How Poor Documentation Does Damage in the Courtroom

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by Sharon Schott, RN

Poor documentation practices can result in a host of problems, and even minor errors can come back to haunt an organization. Here, learn how documentation errors can be used against your facility in a lawsuit.

In our increasingly litigious society, medical malpractice lawsuits are becoming as common as parking tickets. In such a lawsuit, the medical record is used as written evidence of the care and services given to a patient. The plaintiff's attorney attempts to prove that there has been deficient care, abuse, or neglect through a lack of response to the patient's needs. One way this is accomplished is using errors found in the documentation, such as conflicting statements, omissions, lack of proper assessment, missing pages, and incomplete documentation. These errors are also used by the plaintiff's attorney to demonstrate staff incompetence.

On the other side of the courtroom, the defense attorney has the difficult task of finding witnesses who can attest to a high level of care despite poor documentation. These witnesses may have trouble remembering the patient because lawsuits generally take one to two years to be filed, long after the incident occurred. Details can become fuzzy or entirely forgotten. And jurors may be skeptical about oral testimony that is not substantiated by the medical record. The old adage, "if it wasn't documented, it didn't happen," has never been more true.

In this article, a review of recent cases will illustrate how even seemingly minor documentation errors can harm a healthcare organization's defense in court. In many of the cases, poor documentation practices weren't the cause of the event leading to litigation, but still diminished the organization's credibility.

The Medical Record as Evidence

The medical record is the only written evidence of the quality of care delivered in a healthcare organization. It is used to communicate important clinical information to other caregivers. This ensures patients' needs are met and care is coordinated among providers.

The documentation in the medical record should demonstrate adherence to the appropriate "standard of care." The standard of care describes actions taken consistent with minimum, safe, professional conduct as determined by peer professional organizations. The standard of care is based on current best practices, so it can change as new practices evolve. The plaintiff's attorney always tries to prove failure to meet the standard of care, which legally constitutes negligence.

Problems in the Record

Clinician Incompetence

Simple things such as misspelled names of common drugs or procedures can have a major effect on jurors' impression of the competency of the clinician documenting in the record. In one recent case, a nurse administered 5,000 units of Heparin when the order was for 2,500 units. The patient became critically ill as a result. When the documentation was reviewed, it was discovered that the nurse committing the error had misspelled Heparin as "Hepirin." This spelling error was presented to the jury as an additional demonstration of incompetence. The plaintiff's attorney argued that Heparin is a commonly used drug and obviously this nurse had no knowledge of it, because she couldn't spell it correctly. Juries will also doubt the competence of a nurse who writes "The wound on the left heal is healed."

Competency again comes into question when a pressure sore appears to "wander." This refers to a nurse's description of a pressure sore located on the left hip, which mysteriously moves to the right hip in the documentation two days later. The sore may return to the left hip a day or two later, according to the documentation. The plaintiff's attorney will use this error to further substantiate the claim of incompetence of the nurses. The plaintiff's attorney will ask the nurse how she was able to describe the wound when she didn't know where it was.

Falsified Documentation

Falsification of documentation can refer to several errors:

- filling in blanks in the record after the fact
- back-dating entries
- post-dating entries
- pre-dating entries
- writing over existing documentation
- other alteration of the record

Any of these falsifications can have a devastating effect on the outcome in a lawsuit.

Deliberate material falsification of a medical record is a felony and can be punishable by a jail sentence. In a recent case, a nurse completed a patient assessment on Tuesday, but she dated it the upcoming Friday to comply with the date the assessment was due. However, the patient died on Wednesday. The chart was closed and stored. Three years later, the patient's family brought a lawsuit against the organization and the chart was used in the trial.

The nurse who documented the assessment with the post date was called as a witness. She was asked to explain how she could perform an assessment two days after the patient died. The nurse explained that Friday was the actual due date for the assessment but because she had some extra time on Tuesday, she decided to do it early and put Friday's date on it to be compliant with the due date. The plaintiff's attorney then asked, "Is that the only place in the chart that you lied?" Then the jury was suspicious of the integrity of the entire medical record and the nurse.

