



**Special Report:
How to Properly Document
to Reduce Your Liability Risk**

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Special Report: How to Properly Document to Reduce Your Liability Risk

Good documentation can help you defend yourself in a malpractice lawsuit, and it can also keep you out of court in the first place. You have to make sure it's complete, correct, and timely. If it's not, it could be used against you in a lawsuit.

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Legal Case Study #1:

Failure to Document – Death – \$500,000 Settlement

Ten days after being admitted to the hospital with a brain infarction, the patient was transferred to a rehabilitation facility. The next day the patient complained of cramping in left leg and pain in left heel. Physician ordered a heating pad applied to the affected leg.

The next day the leg appeared swollen and the patient experienced pain when trying to get out of bed. The LPN noted a positive Homans' sign, which may indicate the presence of a blood clot. The RN also got a positive response and reported it to the manager.

Believing that manager would notify the physician, the RN did not document the positive Homans' sign nor inform the next shift.

The following day the patient's calf appeared enlarged. The RN informed the physician who advised the patient to go to therapy. Later that afternoon the patient died.

The patient's estate sued for wrongful death. The RN who noted the positive Homans' sign testified that the manager was informed and that the manager would alert the physician. The nurse-manager testified that she didn't recall discussing the patient's condition with the RN.

The physician testified that he didn't recall the nurse-manager notifying him of the positive Homans' sign.

No documentation in the nurse's notes or the physician's orders supports the RN's claim that the physician was notified.

The jury decided in favor of the plaintiff and awarded \$500,000 in damages.

Appropriate nursing assessments aren't enough, if you don't document your findings.

The patient's death may have been averted if the RN had written "positive Homans' sign" in the chart.

8 Common Charting Mistakes to Avoid

Recording information in your patient's chart is an important part of your job as a nurse. There are many ways that charting mistakes can be made. By making yourself more aware of these eight common pitfalls, you can not only avoid making these mistakes but you can also avoid being involved in a lawsuit.

1. Failing to Record Pertinent Health or Drug Information:

Suppose the patient has a food or drug allergy or a disease such as diabetes or hemophilia. His caregivers need to know this information, but you inadvertently forget to chart it. You not only will endanger the patient, but you could end up in court.

2. Failing to Record Nursing Actions:

Record everything you do for a patient right away. You should chart what you observe and what you do as a result of the observation. Not charting something will impact the next shift. They will not know if the same observation is new or a change since you did not chart the observation. Also, timing is everything. Waiting too long to chart your actions means you have to rely on your memory, which can cause inaccurate or incomplete information.

3. Failing to Record that Medications have been Given:

Record every medication you give when it is given-including the dose, route and time. Failing to do so could result in a patient being over medicated, which could be terminal in some cases. If you are the one who observes that a medication is ordered and not charted as administered, question it. Make sure that the medication hasn't been given already so that you don't make the mistake of doubling up on the dose.

4. Recording on the Wrong Chart:

You can't be too careful in any situation that might lead to confusion between two patients. They could have the same last name, same room, same condition or even the same doctor. Always match the chart with the wristband of the patient before you do anything.

5. Failing to Document a Discontinued Medication:

If a patient is taken off a medication for any reason, you need to document that order promptly. Not doing so could result in serious complications for a patient, as well as for you if they decide to sue.

6. Failing to Record Drug Reactions or Changes in the Patient's Condition:

Monitoring the patient's response to treatment isn't enough. You should recognize an adverse reaction or a worsening of the patient's condition, then intervene before the patient is seriously harmed.

7. Transcribing Orders Improperly or Transcribing Improper Orders:

If you transcribe orders on the wrong chart or transcribe the wrong medication dosage, you can be held liable for any resulting injury. You can also be held liable if you transcribe or carry out an order as it is written, if you know or suspect the order is wrong. You should be familiar with the medications, procedures and activities you are responsible for to know when something isn't right. If you are not sure then ask. Questioning an order is better than making a mistake that could affect someone's health.

8. Writing Illegible or Incomplete Records:

For many nurses this mistake rarely causes a lawsuit, but in the midst of proceedings it can help add to the argument of inadequate care.

