THE BEST DEFENSE IS A GOOD DOCUMENTATION OFFENSE:
Nursing Documentation and Legal Implications

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CaroMont Health, Inc.
Why is Documentation Important?

- Patient Safety
- Continuity of Care
- Permanent Legal Record
- Quality/Performance Improvement
- Healthcare Team Communication
- Regulatory Requirements
- Reimbursement
Why is a Permanent Legal Record Important?

In 2007, North Carolina was one of 18 states identified by the American Medical Association as a “crisis state” with respect to medical malpractice claims.
Medical Malpractice Statistics

• Large 2006 Study in New England Journal of Medicine
  – Reviewed 1452 Claims from five insurance providers
  – $449M paid in settlements and verdicts
  – Average jury verdict was $799,000
    • 21% of Plaintiffs prevailed at trial
  – Average settlement was $485,000
    • 61% of cases were settled pre-trial
North Carolina’s 2011 Tort Reform

• Cap on non-economic damages
• Additional requirements for pre-suit expert review
• Bifurcation of trials
• “Clear and convincing evidence” standard for Emergency Department providers
• Limited recovery of medical expenses to expenses actually incurred
North Carolina’s 2011 Tort Reform

Medical malpractice lawsuits filed between July 2009 and June 2015

(Chart 1)

Number of cases filed

Month before changes took effect

Months
Did Tort Reform Solve North Carolina’s Medical Malpractice Crisis?

- Average monthly filings decreased from 40.1 to 25.5
  North Carolina Lawyers Weekly, July 2015

- But in 2015, North Carolina Healthcare Providers paid $51.5M in claims in 2015 compared to $51M in 2011
  www.diederichhealthcare.com/the-standard/2012-medical-malpractice-payout-analysis/
What is a Medical Malpractice Claim?

Plaintiff must prove 4 things:

1. **Duty**
   - To use his or her best judgment
   - To use reasonable care and diligence
   - To provide healthcare in accordance with standards of practice among members of the same healthcare profession with similar training and experience situated in the same or similar communities

2. **Breach of Duty**
   - Expert Testimony required to prove deviation from “standard of care”

3. **Causation**
   - Medical opinions must be expressed to a “reasonable degree of medical probability”

4. **Damages**
Medical Malpractice Nuts and Bolts

• Complaint filed by Plaintiff
• Defendants file an Answer
• Discovery
  – Written discovery (Interrogatories and RFPs)
  – Depositions of parties and fact witnesses
  – Depositions of experts
• Mediation
• Trial
What is a Deposition?

• A deposition is a sworn statement taken under oath during ongoing litigation.

• Majority of cases are settled prior to trial – the deposition is often the turning point and the only opportunity to explain the care you provided.

• Plaintiff’s counsel’s goal is to gather as much information about your case
  – Make a record of your assessment, plan of care and nursing interventions for the patient
  – Lock down your testimony and commit you to a set of facts and opinions that the plaintiff’s attorney hopes will help his case.
  – Size up your potential impact on jury
What is a Deposition?
Factual Summary

- Plaintiff presented to OB Triage on 11/22/09 at 39 weeks complaining of abdominal pain, bleeding and leaking fluid. (Patient had also been seen by the CNM the night before in Triage.) Nurse assessed patient for possible rupture of membranes by completing a nitrazine test.
- Nurse called OB on call for group but OB did not come to hospital.
- Nurse, in consultation with OB, concluded that patient was not in active labor and had not ruptured membranes. Pt. discharged.
• Patient returned to the hospital the following day at 11:07 a.m. complaining of fever and regular contractions. CNM examined the patient and determined that membranes were ruptured.
• Patient was GBS positive and CNM ordered prophylactic antibiotics to be started after obtaining a catheterized urine culture.
• While in triage, there was a prolonged decel. After this resolved, patient was moved to room.
• There was a second decel while the nurses were attempting to obtain a catheterized urine specimen. MD was paged and ordered an emergent C-Section.
• Patient received single dose of Clindamycin in OR just prior to C-Section.
• Baby born with APGARS of 0, 1 and 3.
• HRT responded to delivery and intubated infant.
Factual Summary

- Baby was diagnosed with meconium aspiration syndrome, possible sepsis and severe acidosis.
- Blood culture was positive for GBS.
- Transferred to Tertiary Care Center
- Minor has severe, permanent neurological impairment and developmental delay secondary to GBS sepsis.
I Need a Volunteer ....

