

CHAPTER 22

LEGAL ASPECTS OF NURSING DOCUMENTATION:

THE 25 DOs AND DON'Ts OF NURSING DOCUMENTATION

I. INTRODUCTION

Documentation of patients' records, in the nursing field as well as other health care fields, is one of the most important aspects of the profession. Patient safety, as well as medical malpractice cases, dictates the need for the maintenance of complete, accurate and timely medical records.

Medical records have been kept by physicians since the time of Hippocrates. Today, health care organizations are required by law to maintain a medical record for each patient, whether he is an inpatient and outpatient, in accordance with accepted professional standards and practices. The purposes behind the requirement to keep and maintain medical records include: documentation of the patient's specific facts as to his illness; utilization as a planning tool for patient care; facilitation of communication between the various health care professionals involved in a patient's care; a provision of a data base for use in statistical reporting, continuing education and research; a provision of information necessary for third party billing and regulatory agencies; and last, but not least, assistance in protecting the legal interests of the patients and health care providers.

II. THE IMPORTANCE OF ACCURATE DOCUMENTATION

A health care organization should have integrated the pertinent state and federal laws, regulations and appropriate standards covering documentation into its policies and procedures. A failure to follow an organization's policies and procedures may be deemed evidence of the breach of the standard of care. An organization's policies and procedures should serve as a set of guidelines for a nurse; however, an organization's policies and procedures should not replace independent nursing judgement. In the event that policies and procedures are not followed, documentation should include the facts supporting the nursing decision.

Entries in the medical record should be written with the welfare of the patient in mind, but they should also provide legal protection for the health care providers. Accurately documenting nursing assessments, plans, interventions and evaluations is a method of avoiding untoward occurrences and, possibly, a method of avoiding liability after an incident has occurred. The medical records can be an indispensable part of the defense against any eventual litigation. In contrast, a poorly kept record may not be helpful and could hurt a nurse's defense.

When health care professionals are called as witnesses in legal proceedings, they may refresh their recollections of the facts and circumstances of a particular case by reviewing the medical record. During a legal proceeding the medical record can be admitted into evidence. In addition, portions of the medical record may be utilized as exhibits.

III. TIPS FOR WRITING IN A PATIENT'S MEDICAL RECORD

The following tips are some general for documentation within a patient's the medical records:

A. BE DESCRIPTIVE

Be sure to describe what you observed and what you did. Include the following: status of the patient; changes in status; care given; communications with physicians; documentation that physician's orders have been followed; and documentation that policies and procedures have been followed.

B. BE OBJECTIVE

Be sure to use objective terms. Record the facts, not opinions or assumptions. Never use the clinical record to vent anger or assign blame. Also avoid recording unnecessary information, such as a statement about staffing; that could be misconstrued in court as having a bearing on a patient's injury. A staffing shortage, for instance, may or may not have had a direct effect on a patient.

C. BE CAREFUL

Be sure to pay careful attention to correctness. Never falsify the clinical record to cover up a negligent act. Fraudulently altering or falsifying the medical record is a crime. See Section 395.302, Florida Statutes. A falsified record can destroy the credibility of the entire clinical record. Not only could this influence the verdict, but a falsification could result in the award of punitive damages and punitive damages may not be covered by malpractice insurance.

D. BE UNIFORM

Be sure to be uniform with your institution's approved abbreviations. JCAHO standards and many state regulations require health care facilities to use an approved abbreviations list to prevent confusion. Know your facility's approved abbreviations. Use of an unapproved abbreviation can cause ambiguity in the records. For example, if you use "O.D." for "once a day," another nurse may misinterpret it as "right eye" and mistakenly instill medication into the patient's eye, instead of giving it once a day.

E. BE METICULOUS

Be sure to be meticulous about your charting. When documenting care, use the appropriate form, identify the patient on every page of the form, fill it out in ink, use standard abbreviations, spell correctly, write legibly, correct errors properly, write on every line of a form, and sign each entry with your first name or initial, full last name, and professional licensure (such as RN or LPN).

F. BE EXTENSIVE

Be sure to document as extensively as necessary. You do not need to chart routine tasks, such as changing bed linens, but you do need to chart relevant, material information relating to patient care and reflecting the nursing process.

G. BE NEAT

Be sure to document in the patient's records neatly, so others can read it. Effective documentation requires legible handwriting. Illegible writing may hinder communication between health care professionals.

H. BE TIMELY

Be sure to document when events occur. Be specific about time. In particular, note the exact time of all sudden, material changes, significant events and nursing actions. Block charting, such as "7:00 a.m. to 3:00 p.m.," sounds vague and may be incorrectly interpreted to imply inattention to patient. Document pertinent information as soon as possible after an event. Your charting will be more detailed, accurate and clinically useful. Moreover, if you become involved in litigation, you'll find it easier to defend your actions because prompt charting leaves no question as to when an event occurred. If you can't document in the patient's chart at once, note the time when you charted, as well as the time that event occurred.