So, give your charting careful attention. Make sure you include everything you need to and accompany all documentation with your initials and the time and date. Taking the time to keep good, accurate charts could save you the need to defend yourself in court someday.

Legal Case Study #2:

Failure to Compare Written Record to Doctor's Prescription – Death – \$430,000 Combined Verdict.

A patient who'd sought treatment at a hospital clinic was given co-trimoxazole (trimethoprim-sulfamethoxazole, Bactrim), a sulfa drug. She was allergic to sulfa drugs, however, a fact noted in her written record but not on the computer-generated record the resident reviewed before prescribing the drug.

A day after taking the first dose, the patient became ill and sought treatment at another hospital. She died 16 days after of severe allergic reaction to co-trimoxazole. Her family sued the first hospital for the negligence of the discharge nurse (for failing to double-check the patient's chart), the pharmacist (for failing to cross-reference the patient's allergy history before dispensing a sulfa drug), and the medical-records clerk (for failing to include the sulfa allergy on the computer-generated chart).

At the trial, the family's expert witness testified that the discharge nurse should have compared the doctor's prescription with the patient's written record before sending the patient to the clinic's pharmacy to have the co-trimoxazole prescription filled. If she had, she would have discovered the discrepancy between the written and the computer-generated charts and notified the doctor of the patient's sulfa allergy.

Also, the discharge nurse never told the patient what to do if she had an adverse reaction to the drug. If she had, the expert said, the patient might have survived.

The judge found the hospital liable and awarded the patient's family \$200,000 (the doctor had settled out of court for \$230,000). The hospital appealed.

Although affirming the trial judge's verdict, the appellate court reduced the damages to \$100,000, the cap under the law.

Charting Checkup: You're on trial: How to protect yourself

IF YOU'RE NAMED in a malpractice suit that goes to court, your documentation could be your best defense...if your charting offers a full record of your patient care. How and what you documented—and what you didn't document—will greatly influence the trial.

Believable evidence

The outcome of a malpractice trial usually comes down to one simple question: Who does the jury believe? The patient presents evidence that he was injured because the nurse's care didn't meet accepted standards of care. In turn, the nurse presents evidence that she did provide acceptable care. But if for some reason her evidence isn't believable—and there can be many reasons why it isn't—the jury will accept the patient's evidence. The patient's attorney may then convince the jury that the nurse was negligent.

Was it negligence?

If the nurse did act negligently and her charting truthfully reflects the care she gave, the patient record will be the attorney's best evidence against her—as it should be. These cases are often settled out of court. But if the nurse wasn't negligent, a carefully and accurately charted patient record is her best defense.

The problem is that sloppy charting practices can make a nurse appear negligent even when she isn't. That's an important point for you to remember: If your charting is unclear, incomplete, or conveys a negative attitude toward your patient, the jury may perceive you as negligent, even if you gave your patient excellent care.

You can help protect yourself by knowing how to chart, what to chart, when to chart, and even who should chart. You should also know how to handle sensitive issues, such as difficult or uncooperative patients, and how to avoid misinterpreting medical records. Remember, it isn't only what you chart, but also how you chart that's important.

Keep it objective

Your charting should contain only what you see, hear, feel, smell, measure, and count, not what you think or conclude. If you chart information that's subjective, be sure to back it up with documented facts.

For example, don't record that a patient fell out of bed unless you actually see him fall. If you find the patient lying on the floor, record that. If the patient tells you that he fell out of bed, record that. If you heard a thud and went to the room and found the patient on the floor, record that (see Avoiding assumptions).

Describe events and behaviors clearly, without putting labels on them. Don't say that the patient was "saying strange things" or "acting weird" because this could mean something different to every member of the jury. Instead, record exactly what the patient said or did; don't comment on what you thought about it.

Be specific

Use only approved abbreviations, and document in quantifiable terms. If your patient is in pain, for example, don't just record that the patient appears to be in pain. Record why the patient is in pain: "Pt. requested pain medication after stating that she felt lower back pain radiating to her right leg, 6 on a scale of 0 to 10. No numbness or tingling, no edema. Color of extremity pink, temperature warm."