Ooo! Ooo!
Me! I'll do it!
Pick me!
Triage of the Obstetrical Patient Procedure

When an obstetrical patient greater than 20 weeks gestation presents with a suspected premature or prolonged rupture of membranes or leaking fluid, patient should be seen in OB Triage and evaluated by a physician or CNM.
Content

1. Patient Testing:
   a. When ruptured membranes are suspected, the Labor and Delivery RN or the physician/nurse midwife perform the following:
      1) Explain the procedure to the patient.
      2) Obtain a few inches of the Nitrazine paper.
      3) Touch the paper to the vaginal secretions.
         a) Nitrazine testing may be done in conjunction with a sterile speculum exam by MD/CNM.
            (i) A cotton swab saturated with vaginal secretions is rubbed on the Nitrazine paper.
      4) Observe for color change on paper and determine the results.
   b. After the procedure, the nurse performs the following:
      1) Documents the results in the patient’s clinical record
      2) Notifies the physician or midwife of the results
      3) Completes other testing or orders as needed.
**11/22/2009 Medical Record**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Baseline FHR</th>
<th>Variability</th>
<th>Decelerations</th>
<th>Fetal Interventions Triage</th>
<th>Fetal Movement</th>
<th>UTERINE ACTIVITY</th>
<th>Latex-Free Protocol for yes</th>
<th>CERVICAL EXAM</th>
<th>PROVIDER PROCEDURES</th>
<th>INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/22/09</td>
<td>23:43</td>
<td>150 bpm</td>
<td>Moderate-amplitude 6-25 bpm</td>
<td>None</td>
<td>None required at this time</td>
<td>Present</td>
<td>Frequency: Q 2 minutes; Q 4 minutes</td>
<td>Not in Labor; No active bleeding; Uterine resting tone soft; FHT btw 110-160 bpm; no repetitive variable decels, rep. late decels, new onset tachy, prolonged decels, new onset brady or absent baseline variability.; Vitals signs stable; Intact membranes; Patient condition, impression, lab results discussed with provider; Follow up appointment documented</td>
<td>Dilation: 4.0</td>
<td>Effacement: 70</td>
<td>Recorded By:</td>
</tr>
</tbody>
</table>
Pregnant patients presenting with “suspected” ruptured membranes should be evaluated by either a physician or CNM.
EMTALA Policy

Any person who comes to the Emergency Department must undergo a medical screening examination by a qualified medical professional to determine if they have an emergency medical condition, in which case, they must be stabilized or appropriately transferred to another facility.
<table>
<thead>
<tr>
<th>MR#</th>
<th>NAME</th>
<th>DOB</th>
<th>TIME IN</th>
<th>CHIEF COMPLAINT OR DIAGNOSIS</th>
<th>TIME OUT</th>
<th>ROOM #</th>
<th>STABILIZED AND DISCHARGED FROM</th>
<th>TRANSFERRED TO</th>
<th>ED</th>
<th>LEFT AMA</th>
<th>DATE</th>
<th>INITIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mid pain, leaking fluid</td>
<td>3:50</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Stabilized and Discharged Home
<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>23:43</td>
<td>Baseline FHR: 150 bpm</td>
</tr>
<tr>
<td></td>
<td>Variability: Moderate-amplitude 6-25 bpm</td>
</tr>
<tr>
<td></td>
<td>Decelerations: None</td>
</tr>
<tr>
<td></td>
<td>Fetal Interventions Triage: None required at this time</td>
</tr>
<tr>
<td></td>
<td>Fetal Movement: Present</td>
</tr>
</tbody>
</table>

