Documentation Pitfalls: How to Protect Your License and Avoid Liability

Lisa M Soltis, MSN, APRN, RN-BC, PCCN-K, CCRN-CSC-CMC, CCNS, CES-A, FCNS, FCCM

Lisa.Soltis@yahoo.com

Objectives

- Discuss documentation pitfalls with electronic medical records
- Describe reportable and potentially reportable nursing actions as they relate to patient care
- Outline best practice recommendations to prevent legal recourse

Documentation

- Record of the patient's hospital course and treatments
- Serves as primary source of communication
- Facilitates the continuity of care
- Determines whether the standard of care was met
- Regulatory accreditation and credentialing requirements
- Financial reimbursement purposes
- Quality assurance assessment

Significance of Documentation

- Increased awareness and newsworthy presence
- CMS annual updates to coding & documentation
- Post-event templates
    - Falls, ADEs, Wounds, HAIs, Sentinel events
- Documentation toolkits

Standards are Determined by…

- State Nurse Practice Act/State Laws
- Regulatory requirements
- Accrediting bodies (TJC)
- Specialty nursing organizations (AACN, ASPEN)
- National professional standards (ANA)
- Policies and procedures within your organization

Documentation DO's

- Be Thorough
- Be Objective
- Be Accurate
- Be Timely
- Follow the Nursing Process
- Reflective of Nursing practice
- Maintain Confidentiality
- Meaningful

- Follow organizational policies and procedures for documentation, assessment, and safety interventions
    - Late entries/error corrections
    - Confidentiality
    - Downtime procedures
    - Approved abbreviations
    - Refusal of treatment
    - Safety and comfort measures taken
    - Adverse events

Documentation Don'ts

- Don't point fingers or place blame
- Don't document for someone if possible
- Don't record false information
- Don't document in advance of events/care
- Don't copy and paste notes from shift to shift
- Don't document completion of an incident report
- Don't document a change in condition or relevant symptom without an intervention
- Don't say you made an error, just state the facts
    - morphine 4mg IV administered, morphine 2mg IV ordered, Dr. Smith notified

Other tips

- Pertinent negatives demonstrate understanding of disease process
- Shows knowledge of the standard of care for that particular disease
- Demonstrates critical thinking strategies
- Should be reflective the Plan of Care as well

Charting by Exception

Pros	Cons
• Decreases charting time • Reduces risk of transcription errors • Standardizes assessments • Makes trends in patient status more visible	• Requires development of clear guidelines and standards • Must be well understood by users to be effective • May lead to omissions in documentation or appear less credible

Charting by Exception Tips

- Complete all boxes that are applicable only
- Patient's must meet ALL criteria to be considered WNL/WDL
    - If not, then address in appropriate box/narrative sections
    - Description of what is abnormal, presence or absence or related symptoms, and any action taken

- Narrative notes should be done…..
    - Patient admission, transfer, discharge
    - Patient leaves, or returns from procedures
    - Change in patient condition
    - Nurse/provider communications
    - Family/patient voices concerns
    - Potentially contributing patient acts
    - Anytime you think it's appropriate to chart more

Documentation should be reflective of the nursing process!

Follow Hospital Policy

- Plan of Care reassessment
- No change from previous assessment….
    - Only if it is your assessment!
- Copy & Paste Risks
    - Repetition of expired, irrelevant, or incorrect data
    - Excessive notes detracts from essentials facts
    - Can negatively impact reimbursement and billing
    - Data should only reflect the specific actions/work of the provider documenting

Negligence

- Conduct that falls below the standards of behavior established my law for the protection of others against unreasonable risk of harm
- A person has acted negligently if he/she has departed from the conduct expected of a reasonably prudent person acting under similar circumstances.

Elements of Negligence

- Duty to provide care to patient and to provide acceptable standard of care
- Failure to adhere to standard of care
- Failure to follow standard of care led to patient injury
- The patient suffered damage/injury from negligent actions

Proving Negligence

- The Plaintiff has the burden of proving that the defendant did not act as a reasonable person would have acted under similar circumstances
- Expert Witnesses used to establish the "Standard of Care"

Most Common Treatment & Care Allegations

1. Failure to recognize and/or rescue
2. Failure to follow hospital policies and protocols
3. Failure to monitor and timely report changes in patient condition.
4. Delay in implementing orders
5. Failure to use the chain of command

