The Legal Issues of Documentation: Protect yourself and the patient

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Why is accurate and adequate documentation important?

- Protects you
  - Licensing
  - Liability
- Protects the patient
  - Safe from harm
  - Quality care
  - Accurate diagnosis and treatment
The 5 “rights” of Medication Administration

- Right patient
- Right drug
- Right dose
- Right route
- Right time

http://www.ihi.org/resources/Pages/ImprovementStories/FiveRightsofMedicationAdministration.aspx
## Official “Do Not Use” List

<table>
<thead>
<tr>
<th>Do Not Use</th>
<th>Potential Problem</th>
<th>Use Instead</th>
</tr>
</thead>
<tbody>
<tr>
<td>U (unit)</td>
<td>Mistaken for &quot;0&quot; (zero), the number &quot;4&quot; (four) or &quot;cc&quot;</td>
<td>Write &quot;unit&quot;</td>
</tr>
<tr>
<td>IU (International Unit)</td>
<td>Mistaken for IV (intravenous) or the number 10 (ten)</td>
<td>Write &quot;International Unit&quot;</td>
</tr>
<tr>
<td>Q.D., QD, q.d., qd (daily)</td>
<td>Mistaken for each other</td>
<td>Write &quot;daily&quot;</td>
</tr>
<tr>
<td>Q.O.D., QOD, q.o.d, qod (every other day)</td>
<td>Period after the Q mistaken for &quot;I&quot; and the &quot;O&quot; mistaken for &quot;I&quot;</td>
<td>Write &quot;every other day&quot;</td>
</tr>
<tr>
<td>Trailing zero (.X mg) * Lack of leading zero (.X mg)</td>
<td>Decimal point is missed</td>
<td>Write X mg</td>
</tr>
<tr>
<td>MS</td>
<td>Can mean morphine sulfate or magnesium sulfate</td>
<td>Write &quot;morphine sulfate&quot;</td>
</tr>
<tr>
<td>MSO₄ and MgSO₄</td>
<td>Confused for one another</td>
<td>Write &quot;magnesium sulfate&quot;</td>
</tr>
</tbody>
</table>

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1 Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

*Exception:* A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.
Documentation “Do’s”

- Date and time each entry
- Write or print legibly
- Use permanent black ink
- Use only agency approved abbreviations and symbols
- Write objectively and without bias
- Be clear, concise and specific
- Be specific e.g. size, shape, amount
- Sign all notes (first initial, last name and title e.g. H.Hurst RNC)
- Correcting errors
  - One straight line – write “error” above it, initial and date
- Late entries
  - Clearly state the date and time the late entry was made. Begin with the words “late entry”
SOAP Notes

- Consistency
- Expansion of the chief complaint
  - Onset
  - Duration
Pain Assessment

- Pain (WILDA)
  - **W**ords to describe pain
  - **I**ntensity of pain
  - **L**ocation of pain
  - **D**uration of pain
  - **A**ggravating/alleviating factors
**PAIN ASSESSMENT GUIDE**

**Tell me about your pain**

<table>
<thead>
<tr>
<th>Words to describe pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>aching</td>
</tr>
<tr>
<td>throbbing</td>
</tr>
<tr>
<td>gnawing</td>
</tr>
<tr>
<td>sharp</td>
</tr>
<tr>
<td>tender</td>
</tr>
<tr>
<td>burning</td>
</tr>
<tr>
<td>exhausting</td>
</tr>
<tr>
<td>nagging</td>
</tr>
<tr>
<td>tender</td>
</tr>
<tr>
<td>burning</td>
</tr>
<tr>
<td>penetrating</td>
</tr>
<tr>
<td>miserable</td>
</tr>
<tr>
<td>unbearable</td>
</tr>
<tr>
<td>squeezing</td>
</tr>
<tr>
<td>deep</td>
</tr>
<tr>
<td>deep</td>
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<tr>
<td>deep</td>
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<td>deep</td>
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<tr>
<td>deep</td>
</tr>
</tbody>
</table>

**Pain in other languages**

<table>
<thead>
<tr>
<th>Language</th>
<th>Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Japanese</td>
<td>itami</td>
</tr>
<tr>
<td>Chinese</td>
<td>tong</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>dau</td>
</tr>
<tr>
<td>Spanish</td>
<td>dolor</td>
</tr>
<tr>
<td>French</td>
<td>douleur</td>
</tr>
<tr>
<td>Russian</td>
<td>bolno</td>
</tr>
</tbody>
</table>

**Intensity (0-10)**

If 0 is no pain and 10 is the worst pain imaginable, what is your pain now? ... in the last 24 hours?