### UTERINE ACTIVITY
- **Frequency**: Q 2 minutes; Q 4 minutes
- **Monitor Mode**: Toco
- **Regularity**: Irregular
- **Duration(seconds)**: 40 seconds; 60 seconds
- **Resting Tone**: Relaxed
- **Intensity**: Mild

### Latex-Free Protocol for yes

### CERVICAL EXAM
- **Dilatation**: 4.0
- **Effacement**: 70
- **Station**: -2
- **Exam by**: Nurse
- **Specify name if other than yourself**: 
- **Cervical comments**: Posterior

### Go to pain navigator

### PROVIDER PROCEDURES
- **MSE Performed by**: RN

### Orders Received
- **Verbal Order Given**: Annotation: Orders given to discharge pt home.

### INTERVENTIONS
- **Recorded By**: [Signature]

### Discharge Criteria
- Not in Labor; No active bleeding; Uterine resting tone soft; FHT btw 110-160 bpm; no repetitive variable decels, rep. late decels, new onset tachy, prolonged decels, new onset brady or absent baseline variability; Vitals signs stable; Intact membranes; Patient condition, impression, lab results discussed with provider; Follow up appointment documented.
Chain of Command Policy

Content
The department manager, assistant manager, or team leader will review the situation to determine if concern(s) should be elevated.

The department manager, assistant manager, or team leader will first speak directly to the physician to discuss concern(s).

If they are unable to come to agreement on the care of the patient or if concern(s) are not affectively addressed, the department manager, assistant manager, or team leader will make provider aware that the next step is to activate the chain of command.

The department manager, assistant manager, or team leader will contact the following physicians until one is available:

For Obstetrics:
First, the Women’s Service Line Physician Lead
Second, the Women’s Service Line Quality Lead or other designee
Third, a member of the Executive Committee of the Medical Staff
6. Labs: RPR – to be ordered on all patients

   If patient Rh negative or blood type unknown, order Type & Screen
   If patient Rh negative or O pos, send cord blood sample to lab for Rh type and Coombs
   First Stream urine for GC/Chlamydia if 25 years or younger
   □ CBC  □ CBC with Differential  □ Routine urinalysis  □ Urine for Rapid Drug Screen
   □ Type & Screen
   □ Rapid HIV if results from current pregnancy not available
   □ Other  Cath UA  CTS prior to start of clenbuterol
   □ Bedside blood glucose on admission and every 2 hours until delivery, or until insulin started
### 11/23/2009 Medical Record

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>11/23/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever; Abd pain</td>
<td>11/22</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gravida</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>39.4</td>
</tr>
<tr>
<td>Record ID:</td>
<td>[redacted]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HGB/HCT</th>
<th>10.9 L/32.3 L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record ID:</td>
<td>[redacted]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chief Complaint</th>
<th>11/23/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractions</td>
<td>12:20</td>
</tr>
<tr>
<td>Record ID:</td>
<td>[redacted]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Progress Notes</th>
<th>11/23/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>H&amp;P dictated.</td>
<td>12:46</td>
</tr>
<tr>
<td>O Calm with uc</td>
<td></td>
</tr>
<tr>
<td>FHTS 160s LTV MIN to Mod</td>
<td></td>
</tr>
<tr>
<td>UC q 3-4 mld to mod</td>
<td></td>
</tr>
<tr>
<td>vag not assessed</td>
<td></td>
</tr>
<tr>
<td>A 39 4/7 Week IUP Fever, SROM</td>
<td></td>
</tr>
<tr>
<td>P IV antibiotics, cath ua C&amp;S, IV fluid bolus,</td>
<td></td>
</tr>
</tbody>
</table>

| Record ID: | [redacted] |
11/23/2009 Medical Record

<table>
<thead>
<tr>
<th>COMFORT/PAIN/INITIAL PAIN</th>
<th>13:30</th>
<th>13:32</th>
<th>14:13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain level</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pain location</strong></td>
<td></td>
<td></td>
<td>Abdomen</td>
</tr>
<tr>
<td><strong>Verbal description</strong></td>
<td></td>
<td></td>
<td>Cramping; intermittent</td>
</tr>
<tr>
<td><strong>Pain observed behaviors</strong></td>
<td></td>
<td></td>
<td>Quiet</td>
</tr>
<tr>
<td><strong>Coach present</strong></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