Remain neutral

Nothing can be used against you more easily than your own careless words. Unprofessional or inappropriate comments in a patient's record can make you look bad to a jury and give the patient's attorney plenty of ammunition against you. In one such case, an older adult patient developed pressure ulcers, which upset her family and made them feel that she was receiving inadequate care. The patient died of natural causes, but because her family was unhappy with her care, they sued. During the trial it was revealed that in her chart, under prognosis, the health care provider had written "PBBB," which stood for "pine box beside bed." Of course, when the jury learned this, they naturally found in favor of the patient's family.

Similarly, using words that suggest that your attitude toward your patient is negative can make you look bad. If you use unflattering words like obnoxious, bizarre, or drunk it's only too easy for the patient's attorney to convince a jury that you didn't like your patient, and, therefore, didn't take good care of him. If your patient is uncooperative, for example, don't chart that; record what he says or does and let the facts tell the story. "I attempted to give the patient his medication but he said, I've had enough pills. Leave me alone.' I attempted to find out why he wouldn't take his medication, but he wouldn't answer me. Patient's health care provider notified that he would not take medication." Likewise, you wouldn't simply record that your patient was drunk, but you would record results of a blood alcohol test or that the patient refused to consent to one. Nor would you say that a patient was violent or abusive without describing exactly what the patient said or did.

Keep the record intact

Be careful to keep patient charts complete and intact. A jury will be suspicious if you discarded pages from a medical record, even if you did it for innocent reasons, such as spilled coffee or a torn page (see The consequences of missing records).

If you must replace an original page with a copy, cross-reference it with a note like, "Recopied from page 4" or "Recopied on page 6." Make sure you attach the original page. If a page is damaged, note "Reconstructed charting" and attach the damaged page.

Jurors must be skeptical in order to do their job. Don't give them any reason to doubt you by discarding pages of a medical record or charting anything that is unclear.

Avoiding assumptions

Always record the facts about your patients, not your own thoughts or conclusions. In this example, the nurse didn't document the facts. Instead, she documented what she assumed happened when her patient fell. As a result, the patient's attorney made her look bad through his cross-examination.

Attorney: Would you please read your fifth entry from January 6?

Nurse: Patient fell out of bed ...

Attorney: Thank you. Did you see the patient fall out of his bed?

Nurse: No.

Attorney: Did anyone see the patient fall out of his bed?

Nurse: Not that I know of.

Attorney: So these notes reflect only what you assume happened to the patient. Is that correct?

Nurse: I guess so.

Attorney: Is it fair to say then, that you charted something as fact even though you didn't know that it was?

Nurse: I suppose so.

Attorney: Thank you.

The consequences of missing records

The case of *Battocchi v. Washington Hospital Center*, 581 A.2d 759 (D.C. App. 1990) illustrates the importance of keeping medical records intact. In this case, the plaintiffs sued the hospital and a health care provider for injuries sustained by their son during a forceps delivery.

The nurse documented the events and her observations of the delivery immediately afterward. Later, the hospital's risk management personnel obtained the chart but lost the nurse's notes.

The court ruled in favor of the hospital and health care provider, maintaining that the jury couldn't presume negligence and causation against them simply because the hospital lost the nurse's notes.

However, on appeal, the District of Columbia Court of Appeals sent the case back to the trial court so that the lower court could rule whether the hospital's loss of the records was a result of negligence or impropriety.

Selected references

Charting: An Incredibly Easy Pocket Guide. Philadelphia, Pa., Lippincott Williams & Wilkins, 2007.

Chart Smart: The A-to-Z Guide to Better Nursing Documentation, 2nd edition. Philadelphia, Pa., Lippincott Williams & Wilkins, 2006.

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Version: OvidSP_UI01.01.02, SourceID 35095

Top 10 Rules of Good Documentation

#1: Never alter a record. If you make an error mark through with one line, indicate correction made and initial/sign correction.

#2: Record only the facts. Chart only observed behavior.

#3: Do not chart critical comments or opinions.

#4: Begin each entry with time & end each entry with signature & title.

#5: Use only abbreviations in accordance with the facility's approved abbreviation list. Do not leave blank spaces.

#6: Record all entries legibly and in ink.

#7: Avoid using generalized phrases such as "the patient had a good day."

#8: Document circumstances and handling of errors.

#9: Chart only for yourself.

#10: Do not allow any unauthorized person access to a patient's medical record.

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