There was no need for the nurse to lie about the date of completion because it is acceptable to perform assessments a couple of days early. However, the proper date must be recorded. All documentation must be dated the day the entry is made, without exception.

Lack of Continuity

The continuity of the record also needs special scrutiny on a regular basis. Some institutions allow the record to be "split," which means placing the progress notes at the bedside while maintaining the rest of the chart documentation at the nurses' station. To avoid having to go back to the bedside to document, a nurse might take a new progress note sheet, document findings, and then put the page in the chart at the nurses' station. This documentation will not be in proper sequence with the progress notes from the bedside when they are entered into the chart.

In a lawsuit, this could be viewed as an attempt to add information after the fact—a possible falsification of the record. The institution must enforce adherence to the proper sequence of documentation. If the progress notes are at the bedside, the nurses must go to the bedside to document findings on the next available line in the notes.

The Record as Battleground

Have you ever seen documentation like this? "The kitchen never sent a tray," "nursing is not following the therapy recommendations," or "Dr. Jones has been paged three times and has not answered as of this time." The clinician may include this kind of documentation from frustration, without realizing that it points a finger at the entire organization. The interpretation of this information demonstrates to a jury that the organization is failing to meet the needs of the patient.

Operational issues need to be handled through management interventions and kept out of the medical record. It should contain only those statements directly related to the care of the patient and the patient's response to that care.

Block Charting

Block charting refers to documentation covering a block of time instead of a specific time of day (for example, "7 a.m.–7 p.m."). In organizations in which nurses work 12-hour shifts, using block charting makes it impossible to determine the actual time of an event. In a lawsuit, staff response to a change in condition of a patient is critical to determine whether the standard of care was met. The shift that a nurse works is irrelevant and can be easily understood when the documentation states actual time of day, so it is redundant as well as dangerous to use block charting.

Parrot Charting

Repetitive, standard assessment terminology assigned to each patient, on each shift, on each day, regardless of the diagnosis or current condition, is known as parrot charting. "Respirations even and unlabored," "abdomen soft and non-tender," "bowel sounds all quadrants," and "Foley patent and draining clear urine" are examples of parrot charting. Every time these statements are documented should indicate that the nurse has fully assessed each patient. Considering staffing ratios during the evening and night shifts, especially in long-term care facilities, completing individual patient assessments on all patients would be difficult.

It is poor judgement and a poor use of time to complete a respiratory assessment on every shift of every day on a patient who has no respiratory problems. In many instances, parrot charting is done only to fill a charting requirement of daily documentation and does not reflect actual care given, which is another example of falsification. Further, if a patient suddenly becomes acutely ill with pneumonia and the previous hour's documentation states "respirations even and unlabored," doubts may be raised about whether or not a respiratory assessment really was performed.

Non-quantitative Terminology

Consider the following statement: "The patient was found in a pool of blood." Was it an Olympic-size pool? A baby pool? Or what about this statement: "Patient suffered a massive gash to side of head." How big is a gash? How large is massive?

Healthcare providers have learned to quantitatively measure pain using a scale of one to 10, which helps every clinician understand the patient's level of pain. Similarly, wounds can be measured for accurate documentation. Loss of body fluids can also be measured for accuracy. Using common objects, such as the size of a nickel or grapefruit, or actual measurements are acceptable ways to describe sizes and shapes when documenting a patient's wounds or status. In short, the record must describe injuries so that everyone who reads the documentation has a clear understanding of all of the factors involved.

Speculation

In 2000, an organization was sued for the wrongful death of one of its patients. A nurse had documented that a patient was found between the bed and the floor with the upper body between the siderail and the mattress with the feet on the floor. The nurse further documented that the patient had suffocated due to pressure on her chest from the siderail and the mattress. This statement was pure speculation and turned out to be untrue. An autopsy showed the cause of death to be acute myocardial infarction. According to the coroner, there was no evidence of pressure on the chest wall.

Documentation must contain only statements of fact. When a patient is found after an unwitnessed accident, such as above, the notes should carefully describe the position of the body, the results of the physical assessment, and any other actions taken, without speculation about the cause.

