

Documentation and Malpractice Prevention: Everything Healthcare Professionals Need to Know

Wendy L. Wright, MS, RN, ARNP, FNP, FAANP
Family Nurse Practitioner
Owner - Wright & Associates Family Healthcare, PLLC
Partner - Partners in Healthcare Education, LLC

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Objectives

⌘ Upon completion of this lecture, the participant will be able to:

1. Discuss the essential components of a successful malpractice claim
2. Discuss causes of malpractice claims against nurses and other healthcare professionals
3. Identify strategies to prevent malpractice claims against nurses such as documentation

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Nurse Practice Act

⌘ Nurse Practice Act is a state law that regulates the practice of nursing

- ☑ Each state has a different nurse practice act
- ☑ Nurse practice act provides general guidelines regarding those duties which can be performed and those which can not be performed by the nurse
- ☑ Your employer has the right to restrict you to a narrower scope of practice BUT can not expand your scope beyond the nurse practice act

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Board of Registration in Nursing

- ⌘ Board of registration in nursing that determines our scope of practice
- ⌘ Job is to ensure public safety by making sure that all individuals, licensed to practice in that state, meet minimum qualifications
 - ☑ Each state has its own set of qualifications

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Legal Terminology

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Tort

- ⌘ The word tort is derived from the Latin word torquere - to twist (Synonymous with wrong)
- ⌘ Tort: wrong or injury that results from the breach of a duty (negligence)
- ⌘ Tort liability: founded on the concept that a person who has suffered an injury to dignity, health, body, life or time has the right to be made whole again
- ⌘ Money serves this purpose, since the person may not be able to be made "whole"

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Intentional Tort

⌘ Nurse commits the act with the intent to bring about the result

- ☒ Assault and battery: forcing a person to take a medication when the person has not been found incompetent
- ☒ Invasion of privacy: divulging information to others without a patient's consent to do so
 - ☒ Giving a progress report on a patient without permission

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Translation

⌘ Always verify to whom you are speaking

- ☒ If a husband calls in to talk about his wife and her lab tests, get the wife on the phone
- ☒ If it is impossible to get the consent in writing to divulge information, 2 nurses should listen in on the conversation and document this in the chart

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Translation

⌘ Never give results to anyone other than the patient unless you have the patient's permission in writing to do so

- ☒ Federal law allows us as health care providers to provide care for minors without parental consent for the following health issues: family planning, drug and alcohol abuse
- ☒ If the individual is at risk of seriously harming themselves or others, this information must be reported

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Hobbs vs. Lopez, Ohio, 1994

⌘ College student had pregnancy test performed by MD. Told MD she wanted a 1st trimester abortion if positive. Test was positive. Physician instructed RN to call and give information to patient. RN called and reached Mrs. Hobb's (patient's mother). Gave mom the results and information on locations of abortion sites. Patient sued for medical malpractice, breach of privilege, and negligent infliction of emotional distress.

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Intentional Tort

⌘ Another example

- ☒ Defamation: Information made public about a living person that can harm the person's reputation (personally and/or professionally)
 - ☒ Slander: oral defamation
 - Verbally demeaning other staff members in public
 - ☒ Libel: written defamation
 - Making false statements about a patient's lifestyle or diagnosis

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Translation: Never Record Your Feelings In The Chart

⌘ Always record objective information in the chart NOT subjective information

- ☒ Example: Patient calls to schedule an appointment. He is offered 3 appointments; none of which is convenient. He is unable to make any of them due to work, children. He yells into the phone...No one in that office cares.
 - ☒ How could you document this?

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Examples of Information Seen During Chart Audits

- ⌘ COM (Crotchety old man)
- ⌘ FLK (Funny looking kid)
- ⌘ FLK from FLP (Funny looking kid from funny looking parents)
- ⌘ Two hands stamped on the chart (Treat with kid gloves)
- ⌘ FFC (Fit for coffin)
- ⌘ DIIK
- ⌘ 29 year old well-endowed beautiful young woman
- ⌘ T/T = 2/3

Additional Examples

- ⌘ DFO – “done fell out” or “passed out”
 - ⌘ PPBABS – “Place pine box at bedside”
 - ⌘ TOBASITH – “Take out back and shoot in the head”
 - ⌘ Positive “O” sign – Unconscious with tongue visible in open mouth
 - ⌘ Positive “Q” sign – Unconscious with tongue hanging out of open mouth
- Courtesy – Wesley Myers, NP; North Carolina

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Why Do People File Malpractice Claims?

