Stay out of court with proper documentation

By Sally Austin, JD, ADN, BGS

AFTER A LONG and difficult day at work, you try to remember if you documented everything that happened to your patients during your shift. You can't recall if you documented the stat drug that was prescribed for Mr. S, or all your attempts to reach Mrs. B's healthcare provider when her condition began to deteriorate. After a restless night, you decide to review yesterday's documentation, hoping beyond hope that you didn't leave anything out.

No matter how skilled or experienced you are, inaccurate or incomplete nursing documentation can mean serious trouble for your patients—and for you if you're ever involved in a lawsuit. This article provides practical guidelines to help you document your assessments and interventions completely, accurately, and concisely. Doing so not only improves patient care, but also shields you from legal fallout if something goes wrong.

The medical record is a legal document that has many functions (see Defining the medical record). Because this article focuses on its role in lawsuits alleging professional negligence, let's review some legal terminology.

Terms and concepts

Professional negligence is failure to provide the standard of care to a patient, resulting in an injury or damage to the patient. The person filing a negligence lawsuit (the plaintiff) must prove these four elements in order to prevail.

• A duty to the patient existed. Duty is established when you accept care of a patient under your scope of practice, licensure, and employment. It requires you to provide the standard of care that a reasonably prudent nurse would provide for a similar patient in a
similar circumstance. Factors that define the standard of care include the scope of nursing practice under your state’s nurse practice act, nursing accreditation bodies, applicable policies and procedures of the facility where you work, nursing certification, and acceptable treatment standards as outlined in current nursing journals and textbooks.

- **A breach of duty occurred.** This means the care rendered wasn’t consistent with what a prudent nurse would do in a similar circumstance. In a professional negligence case, the plaintiff must prove that care provided by a nurse was substandard by calling upon a nursing expert witness (or, in some states, a physician expert) to establish the appropriate level of care. The expert may rely on some or all of the sources stated above.

- **The patient was injured.** There are times when a nurse may perform duties to a patient in a manner that falls below the standard of care required but, even though an incident occurs with the patient, the patient isn’t injured. An example would be a patient receiving medication an hour late but not suffering any ill effects even though the medicine was given outside of the prescribed time.

- **The injury was directly caused by the breach of a standard of care.** At times, the foreseeability of harm comes into consideration when determining negligence. Should the nurse fail to provide care that’s within the recognized standard of care (failed to give a dose of an antibiotic) but the patient experiences an injury unrelated to the nurse’s failure (patient tries to stand despite being instructed to stay in bed and falls, fracturing a hip), this element wouldn’t be proven. The plaintiff must prove a direct connection to the nurse’s failure to provide care within the recognized standard (for example, that missing the dose of the antibiotic set back the patient’s recovery from infection).

In a professional negligence lawsuit, the plaintiff is required to prove all four elements through an expert witness unless a written standard of care speaks for itself. Typically the expert is another nurse with a similar skill set or similar expertise in the standard of care as that of the defendant nurse. The expert will look at the nursing documentation for clues and evidence that the care rendered wasn’t consistent with appropriate nursing care in order to form an expert opinion.

If the plaintiff proves all four elements, damages will likely be awarded to compensate the plaintiff for economic losses (medical costs, lost wages) and noneconomic losses (pain and suffering).

### Avoid documentation pitfalls

When reviewing the medical record, the plaintiff’s attorney looks for facts to prove each of the four elements. See Waving red flags for documentation mistakes that are sure to catch an attorney’s attention.

Many common documentation errors, such as illegible handwriting, have been eliminated or minimized by electronic medical records (EMRs). But not all facilities have fully adopted EMR systems, so documentation may include both electronic and handwritten entries.

Even a fully integrated EMR doesn’t eliminate potential documentation pitfalls, however. Although it helps establish consistent documentation practices, it’s still up to you to properly document your nursing assessments and patient care. Take care to follow these guidelines to prevent a plaintiff’s attorney from raising questions about the quality of care you gave your patient.

**Be objective.** Perform assessments using your senses of touch, sight, hearing, and smell, and document facts, not your subjective opinions. To avoid bias when documenting a patient’s statements, document the patient’s exact words using quotation marks.