Legibility and Obliteration

Jokes about physicians and nurses and their handwriting are common, but in truth, legibility is a serious issue. For example, if the lab calls the nursing unit directly with critical lab values, the person receiving the call will document the information in the record. Later, the physician sees what appear to be normal values. However, because of illegible handwriting, the real numbers indicated a critically high value. The patient could go without important treatment until the lab results are clarified.

Obliteration is seen as a deliberate attempt to cover up, and it is never permissible. Writing over documentation, scribbling over it, or using any other means to disguise the original entry is unacceptable practice. Instead, a single line through the documentation, the word "error," the initials of the writer, and the date is the proper way to remove information from the record. It is also essential to state the reason for the error and to provide written correction immediately.

Corrections to the Record

Late Entry

A late entry is written to supply information that was omitted at the time of the original entry. It should be done only if the person completing it has total recall of the omission. For example, a nurse completed her charting on December 12, 2002, and forgot to note that the physician had talked with the patient. When she returned to work on December 13, she wrote a late entry for the day before and documented the physician visit. The clinician must enter the current date and the documentation must be identified as a late entry including the date of the omission. Additionally, a late entry should be added as soon as possible.

A late entry cannot be used to supplement a record because of a negative clinical outcome that occurs after the original entry. For example, while a patient received an antibiotic for two days, the nurse charted nothing unusual. Yet, on the third day, the patient had an acute episode of shortness of breath and chest pain and died later that same day. At the time of death, documentation revealed that the patient had a dark red rash on his chest.

An investigation into the cause of death was conducted and all the nurses who provided care during the three days were interviewed and asked whether they had seen the rash prior to the patient's death. None of the nurses remembered the rash. However, one nurse wrote a late entry for each of the first two days that the patient was receiving the antibiotic stating that there was no rash on those days. This is an incorrect late entry. Her statement is part of the investigation conducted after the fact and was not an omission from her original entry.

Addenda

An addendum is used to provide additional information that may not have been available at the time of the original entry into the record. Sometimes, during a medical crisis, notes are written quickly and may not clearly describe the incident. An addendum can also be used to clarify existing documentation and entered on the next available line in the progress notes. Again, the clinician must enter the current date and state the reason for the addendum. He or she should also identify any sources of information that help validate the additional documentation. The addendum should also be done as soon as possible.

Incomplete Records

Copies of missing lab results, x-rays, and other electronically recorded information usually can be obtained to complete the medical record. When the record cannot be completed, the facility should have a procedure in place for closing an incomplete record.

Medical Record Audits

There is no statute for frequency of record audits but they should be performed on a regular basis to identify system failures. Audit checklists containing specific state and federal requirements for documentation are useful in tracking documentation errors and misstatements for ongoing training purposes.

An HIM professional should be responsible for regular audits of the medical record. Further, the HIM professional should be part of the facility's quality improvement efforts to ensure continued focus on the integrity of the documentation.

Taking Care at the Point of Care

The medical record is the only written evidence of the quality of care provided to a patient. Because documentation occurs at the time of care, it is also considered the most accurate and reliable source of information related to care and services. In

many lawsuits, damage to an organization's defense comes from documentation that fails to reflect the actual care and services provided to the patient. If clinicians document their observations and assessments but fail to include the actions taken, it can appear that nothing was done. Even though some clinicians may be able to recall some actions taken to provide quality care to a patient, much of the important information may simply be forgotten.

Sharon Schott *(sschott@extendicare.com) is litigation support services national director at Extendicare Health Services, Inc., in Milwaukee, WI.*

For more information on sound documentation practices, see the following AHIMA practice briefs available in the FORE Library: HIM Body of Knowledge at www.ahima.org:

Authentication of Health Record Entries
Correcting and Amending Entries in a Computerized Patient Record
Documentation Requirements for the Acute Care Inpatient Record
Maintaining a Legally Sound Health Record
Recommended Regulations and Standards for Specific Healthcare Settings (Updated)

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