**Location**

Where is your pain?

**Duration**

Is the pain always there? Does the pain come and go? (Breakthrough Pain) Do you have both types of pain?

**Aggravating and Alleviating Factors**

What makes the pain better? What makes the pain worse?

**How does pain affect**

sleep  energy  relationships
appetite activity  mood

**Are you experiencing any other symptoms?**

nausea/vomiting  itching  urinary retention
constipation  sleepiness/confusion  weakness

**Things to check**

vital signs, past medication history, knowledge of pain, and use of noninvasive techniques
Errors of Omission

“Omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.”

The NP/MD orders an antibiotic ointment be applied to a wound before application of a dressing and the nurse forgets to do it.
Errors of Commission

An act of commission (doing something wrong) that leads to an undesirable outcome or significant potential for such an outcome.

For instance, administering a medication for a patient with a documented allergy to that medication would be an act of commission.
Standard of Care

- Whether an “Error of Omission” or an “Error of Commission” BOTH error types reflect a deviation from the “Standard of Care”
- Standard of Care – Adhering to established professional standards that a prudent and reasonable nurse would exercise under the circumstances
ANA Standards of Practice

Assessment – The nurse collects comprehensive data pertinent to the patient’s health or situation

1. Collects data in a systematic and ongoing process.
2. Data collection involves the patient, significant others, and health care providers, when appropriate.
3. Priorities data collection activities based on the patient’s immediate condition or needs determine the priority of data collection.
5. Document relevant data in a retrievable form.
ANA Standards of Practice

- **Diagnosis** – The nurse analyzes the assessment data to determine the diagnoses or issues
  1. Derives diagnoses from the assessment data
  2. Validates the diagnoses with the patient, significant others, and health care providers when possible
  3. Documents diagnoses in a manner that facilitates the determination of expected outcomes and plan of care

The “Do Nots of Documentation”

- Don’t document care *before* you give it
- Don’t leave blank spaces
- Don’t use vague terms
- Don’t use personal opinions
- Don’t use slang terms
- Don’t leave blank lines between entries
- Don’t use white out or obliterate entries
Legally:
Common Mistakes to Avoid

- Failing to record health or drug information
- Failing to record nursing actions
- Recording on the wrong chart
- Failing to document a discontinued medication
- Transcribing orders improperly
- Illegible or incomplete records.
Recent Louisiana Cases

- *Washington v. Waring* (2014) - Failure to report premature infant’s condition was not cause of premature infant’s death

- *Johnson v. Ray* (2012) - Failing to notify charge nurse or physician in change of patient’s condition – Hospital and nurse found liable ($1.3 Million Judgment)
Recent Louisiana Cases

- **Johnson v. Morehouse G.H. (2011)** - Failing to timely notify OB/GYN of lab test results and abnormalities in fetal heart rate was below standard of care

- **Harris v. St. Tammany Parish Hosp. (2011)** – Failure to chart medication

- **Benefield v. Sibley (2008)** – failure to notify physician of patient’s abnormal breathing was cause of patient’s embolus and death
Consequences

- “Failure to document administration of treatments or medications can impact patient safety”
- Effect – “the next shift coming on” lacks knowledge of “whether or not the [patient] received the care that was prescribed by the physician”
- Could result “in repeated and unnecessary administration” of treatment or medications
Even if you win, you still lose

- Failure to properly document the file every time increases the odds that:
  1. You and your employer will be exposed to claims that your actions were below the standard of care
  2. Plaintiffs will hire nurses to review your records for errors
  3. You may have to testify at deposition or at trial
On the lighter side

- “She has no rigors or shaking chills, but her husband states she was very hot in bed last night.”
- “The patient is tearful and crying constantly. She also appears to be depressed.”
- “Skin: Somewhat pale but present.”
- “She is numb from her toes down.”
- “Patient has chest pain if she lies on her left side for over a year.”
- “The patient has no previous history of suicides.”
- “The skin was moist and dry.”