

Clinical negligence and Covid-19

The pandemic creates different clinical negligence risks that could result in claims. This guidance provides advice on how our members can manage the risks associated with claims.

It remains the case that the most effective way to prevent claims is by supporting staff to provide the best care possible.

Evidence

Our ability to respond effectively to claims often depends on evidence contemporaneously recorded at the point of harm, or shortly thereafter.

Covid-19 creates or enhances risk in several areas. Many of these risks will apply equally to patients who have Covid-19 and to those who do not, but are treated for an unrelated medical condition, during the response to the pandemic.

The following guidance is designed to assist our members identify key areas where evidence will be required, in order to help facilitate the investigation of claims.

Key headlines:

- ensure all decisions that change standard policies are documented
- record how consent is obtained
- encourage everyone to continue to document all key decisions they make
- record details of any unusually busy or critical staffing periods
- ensure a central and robust record of all staff (including temporary staff) is kept.
- where possible, up to date contact details for staff should be available

Where a risk applies to a whole service area, for example, all consultations being conducted remotely due to the risk of Covid-19 infection, then documenting this in a policy/procedure change will be sufficient. This will prevent the need for staff to document each patient consultation with the same rationale, as the policy/procedure change will document it. The fact the consultation took place via remote means should still be documented.

Helpful links:

<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice>

<https://www.nmc.org.uk/standards/code/record-keeping>

[Royal College of Physicians ethical guidance for frontline staff](#)

Risk	Possible evidence
Consent	Ensure consent to any treatment, including alternative methods of providing health care, are documented.
Inexperienced staff	<p>Document any decisions/rationale for redeployment of staff across specialties.</p> <p>Wherever possible, ensure and document adequate supervision.</p> <p>Training records showing what the staff member has been told, when, how, and how has the staff member's understanding been tested.</p>
Cross-site working and clinical decision making	<p>Governance arrangements (evidenced in policies and other documents) around the creation and storage of records from sites other than the Trust's main location will assist in ensuring the integrity of patient data.</p> <p>Accurate records in at least one location of telephone consultations between remote staff and central specialists.</p>
Remote consultations	<p>If personal protective equipment (PPE) or similar requirements make an examination more difficult this should be recorded. Where possible, guidance should be provided (through policies/procedures) as to what steps should be taken to achieve a more effective examination if this is possible.</p> <p>Where there are remote consultations (e.g. telephone or video) a note should be made of any limitations (e.g. low resolution on a video link) and consideration should be given to whether those limitations can be addressed.</p> <p>There should be clear documentation of any assessments undertaken and how. Document patient consent to such assessments, their limitations and general consent to decisions taken.</p>
Exceptionally busy clinical settings.	<p>Centrally held rota data to track who was on duty at what time, staff numbers and ratios.</p> <p>Centrally held records of activity levels and ward occupancy (e.g. on a daily or half-daily basis). This will assist in comparing peak periods of activity compared to normal levels.</p>

Ventilation	<p>Processes/policies leading to the decision to not ventilate or to withdraw ventilation. These should meet national guidelines.</p> <p>If decisions are made by internal ethics committees, the rationale for decisions must be clearly documented with reference to any guidance/alerts that have been relied on.</p> <p>Use of more novel ventilation equipment should be documented including type/manufacturer and rationale for use.</p>
Discharge	<p>Document if the patient was tested before being discharged. The national discharge guidance should be used and applied and any deviation documented.</p> <p>It is important to maintain records relating to the suitability of the home/care environment for vulnerable patients.</p>
Cancellation of non-urgent surgery	<p>At the time of cancellation, evidence of what consideration was given to the risk of harm to the patient.</p> <p>How the risk of harm has been tracked over time since the cancellation.</p> <p>Any safety netting advice given to the patient.</p> <p>Any specific patient support should be clearly documented.</p>
Delays in screening and treatment	<p>How the risk of harm has been tracked over time since the delay.</p> <p>Any safety netting advice given to the patient.</p> <p>Any specific patient support should be clearly documented.</p>
Changes in treatment regimes and/or medical devices	<p>Document the rationale behind the use of alternative treatment or device.</p>
Hospital acquired infection (Covid-19)	<p>Central record of PPE availability in locations on a daily or more frequent basis.</p> <p>Records of staff who have tested positive for Covid-19 or who have exhibited consistent symptoms but not been tested.</p>

*The list of risks and evidence is not exhaustive.