Never use labels to describe a patient or a patient’s behavior. Words such as obnoxious, belligerent, or rude might lead to serious allegations of defamation or let an attorney argue that you didn’t like taking care of your patient, resulting in substandard nursing care. Rather than attaching labels, simply describe the patient’s behavior using direct quotes when appropriate. An example of documenting a patient’s rude behavior might look like this:

> **Upon entering the patient’s room, patient stared at me with what appeared to be an angry expression. Upon asking the patient how he was feeling this morning, he responded in a very loud voice, “Get out of my room and don’t come back. You’re always interfering with visitor time.”**

If the patient refuses prescribed treatment, document the refusal, including the patient’s stated reason, if provided, and your actions, such as patient teaching and notifying the healthcare provider. A patient who refuses to accept treatment recommendations may bear partial responsibility for a subsequent injury (contributory negligence). The patient’s contributory negligence can mitigate the damages and reduce your portion of a damage award or, in some cases, the defendants might
be exonerated based on the degree of the patient's contributory negligence.

**Document at the same time as your assessment and/or treatment.** Make sure to date, time, and authenticate each entry with your signature and professional credentials as close as possible to the time you performed an assessment or intervention. Any lag in documentation undermines patient safety.

Here’s an example: Let’s say you just gave your patient pain medication and the charge nurse tells you to take your lunch break. You ask a colleague to monitor your patient while you’re on break. You advise her that the patient is stable, but you leave without documenting your administration of the medication. While you’re at lunch, the patient asks your colleague for something for the pain. Checking the EMR, your colleague sees no documentation of the drug dose you administered before leaving and administers an additional dose of opioid. This error could have been avoided had you documented the pain medication administration and informed your colleague.

**Avoid gaps in the medical record.** Adoption of an EMR should help eliminate gaps in the medical record because you’re prompted to document what’s considered standard for your facility. However, when the EMR isn’t available (or in situations where an EMR hasn’t been adopted), you’ll have to revert to written documentation. Gaps in the patient’s medical record let someone else create the rest of the story.

A common documentation error is to leave space to accommodate late documentation. If the space is too small and subsequent documentation is squeezed in, an attorney reviewing the record could allege that the squeezed documentation was added to try to cover up something. If the space is too large, blank space remains unaccounted for. All documentation should follow your facility’s policy, if the facility provides a means for providing late entries, follow that policy and document accordingly.

**Follow your facility’s documentation policies.** Deviating from your facility’s standards can lead to mysteries in the medical record and create liability exposure when none is warranted. In addition to documentation style (such as documentation by exception, Problem-Intervention-Evaluation [PIE] charting, and so on), facilities also establish policies regarding the documentation of late entries and correcting entries. When a late entry is made several days after the date it should have been made, include a rationale for the delay. Any late entry must follow the format established by your facility. A facility may limit the time period when the entry can be made. If it’s being made late, it should be labeled “late entry.” It could be difficult to document late entries into the EMR depending on when the facility determines to close the medical record from further entries. A good practice is to stay current with all policies that affect documentation of patient care to ensure that the documentation reflects the care provided.

**Document adverse events properly.** Everyone’s goal is to provide safe patient care without incident, but adverse events still occur. Should one of your patients experience an adverse event, follow your facility’s policies and procedures for documenting an adverse event. Document relevant clinical facts related to the adverse event in the medical record; for example, your assessment of the patient’s condition, prescribed treatment, nursing and medical interventions, and the patient’s response. Never document in the medical record that an event report was filled out, and never document the alleged cause of the event. This is better documented on the event report.

More in-depth investigation and documentation may be required by your facility, which should have a policy on when to complete an event report and what should be documented on the form. In general, event reports request information on what happened to the patient/visitor to cause the adverse event. It’s a place to document the findings of the investigation: what happened, why it happened, what harm was done, what responses were made, and what changes are required to prevent a similar event in the future. Event reports generally go to risk management for use in determining any policy changes required to eliminate future risk and in education to avoid similar errors.

**Cases in point: Avoid these errors**

The following cases illustrate how documentation errors can lead to allegations of a failure to meet the standard of care.
Scenario 1: Failure to communicate and monitor
Mr. S died while a patient in the hospital.1 His death was attributed to obstruction of his endotracheal (ET) tube by a mucous plug. Following his death, Mr. S’s family brought a professional negligence action against the hospital and some of its nurses and respiratory therapists. The allegations against hospital nursing staff were failure to suction the ET tube and failure to communicate breathing difficulties to the patient’s healthcare provider.

Before his death, Mr. S began experiencing breathing difficulties at least as early as 2000. He’d written a note to visiting family members that he was having difficulty breathing, and a family member shared the note with a nurse. The ET tube was suctioned once at 2200. The patient’s difficulty breathing continued, and by 0200 he was gasping for air. A healthcare provider who arrived at his bedside at 0230 was unable to ventilate Mr. S because a mucous plug had formed at the end of the ET tube. Mr. S died from cardiac arrest due to the airway obstruction.

The plaintiff’s expert, a physician, testified that the nurse breached the standard of care by not appropriately suctioning the ET tube and failing to communicate the patient’s breathing difficulties to his healthcare provider. The jury found for the plaintiff.