**INTERVENTIONS**

**COMMENTS, LABOR**

| Comments | Monitors applied, Pt. signing consents. | M. Kresbach, CNM at bedside, plan of care discussed. Pt. and family voiced understanding and agreement. | Pt. positioned for cath UA |

**Recorded by**
THOUGHTS?
How Do I Avoid a Lawsuit?

• Provide excellent patient care every day
• Be kind to your patients – and their families
• Document accurately and completely
• Know CaroMont’s policies and procedures
• Perform (and document) timely interventions and assessments
• Ensure medications administered properly
• Communicate in a timely manner with other care team members
Common Errors in Nursing Documentation

- Incomplete assessments
- Nurses appear robotic and inaccurate
  - “Occasional, constant, infrequent headaches”
- Templates may by default populate information that is inaccurate
- Nurses click too many yes or no boxes
- Nurses fail to type narrative notes, relying instead on checkboxes and templates
  - No record of calling providers
  - No record of significant changes in patient condition
- Sloppy charting (incorrect times, contradictory statements, pulling forward information without confirming it)
Maryland Board of Nursing Survey

- 29% of nurses reported spending over half of their shift documenting.
- 55% of respondents reported that the documentation process was redundant often or very often.
  - 53% indicated that they felt EMRs increased redundancy.
  - 66% indicated that EMRs increased the time they spent on documentation.
- Only 44% of nurses felt that EMRs increased the completeness of their nursing documentation.
- 43% indicated that EMRs increased quality of documentation while 34% felt that EMRs decreased quality.
Legal Tips on Documentation

• Be specific and present facts clearly
  – Example: “Pt. complaining of pain” vs. “Pt. requesting pain meds for severe lower back pain radiating into the left leg”

• Chart facts objectively
  – “Pt. exhibiting bizarre behavior” vs. “Patient is mumbling to self, pulling at lines.”

• Be professional and use neutral language
  – “Pt. lazy, complaining and uncooperative” vs. “Pt. is resistant to requests to ambulate”

• Document care when you perform it as soon thereafter as possible

• Always put the time the care was performed or the order noted (if different from time you are entering note)
Legal Tips on Documentation

- Late entries – especially after a bad event or outcome – are huge red flags
- Be aware of information that is auto-populated or pulled forward from last assessment.
- Document Follow Ups
  - Timely perform and document follow-up assessments – especially for pain and medications
- Timely report significant findings to patient’s providers and take credit for what you do!
  - If you call a physician or ACP about your patient, describe the purpose of your call and subsequent actions taken in the clinical note.
- Utilize your chain of command when necessary
- Don’t use text lingo in your documentation
Legal Tips on Documentation

• Chart Narrative/Clinical Notes
  – Take time to chart a narrative note during daily assessments and when there are changes in the patient’s condition. This makes it easier to see the “whole patient picture”
  – Clinical notes should be used at least in the following situations:
    • When patient is admitted or discharged to unit
    • When you add or wean oxygen
    • Dressing changes
    • The need/reason for a sitter
    • Anytime there are issues with the patient’s family
    • When a rapid response or code is called
    • When a patient has a suspected or actual fall or other injury
    • Anytime a provider is contacted
  – Consider writing a clinical note at least every 2 hours during shift to describe patient condition or activity
  – Continue to use designated flow sheets for things like LDAs (IVs, foleys, drains), pain and I&O. Clinical notes should supplement these flow sheets
A Note about Incident Reports ...

• If an event warrants an Incident report, the event (code, fall, etc.) should be described in the medical record
  – Factual description of event should be included
  – Medical record should not reference “Incident Report”
“Occasional, constant, infrequent headaches”

“The patient gets hives from contrasts, strawberries and shrimps and also two of her children.”

“Healthy appearing decrepit 69 year-old male, mentally alert but forgetful.”

“The baby was delivered, the cord clamped and cut, and handed to the pediatrician, who breathed and cried immediately.”

“Patient has left his white blood cells at another hospital.”