IV. 25 LEGAL DOs AND DON'Ts OF NURSING DOCUMENTATION

1. "If you did not write it down, you did not do it. If you did not do it, you were negligent." You need not just to chart what you did but how you did it. Otherwise, how will you testify years later, with no actual recollection of the patient in question, that you did it right? For example: "ketorolac 20 mg IM" versus "The appropriate injection site in the gluteal muscle was located by reference to the patient's iliac crest. Then the injection was administered into the muscle tissue using a pre-filled 30 mg syringe with a 1 ¼ inch 18 gauge needle, after having attempted unsuccessfully to aspirate blood upon insertion of the needle. No complains of numbness or tingling in the lower extremity. 10 mg of the medication was wasted." What if the patient sues five years later claiming a sciatic nerve injury from your injection technique – which of those two progress notes do you want to have with you on the witness stand? The first one gives you no positive basis to testify that you did the injection correctly, and it is basically a toss-up whether or not you will be found liable.
- 2 Do chart your normal findings. This is especially important where the

nurse is monitoring a patient who is critically ill or in labor, where things can change from good to bad on a moment's notice. The legal question after the fact will be how quickly the nurse picked up on what was happening and took action. How closely was the nurse really monitoring the patient before the change in status occurred? It will be really important after the fact, after something abnormal does occur when you charted your last normal finding before the abnormal events began. For example: "3:00 a.m., patient in bed sleeping soundly." What is the point of charting that? Suppose the patient is found on the floor at 3:05 a.m.? How long had the patient been there? How do you prove that? What if they claim the patient was lying there in agony with a broken hip since dinner time the night before and nobody did anything? When was the last charting, when the patient ate dinner on the p.m. shift? When was your last progress note? Shift change at 11:00 p.m.? Did you even write a progress note yet on the night shift?

3. Don't jump to conclusions. It is your job to observe carefully. It is your job to chart data, not conclusions. For example, a patient is found on the floor. Did the patient fall out of bed? Did the patient fall trying to ambulate on his or her own when they knew they should not have? The conclusion you chart in the progress notes will have great weight with the jury, even if it is not what really happened. That is, if the patient fell out of bed you may be liable but if the patient tried to ambulate knowing he or she should not have you are not going to be liable.
4. Don't diagnose patients. Nurses formulate nursing diagnoses in their care planning, but in everyday progress charting it is not good to speculate about possible medical diagnoses or editorialize about the issues that are going on in a patient's life. For example, it is proper to note that vital signs or lab values are above or below accepted values, but it is not proper for a nurse to speculate what it means. A nurse is supposed to understand what is going on with a patient with low red count or high white count or elevated BUN, but a nurse is not supposed to chart speculations about medical or psychiatric issues.
5. Don't blame yourself. Again, that is jumping to conclusions.
6. Don't blame another person. As a nurse you have a duty to advocate for your patient. If the physician or another nurse drops the ball, there are steps you must take to do something about it. It is wrong to sit back, and chart your criticisms of others and not do anything about it yourself.
7. Don't chart defensively after an incident has occurred. This is a red flag to lawyers later on. Defensive charting is not necessarily going to stand up in court as actual evidence of negligence, but it does telegraph the

message that you believe you were at fault, and that's the red flag the lawyers will be looking for. Correct assessment and proper charting has to be done before the fact as a matter of routine, before you know something bad actually is going to happen.

8. Don't back-date your charting. As clever as you think you are this is probably not going to work, and it only waves a red flag in front of the lawyers.
9. Don't alter or destroy any charting. The legal term for this is spoliation of the evidence. The legal principle of spoliation of the evidence is: if the other side can convince the judge that a chart was intentionally altered or destroyed in whole or in part, the judge can instruct the jury to assume that what is now missing from the chart would have been detrimental to the healthcare providers and the facility and favorable to the patient in the patient's civil malpractice case. That can put you in just the same or even in a worse position that if you had just left things alone.
10. Don't copy things from patient's charts for your own use. Patients' charts are confidential. There is no excuse for breach of medical confidentiality.
11. Don't chart something about one patient in another patient's chart.
12. Don't chart anything that is false.
13. Don't assume a family member has permission to get something out of a patient's chart. That may or may not be true. The family member should be referred to medical records or to a supervisor, and they can refer the family member to the legal department if they think that is necessary.
14. Don't complain in a patient's chart
15. Don't confuse incident reports with patients' charts. This is a very complicated area. The rationale is that what goes to quality review may be highly critical of how an incident transpired, but it is confidential and stays with quality review, while what goes into the patient's chart is guaranteed to come out in court.
16. Don't leave flow charting blank. Flow charting has two purposes: first, to provide a convenient and uniform way to chart basic patient-care data and second, to prompt caregivers as to the care they are supposed to be giving. Thus it is not a good idea to leave flow charting blank or to allow aides or nurses you supervise to leave anything blank on a flow chart.
17. Don't ignore lab reports. Often the courts will blame the nurses if lab

reports are not in the chart or not on the front of the chart or where they should be so that the physician can and will see them.

18. Do pay attention when a patient signs a will. If you work in a nursing home and a patient has visitors coming in to sign a will, it is probably a good idea to put a progress note in the chart about the patient's current mental status that very day. Nurses are being called into court as disinterested witnesses in family will dispute cases.
19. Don't forget physicians' standing orders. The nurses must put the admitting orders as well as the standing orders in the chart and see that all the orders are carried out.
20. Don't explain surgical consents. It is the physician's responsibility to explain an upcoming medical procedure, answer the patient's questions and make sure the patient consents with actual understanding of what the patient is consenting to.
21. Don't chart "I left a message." Nurses have a duty to advocate for the patient. If you do not hear from the doctor, you have to call back, or call another doctor or ask your supervisor what to do.
22. Don't ignore mechanical or electronic recording devices.
23. Do be careful about cross charting. Be careful about time-specific charting in more than one patient's chart.
24. Do put copies in a patient's chart of materials given to patient. If you give a patient a brochure it is probably a good idea to put a copy of the brochure in the chart so there is a record of what you gave to the patient.
25. And finally do remember the Number One Rule, the Golden Rule. It deserves repeating. If you did not write it down, you did not do it. If you did not do it, you were negligent.

V. CONCLUSION

Nursing responsibilities have continued to increase greatly, and with that increase the potential for legal claims against professional nurses has increased as well. As a result, documentation has become increasingly more significant as a method of avoiding potential liability, and should be considered a prescription for avoiding legal liability.