Lessons to be learned: A nurse is responsible for knowing and following the recognized standard of care. In this case, the standard required suctioning of the ET tube to avoid or remove the mucous plug. The nurse also had a duty to monitor the patient and immediately alert the healthcare provider of the patient’s breathing difficulty and the note he’d written communicating his difficulty. Because nothing in the medical record indicated that the nurse had done these things, she had no defense against the allegations.

Scenario 2: Medication errors
In this case, parents filed a medical negligence case against a hospital for their baby’s death.2 The issue here involved a nurse administering a high-risk drug.

Baby D was born with a heart defect and underwent surgery to correct it. Following surgery, he experienced cardiac dysrhythmias. When other efforts to treat the dysrhythmias failed, a physician prescribed digoxin, a drug with a narrow therapeutic window that can raise serum potassium levels. Because digoxin is a high-risk drug, the hospital controlled access to it, permitting it to be acquired only through a special dispensing machine that required a user name and password.

Baby D was to receive 450 mcg of digoxin. The initial dose was to be 225 mcg followed by two doses of 112.5 mcg over 2 days. A nurse obtained an ampule of digoxin and administered the initial dose, but incorrectly charted it as 225 mg (not mcg). That this was simply a documentation error wasn’t disputed; the ampule contained only 500 mcg. However, the amount given couldn’t be calculated by the amount that remained in the ampule because the unused drug had been destroyed as required by policy. Digoxin doesn’t require a destruction record, so no evidence existed to prove the facts.

Baby D’s potassium level, which was high to begin with, became even higher and he went into cardiac arrest and died soon after receiving the initial dose of digoxin. Autopsy blood tests indicated elevated potassium levels that could be consistent with a digoxin overdose. Baby D’s parents filed a medical negligence case for failure to properly monitor his condition and for administering an overdose of digoxin.

In testimony at the trial, the nurse stated that she’d calculated the dose. She also testified it’s her facility’s policy to require double-checking the dose of certain drugs, including digoxin, before administration. She testified it was her practice to have another nurse check the dose before administering these types of high-risk drugs. The trial ended with a verdict for the plaintiff, awarding $2 million in damages. The hospital appealed, and the appellate court found that the trial court committed a reversible error in not permitting the hospital’s nurse to testify in person before the jury. A new trial was granted.

Lessons to be learned: Allegations of medication errors are one of the most common causes of negligence lawsuits involving nurses. Know and consistently follow your hospital’s medication administration policies and procedures, particularly regarding high-risk medications. If the error in documentation had been found before the initiation of a lawsuit, the nurse who made the documentation error could have made a correction entry and the nurse who provided the double-check could have documented her findings as well, following facility policy and procedure for late entries. If the facility requires that an event report be completed for making the correction...
entry, then such policy should be followed. This might have helped protect the nurse and hospital from the parents’ negligence claim.

**Scenario 3: Discharge error**

Mrs. R raised allegations against her physician for negligently performing a nerve block and against the hospital and nursing staff for failing to properly monitor her and negligently discharging her from the hospital. She claimed that these errors led to her suffering a stroke.

Mrs. R underwent a C2 nerve block for treatment of migraine headaches. Following the procedure, she was taken to the postanesthesia care unit and monitored by the nurse on duty. After 1 1/2 hours, the nurse told Mrs. R to give try to sleep in a dark room, fill her anti-inflammatory prescription, and call back if she had further problems. Later that evening, Mrs. R developed trouble breathing and walking. Upon losing consciousness, she was taken to the ED of another hospital where she was diagnosed as having had a stroke. She underwent a craniotomy.

The question in this case is whether the nurse Mrs. R spoke with on the phone advised Mrs. R’s physician that she’d called with the complaints noted above. No documentation indicated that she did. According to testimony from a medical expert, the nurse should have advised the patient to go to an ED when she called in with her complaints.

**Lessons to be learned:** This case points out the importance of documenting conversations with a patient who calls in with issues shortly after discharge. Documentation establishing that the nurse had spoken with the patient’s physician could have gone a long way in warding off allegations of negligence against the hospital and the nurse.

**Think like a jury**

As these cases demonstrate, properly documenting the care given to a patient and following facility policies and procedures can go a long way toward helping you defend your actions if you’re ever named in a lawsuit—or avoid legal problems altogether. The care you take in documenting nursing assessments and interventions could prove you met the standard of care and establish your credibility with a jury.

**REFERENCES**


Sally Austin is Assistant General Counsel at Children’s Healthcare of Atlanta in Atlanta, Ga. The author has disclosed that she has no financial relationships pertaining to this article.

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