According to NSO

- Death is the most common outcome that leads to a negligent lawsuit (40.9%)
- Documentation deficiencies were contributing factors in many nurse professional liability claims and State Board of Nursing matters
- In both the 2015 and 2020 claim reports, many of the nursing malpractice claims related to medication administration were difficult to defend secondary to “work arounds” in the care environment

Reasons for Errors

- Incomplete patient information
    - Allergies
    - Complete and accurate list of home medications
    - Diagnoses
- Miscommunication of orders
    - Look a like, sound a like meds
    - Verbal orders
    - Orders on wrong patient
    - Confusion of dosing units

Independent Double Check

- Take it a step further for Safety!
- TEAM checks (Together Everyone Avoids Mistakes)
- Cognitive review of the appropriateness of the medication, dose, route, etc.
- Does the drug indications match the patient’s diagnosis or condition?

Chain of Command

- A specific course of action involving administrative and clinical lines of authority established to ensure effective conflict resolution in patient care situations.

Purpose

- To clarify a care management plan
- To resolve a conflict involving patient care
- To obtain necessary care interventions
- To advocate on behalf of the patient
- To support patient safety and risk management

Chain of Command Documentation

- Factual and objective
- Record orders received and carried out
- Clearly document the patient’s response
- Avoid blaming others in the medical record

Teamwork

- Remember to focus on the PATIENT!
- Team members must interact in a positive way to achieve a common goal. Respond to facts, not emotions.

- Negative team factors include:
    - Communication breakdown
    - Competing priorities
    - Poor coordination of patient care activities

Patient Safety

- Prevention is focused on the design of system that can prevent errors, safety measures that won't allow you to make a mistake
- "We cannot change the human condition, but we can change the conditions under which humans work."

Communication is critical

- SBAR communication
- Handoffs/change in provider
- Paging/texting
- Verbal orders

Protect yourself…..

- Follow your employer policies
- Promptly report any identified breach of confidentiality or privacy
- Do not make disparaging remarks about patients, coworkers, or employers
- Don't leave any printed documents unattended
- Log out when you leave your computer

Protect your Practice

- Know and comply with scope of practice and institutional policy and procedures
- Follow documentation standards
- Develop strong written and verbal communication skills
- Perform ongoing assessment and monitoring
- Maintain clinical competencies
- Invoke chain of command when appropriate

Deposition

The taking of sworn (under oath), out-of-court oral testimony of a witness that may be reduced to a written transcript for later use in court or for discovery purposes.

Prior to the actual trial date allows attorneys to develop insight regarding the potential witness' temperament, ability to answer and comprehend questions, as well as the overall impression that may be conveyed to jurors should the witness testify.

Deposition Tips

- Be prepared
    - Review the facts and refresh your memory
    - Review the areas of strength for your case
    - Listen to tips for managing the weaker areas
- Most Importantly… Be Truthful!

- Take your time, think before answering.
    - Listen to the entire question before starting to answer.
- Try not to volunteer information or give testimony to something that wasn't asked.
    - Your duty is to tell the truth and answer only what was asked.
    - Yes and No are complete sentences!
- Make sure you understand the question. Ask for clarification if you don't.
- You must tell the truth, even if you think it will hurt your case.
    - Getting caught being untruthful is far worse than any harm caused by being truthful.
- Silence and breaks
    - You can ask for a break when you need it.
    - Stay silent between questions
- Don't bring documents or notes of any kind
- Correct any mistakes, ideally during the deposition.
- Just try to relax and stay calm!

Rules of Engagement

- Make a good impression
- Wait until the attorney has finished asking the question.
- Be brief, Keep it professional
- Remember the transcript
- It's okay to say "I don't know, or I don't remember".

References

American Nurses Association (ANA). (2015). Standards of practice. Nursing: Scope and Standards of Practice (3rd ed.) (pp. 53 – 66). Silver Spring, MD: ANA

Hess, Cathy Thomas BSN, RN, CWOCN 2014 OPPS Final Rule Drives Critical Documentation Elements, Advances in Skin & Wound Care: February 2014 - Volume 27 - Issue 2 - p 96 doi:10.1097/01.ASW.0000442659.24764.3e

Scruth, E.A. (2014). Quality nursing documentation in the medical record. Clinical Nurse Specialist, 28(6), 312-314. doi: 10.1097/NUR.0000000000000085

CNA and NSO Professional Liability Exposure Claim Report, 4th Edition (2020) www.nso.com/nurseclaimreport

CNA and NSO Nurse Spotlight: Healthcare Documentation. (2020) www.nso.com/NSO-CNA-Nurse-Spotlight_Healthcare-Documentation