat and store all data and research findings appropriately

The role of the Ombudsman

The Local Government and Social Care Ombudsman has always investigated councils' adult social care departments and the services they commission.

When our jurisdiction was extended in 2010 to cover all registered adult social care providers, we became the sole independent means to redress for any type of unresolved adult social care complaint.

Where a complaint involves elements of health and social care services, we can carry out a single joint investigation, with one person investigating across all areas of the complaint, in tandem with the Parliamentary & Health Service Ombudsman.

People must complain to the care provider and complete all stages of its complaints process before they can bring a complaint to us. If we decide to investigate a complaint and find the provider at fault, we will decide if the fault has caused injustice. If it has, we will recommend what the provider should do to put things right.

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