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Reasons for Malpractice Claims

⌘ Reasons for Malpractice Claims

- ☒ Expectation: Expect better outcome
- ☒ Investigation: Want to see if anyone is at fault
- ☒ Blame: Someone else's fault
- ☒ Retribution: Punish nurse
- ☒ Remuneration: Money
- ☒ Institutionalization: Punish the system

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The Nurse's Liability

⌘ The Nurse's Liability

- ☒ In today's malpractice arena, nurses are increasingly being named in malpractice suits even when at first appearance the nurse does not seem negligent or even involved
- ☒ Malpractice attorneys often name anyone and everyone remotely connected with the case
 - ☒ It is easier to let defendant's fall out of a case than it is to bring them in later

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Most Common Sources of Liability for Nurses

- ⌘ Falls
- ⌘ Medication errors
- ⌘ Burns
- ⌘ Failure to assess a patient
- ⌘ Failure to supervise, observe and monitor patient, report changes and notify provider
- ⌘ Failure to communicate

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Most Common Sources of Liability for Nurses

- ⌘ Violation/failure to follow policies and procedures
- ⌘ Safety and use of equipment
- ⌘ Drug distribution
- ⌘ Failure to document appropriately
- ⌘ Altering records
- ⌘ Mistaken identification of patient

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Most Common Sources of Liability for Nurses

- ⌘ Failure to remove foreign objects
- ⌘ Failure to refer to a physician or health care provider

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Strategies for Preventing Malpractice Claims

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Documentation



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Purpose of Documentation

- ⌘ Provides continuity of care
- ⌘ Planning for patient care
- ⌘ Provides information for financial reimbursement
- ⌘ Serves as a legal record to accurately and completely reflect the care provided to a patient
 - ☑ In the courtroom – the medical record is the witness

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Documentation

- ⌘ Documentation is crucial at a malpractice trial
- ⌘ It provides a record of the quality of care you provided
- ⌘ Lack of documentation can make you vulnerable to a malpractice claim

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American Journal of Nursing Study

⌘ Many nurses in the study were disciplined for consistently failing to chart or for falsifying or destroying patient records

☒ State boards of nursing interpret inappropriate or inaccurate documentation as a sign of disregard for patient safety and welfare

☒ State boards of nursing conclude that nurses must document their assessment, nursing care and patient responses as the best defense against a lawsuit and the nursing board

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Historically

⌘ 4 problems with documentation

☒ Missing documentation

☒ Altered documentation

☒ Failure to correct

☒ Failure to document

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Principles of Documentation

⌘ NOT DOCUMENTED.....

NOT DONE!!!!

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Document, Document, Document

⌘ Always document telephone calls and conversations no matter how trivial they may seem

☑ It might be crucial later

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Forgot to Document?

⌘ Late entry

☑ Must be explained why you are late

☑ Date and time

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Documentation

⌘ Never document before an event or activity takes place

☑ May not occur

☑ May occur differently than expected

☑ Becomes very difficult to explain why documentation had to be changed

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Frequency of Documentation

⌘ Dictated by:

- ☑ Rules of facility
- ☑ Patient's acuity or seriousness of the condition
- ☑ Degree of risk with particular patient or condition

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Altered Records

⌘ Never alter records

- ☑ Many cases are lost or hurt by altering charts
- ☑ ABSOLUTELY, no white-out in the medical records

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Remember...

⌘ By the time the nurse receives notification of a lawsuit, the attorney already has a copy of the record

- ☑ Any changes stand out like a sore thumb

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Correcting a Record

⌘ If you must amend a record

- ☑ Include date, reason for change, signature and title of the person making a change

⌘ SLIDE Rule

- ☑ Single Line
- ☑ Insert initials
- ☑ Date and time
- ☑ Enter correction information and why edit was made

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Failure to Document

⌘ Never leave blank flow sheets (implies care not performed)

- ☑ Flow sheets should not be in a chart if they are not used

⌘ Also....never leave blank spaces in chart

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Important Documentation Reminders

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Document All

- ⌘ No shows
- ⌘ Canceled appointments
- ⌘ Telephone calls made to a patient to check on him/her
- ⌘ Letters sent and calls made to remind patient of a particular test needing to be done
 - ☑ Keep copies in chart of these letters

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Noncompliance / Nonadherence

- ⌘ Always document discussions trying to get the patient to improve compliance
- ⌘ Document the patient's verbal responses
- ⌘ Most importantly
 - ☑ Document that you have discussed potential consequences of nonadherence to recommended treatments

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Document a Patient's Refusal of Care

- ⌘ Document that you have explained the risks, benefits and alternatives of treatment
- ⌘ Also discuss and document the risks of refusing treatment

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Documentation

- ⌘ Use accepted abbreviations only
- ⌘ Document all nursing care

- ⌘ Document all teaching
 - ☑ Document what patient said in response

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Names

- ⌘ Name and DOB should be on every page in the patient record

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Time and Date

- ⌘ Every entry should be dated and timed
- ⌘ What happens with electronic medical records?

