Documentation of Patient Care – It is Your Best Defense Against Allegations of Professional Negligence

written by Nancy Brent | August 31, 2012

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By now I'm sure you are "sick and tired" of hearing that accurate, complete and timely documentation is your best defense against allegations of professional negligence. Well, despite your reaction to hearing it, this is a true statement. Documentation of patient care, whether in narrative form or in an electronic format, is an essential component of patient care and an invaluable risk management tool from a defensive perspective.

There are many court cases that have been won or lost based on nursing documentation. For example, in Crawford v. Beth Israel Medical Center (1), the patient, who had just had a coronary bypass graft procedure, which required the placement of clips during the surgery, left the OR for the PACU/ICU between 2:45 pm and 2: 50 pm. Dr. Hoffman, one of the surgeons, checked the clip placement several times in the OR with no bleeding noted and stayed in the OR until the chest was closed. He then dictated his OR report and left the hospital for a meal.

At 2:45 pm, the patient's BP was 115/70. However, shortly after, the attending nurse realized Mr. Crawford had a "precipitous" blood pressure drop and knew he was hemorrhaging internally. (2) The surgeon returned to the hospital about the time the hemorrhaging began. He was paged and he and a colleague treated the patient in the ICU and the patient was then transferred back to the OR.

The nurse's note, timed at 2:45 pm, summarized what had occurred with the patient, as did a 3:00 pm note on the Cardiac Surgery Flow Sheet which indicated that the patient had been sent back to the OR. This time line corresponded with the OR log which reflected the patient returned to the OR at 3:05 pm, with OR nurses already assembled there at 3:00 pm.

The doctor's note about the incident, however, indicated that the patient's bleeding was discovered at 3:00 pm, not at 2:45 pm as documented by the attending nurse. The patient survived this event, but died at home after being admitted to another facility twice, then discharged, for an infection of his valve annulus.

Prior to his death, Mr. Crawford and his wife filed a professional negligence case, with additional allegations, against Beth Israel Hospital and the physicians and nurses involved in Mr. Crawford's care. After his death, the case was amended to include a wrongful death count, alleging that the Hospital

failed to timely diagnose and treat Mr. Crawford's infection.

Except for Dr. Harris, the defendants moved for summary judgment (dismiss the case without a trial) because the case was filed after the statute of limitations for ran to file the case against them.

The Supreme Court of New York County held that the statute of limitations did prohibit the case from going forward against all defendants but Dr. Harris. The case against the surgeon for the additional allegations of wrongful death and lack of informed consent were also dismissed. However, the surgeon's failure to eliminate the issue of timeliness in dealing the patient's post-operative bleed should proceed to trial. (3) In short, the reliance on the nursing notes created an issue of fact that could only be resolved by a full trial.

In another case focusing in on nursing documentation, the nurse's notes supported a decision against the medical center in which the nurses worked and cared for an elderly man. (4) Mr . Meier , 81 years old, was admitted to Columbia Medical Center for abdominal pain which required surgeries for gallstones and a bowel obstruction. His condition deteriorated after the surgeries and he was admitted to the ICU with adult respiratory distress syndrome and septic shock, among other medical conditions. He was given a sedative and put on a ventilator and a DNR order was written. Shortly thereafter, he developed a decubitus ulcer on his tailbone. (5)

Four weeks later, Mr. Meier was transferred to a rehabilitation facility after his decubitus ulcer improved. While there, Meier developed decubitus ulcers on his heels. The patient was then sent to a VA facility, from which he was discharged. Even though the decubitus ulcer healed on his tailbone, it was "hard and painful" and was no longer able to perform many of the things he could do before the hospitalization.

Mr. Meier brought a suit against the Medical Center due to the negligence of its nurses to prevent the decubitus ulcer on his tailbone. The jury returned a verdict in favor of Mr. Meier. The Medical Center appealed.

The appellate court record detailed the testimony of a nurse expert witness for Mr. Meier. She testified that skin assessments and pressure sore relief is to be provided every two hours and that documentation of this assessment and relief is required.

