25 Legal Dos and Don'ts of Nursing Documentation Transcript

www.TheHealthLawFirm.com

THE HEALTH LAW FIRM

Main Office:
1101 Douglas Avenue
Altamonte Springs, Florida 32714

Phone: (407) 331-6620
Fax: (407) 331-3030

Website: www.TheHealthLawFirm.com

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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 ¾ 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.

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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?

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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.

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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.

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5. Don’t blame yourself. Again, that is jumping to conclusions.

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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

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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.

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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.

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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.

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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.

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11. Don’t chart something about one patient in another patient’s chart.

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12. Don’t chart anything that is false

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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.

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14. Don’t complain in a patients chart

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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.

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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.

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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.

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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.

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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.

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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.

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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.

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22. Don’t ignore mechanical or electronic recording devices.

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23. Do be careful about cross charting. Be careful about time-specific charting in more than one patient’s chart.

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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.

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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