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Michigan Case

- ⌘ DVT vs. Arterial Occlusion
- ⌘ Time – different ink than remainder of the note

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Only You....

- ⌘ Should be documenting what **YOU** did or what **YOU** observed!!
 - ☑ Do not document – vital signs obtained by others
 - ☑ Do not document what you were told verbally without....recording that this was a verbal order from... with date and time.

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Libelous Documentation

- ⌘ Defamation: Information made public about a living person that can harm the person's reputation (personally and/or professionally)
 - ☑ Libel: written defamation
 - Making false statements about a patient's lifestyle or diagnosis

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How Do You Document This?

⌘ Example: Patient calls you for her lab results. You are in with patients when she calls. Advised by the staff that you will get back to her. When you call her back at the end of the day, she is angry and yelling obscenities. She threatens to call the physician and complain about your non-professional behavior and to report you.

☑ How could you document this?

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Documentation:

8:06am - Telephone call from patient inquiring regarding lab results. 3:40pm - Call returned to patient. Patient advised that all tests were normal. She stated that she was very angry at having had to wait for these results. She reports that something is not right; the abdominal pain is still present, although slightly better than 24 hours ago. Discussed importance of lab results and need for additional testing given continued abdominal pain. Patient to be evaluated in the am. Patient verbalizes an understanding of the instructions/lab results and has agreed to the appointment time and date. RV/Call for PCWAS - ED for any increase, worsening, change in symptoms. Agrees with above plan.

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Subjective vs. Objective Statements

⌘ Subjective

☑ Wound ok

☑ Appears angry

⌘ Objective

☑ Surgical incision well-approximated - no redness or discharge

☑ Shouting and pacing in the examination room

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Document Patient Activity

⌘ For instance

- ☑ 6 year old child running around in the exam room – jumping up and down while playing with sister
- ☑ 84 year-old female who walks into the examining room without assistance and in NAD

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Follow-up on High "Ticket" Items

- ⌘ It is the practice's responsibility to follow-up on potentially serious problems
- ☑ This is true even if the patient does not complain of continued symptoms
 - ☑ Duty to follow-up with the patient is yours until the issue has been resolved
 - ☑ I.e. Mammogram, Pap smear, Breast lump

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Tracking System

- ⌘ Should institute some type of tracking system to follow-up on these items
- ☑ Calendar
 - ☑ EHR electronic reminder

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Document

- ⌘ All attempts you make to improve adherence
- ⌘ All attempts you make to contact a patient
 - ☑ What is the magic number?
 - ☑ What is the magic bullet?

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Always Obtain Informed Consent

- ⌘ Signed Informed Consent
 - ☑ Document that establishes proof that the procedure was discussed with the patient; including the risks and benefits
 - ☑ Allows patient or proxy to ask and have all questions answered
 - ☑ No coercion
 - ☑ Person performing the procedure must be involved in the informed consent process

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Procedures Needing Informed Consent

- ⌘ Surgery
- ⌘ HIV Testing
- ⌘ Some procedures that have been argued in court include:
 - ☑ Oxygen to a newborn
 - ☑ Radiation therapy
 - ☑ Gastroscopy
 - ☑ States all have different laws
 - ☑ One state said no to immunizations, another found that bedrest orders required informed consent

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Illegible Documentation is Dangerous

⌘ Notes and prescriptions must be legible

- ☒ Cardiologist wrote prescription for Isordil. Pharmacist read it as Plendil and filled the prescription. Patient died as a result
- ☒ Settlement: \$225,000 from cardiologist and \$225,000 from pharmacist

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What Else Can You Do?

⌘ Always Document

- ☒ Clearly
- ☒ Legibly
- ☒ Correct Spelling
- ☒ Neatly
- ☒ Accurately

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Prevention is Always Better Than Having to Defend a Malpractice Claim

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Caution with Those Who Have Sued a Provider

- ⌘ Patients who have sued once are more likely to sue again

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Keep Up With the Latest Treatment Options

- ⌘ Review textbooks and journals
- ⌘ Discuss cases with colleagues
- ⌘ Continuing education programs
- ⌘ Agency for Health Care Policy and Research (AHCPR) Guidelines

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Always Assume the Worst

- ⌘ Rule-out or in the most serious diagnoses first
 - ☒ In particular, consider myocardial infarction, ectopic pregnancy, testicular torsion, breast cancer, appendicitis, aneurysm

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When a patient asks...