The nurse expert further testified that the standard of practice in attempting to provide pressure sore relief includes turning the patient and re-positioning the patient with foam wedges or pillows. She also testified that "specialty beds" existed for patients when a patient cannot be re-positioned or turned. If a full turn of the patient is not possible, then the patient's "bony prominences" must be protected with, again, foam wedges or pillows. If a patient cannot be re-positioned or turned, there must be documentation in the patient record indicating why this care did not occur. (6)

In addition, the nurse expert further explained the standard of practice for assessing a patient's skin and ulcer status. A detailed description of the decubitus ulcer must be included in the notes so that

anyone reading it can “draw a mental picture of what the nurse [caring for the patient] saw. Likewise, charting should include the color, location, size, depth, presence or absence of infection, and whether the tissue was dead or perfused. (7).

In short, the nurse expert testified, the nurses’ failure to provide required care was the direct and proximate cause of the formation of Mr. Meier’s decubitus ulcer.

The court pointed out that the patient’s ICU record had no documentation that the interventions testified to by the nurse expert witness occurred. Likewise, the court continued, the physician should have been notified at once at the onset of the decubitus ulcer rather than, in this case, waiting until the next day to inform Mr. Meier’s doctor of his condition.

The doctor did order a wound- care nurse consult and a special pressure bed for Mr. Meier. The wound care nurse did not see the patient until three days after the report was written. The special bed was never obtained for Mr. Meier.

Last, the court stated, whatever the wound-care nurse specialist ordered was never documented in the patient’s record nor was there any documentation that her orders were being carried out.

A jury verdict of $240,000.00 at the trial was upheld by the Appeals Court.

These cases are but two examples of where nursing documentation was helpful and where the lack of nursing documentation—indeed, the lack of nursing care—was the basis for the facility’s liability. Although each and every principle of good documentation is beyond the scope of this Bulletin, some general principles should be kept in mind at all times when documenting the care you provide. They include:

- Document nursing care factually, fully, accurately and timely;
- Document the date, time, and details of any notification to a physician or other health team member, of the patient’s condition, including any orders for medication changes, changes in care plans, and the ordering of special equipment;
- Document your nursing assessment of the patient and his condition;
- Date, time and sign every entry pursuant to your facility policy;
- A patient’s responses to treatments, medications, and patient teaching, as examples, must be thoroughly documented;
- If nursing care was not provided, or the patient refused a treatment or medication, document this and who was contacted about the non-treatment or refusal;
- Don’t leave blank spaces in nursing narrative notes, flow sheets, or electronic forms;
- Use only facility accepted abbreviations that are used consistently throughout the facility;
- Don’t use the patient’s medical record to air grievances about other staff members, the patient, or the patient’s family; and
- Remember, if care wasn’t documented, you are going to have a very difficult time convincing a

jury or the board of nursing, for example, that the care you reportedly gave *did* take place.

There is a wealth of information available to you about nursing documentation and it would be helpful to review that information on a regular basis. Texts on nursing documentation alone are quite numerous. Some examples include Lippincott Williams & Wilkins' *Nursing Know-How: Charting Patient Care (2008)* and *Complete Guide To Documentation (2007)*.So, too, are articles in nursing journals, especially as documentation pertains to specialty nursing practice. A general article for review is Sally Austin's 2011 article, "Stay Out Of Court With Proper Documentation", 41(4) Nursing 2011, 24-29 (CE Module).

The next time you are documenting your care of a patient, keep in mind one thing: someone outside of the facility—an attorney for the patient, the surveyor of the state public health department, a board of nursing member, or a nurse expert witness for both sides in a lawsuit—may someday read your entry. You want to ensure that the quality care you gave was what the patient needed and that you met your standards of practice, and the standard of care, for that patient.

FOOTNOTES

1. 2008 NY Slip Op 51934U [21 Misc 3d] 1103(A). The entire case can be found at http://law.justia.com/cases/new-york/other-courts/2008/2008-52282.html . Accessed September 14, 2012.
2. Id., page 3
3. Id., page 7.
4. Columbia Medical Center Subsidiary, d/b/a North Carolina Medical Center v. Meier,

198 S.W. 3d 408 (Ct. of Appeals, Dallas, Texas) (2008).

1. Id., at 409.
2. Id., at 415-416.
3. Id.