

Keep records of all evidence and decisions

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A good investigation will document all evidence and a clear rationale for decisions. If a referral to us is needed at any stage, well-documented evidence and rationales will help us understand the concerns and any action you've taken. This can include:

- Statements from people who saw the events taking place or can explain directly what happened (whether staff, people who use services, or relatives). Make sure they're typed, signed and dated. They should also include confirmation that the person making the statement believes the content is true to the best of their knowledge and recollection. We know that workforce changes can happen during the course of an investigation and would recommend that you take personal contact details for all witnesses. This means you can keep in touch with them and can pass their details on to us if a referral is needed later.
- Clear copies of relevant records. This could include patient notes, care plans, and medication administration records.
- Evidence of staffing levels at the relevant time and what the expected staffing level was, including rotas and details of handovers.
- Evidence of how busy the setting was, whether this was normal, and whether there were any people using services with unusually challenging or complex needs at the time.
- Relevant policies or standards in place at the time.
- Any evidence from the nursing or midwifery professionals involved about their own health and wellbeing at the time, as well as any statements about how they've reflected on their practice and made improvements.
- Records of your attempts to work with the professional to address the concerns (see more on [managing concerns locally](#)).
- Documented evidence of any action plans put in place, such as supervision or guidance for the professional. Explain how this compared to supervision or guidance you'd normally expect to give those with similar experience and qualifications. Also give details of any further training they've done (referencing the course provider, for example online tuition, or class based/practical learning).
- Documented decisions, such as correspondence with the professional about the outcome of an investigation or disciplinary proceeding.

It would be helpful if from the outset, investigators are familiar with [the types of evidence and documentation we need for a fitness to practise referral](#).