- ⌘ Strongly consider getting the test
- ⌘ Particularly when some other providers may consider the test standard of care
 - ☒ million dollar settlement paid in NH
 - ☒ 52 year old male patient asked a family physician for a PSA test
 - ☒ Physician told patient that the test had a lot of false positives and was often an inaccurate test
 - ☒ Patient had prostate cancer

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Dispensing Medications or Samples

- ⌘ Most state practice acts forbid a nurse from dispensing medication unless so ordered by a health care provider
- ⌘ Be very cautious re: standing protocols

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Little Things Mean More Than You Know

- ⌘ Pleasant receptionists and nurses
- ⌘ Do not create guilt
- ⌘ Receptionists and nurses should not argue with patients regarding referrals, prescriptions, appointments
- ⌘ Avoid long waits

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Happy Patients Do NOT Sue



Angry Ones Do!!!!

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Components of a Successful Malpractice Case

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Malpractice

⌘ Components of a Malpractice Claim

☑ In order to be successful with a malpractice claim, the plaintiff must prove the following:

- ☑ Duty
- ☑ Breach of Duty
- ☑ Causation
- ☑ Damages / Harm

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Duty

⌘ Duty

- ☑ Nurse and the patient had an established relationship
 - ☑ Telephone call
 - ☑ Observe a patient being treated poorly by another provider
 - ☑ Giving samples to family or friends
 - ☑ Giving advice at a party

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Example of a Case

⌘ Husband and wife were driving in Texas. He began having chest pain and numbness in his left arm. They stopped at the closest hospital. They spoke to a doctor and a nurse. The nurse observed the man complaining of cardiac symptoms. The doctor told the nurse to send him to another hospital 24 miles away. On the way to the other facility, he died.

- ☑ Court ruled: nurse failed to evaluate the patient and initiate proper care. License suspended. Nurse claimed there was no relationship. Court declared there was a relationship by virtue of her license and job.

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Breach of Duty

⌘ Breach of Duty

- ☑ The standard of care fell below acceptable standards
- ☑ Another nurse with the same educational background and experience would have done the same thing in the same circumstances
- ☑ Basically, if there is a breach of duty, negligence occurred

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Breach of Duty

- ⌘ Can result in a malpractice case in which compensatory damages are sought for negligence
- ⌘ Can also result in the loss of the nurse's license

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Causation

- ⌘ Must prove that the breach of duty or negligence caused the harm
- ⌘ Often difficult to prove
- ⌘ Foreseeability: One issue that the court considers when trying to establish causation
 - ☑ Should the nurse have foreseen the situation in order to have prevented it?

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Example of Causation

- ⌘ 2 nurses were helping a man into a chair. One nurse let go of the patient to go and find a chair. He fell and broke his hip. Court ruled that the nurse was responsible because she should have foreseen that the patient would need a chair and therefore had the chair ready before moving the patient

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Damages

- ⌘ Must prove that the negligence caused actual physical or emotional harm
 - ☒ For instance, there are cases where a nurse in negligent but no damage or harm occurred as a result
- ⌘ If the malpractice case is successful, damages will be paid
- ⌘ Damages: monetary compensation paid for loss or injury which resulted from an act of omission or negligence committed by another

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Punitive Damages

- ⌘ Punitive damages: Punish defendants
 - ☒ Some states do not allow these
 - ☒ Other states allow them in situations where the defendant acted with reckless disregard for the plaintiff's safety
 - ☒ Huge awards
 - ☒ Because the actions involved malice, malpractice policies often do not cover the award

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Starkey vs. St Rita's Medical Center, 1997

- ⌘ 36 year old male began experiencing chest pain and pressure, fatigue, diaphoresis at work. Came home and went to bed. Wife gave him antacid with no improvement. He went to bed and wife called a general triage number at the local hospital. Nurse advised her that it sounded like he may be having a heart attack but not to wake him. Let him rest and see how he was when he awoke. When he awoke, symptoms continued. Suffered an MI and is now unable to work.

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Example of a Punitive Damage

⚡ Nurse moved a terminal “no code” patient with less than 24 hours to live to a new room. Patient was on supplemental oxygen. Nurse chose to move the patient without the oxygen despite the family’s request. Patient cardiac arrested on the way to the new room and died.

☑ Court found that the nurse’s action was a gross deviation from the standard of care and awarded punitive damages

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Thank You!!

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