The patient’s chart is a legal document. Your documentation is of extreme importance and must provide a complete and accurate accounting of the patient’s condition and the care you provided. Your documentation record should be complete, accurate, and legible in order to defend yourself against allegations of improper care. Your documentation can discourage a plaintiff from pursuing a legal claim or can provide the fuel for a lawsuit.

The law defines negligence as:

Negligence is the failure to provide a patient with the standard of care that a reasonably prudent nurse would exercise under the same or similar circumstances.

Patient’s attorney must prove four elements to prove that the nurse was negligent:

1. The nurse had a duty to provide care to the patient and to follow an acceptable standard of care.
2. The nurse failed to adhere to the standard of care.
3. The nurse’s failure to adhere to the standard of care caused the patient’s injuries.
4. The patient suffered damages as a result of the nurse’s negligent actions.

By practicing in a nursing specialty area, American Society of PeriAnesthesia Nursing (ASPN), we must be familiar with and demonstrate compliance with the Standards developed by our specialty organization, the Perianesthesia Nursing Standards, Practice, Recommendations and Interpretive Statements as published by the American Society of PeriAnesthesia Nurses, which serves nurses practicing in all phases of peranesthesia, postanesthesia care, ambulatory surgery and pain management.

It is also important to be familiar with the standards developed by The Joint Commission, the National Council of State Boards of Nursing, and the American Nurses Association, as well as following documentation policies established by your employing facility.

The saying “If it wasn’t documented, it wasn’t done” is still valuable today. Your documentation should show that you continuously assessed your patient’s condition and monitored their progress. Documentation of hourly rounding improves the quality of patient care by showing frequent assessment and monitoring. All identified patient problems, nursing actions, and patient responses should be documented.

Nursing documentation that contains misspelled words or grammatical errors can lead lawyers and jurors to conclude that the nurse is uneducated and/or careless.
A Review of Charting: A Legal Document
Janice A. Wilson RN, BSN, CAPA

Your charting should be

1. timely – document care as provided and chart only what you see, hear, smell or feel
2. accurate – write specific, accurate descriptions
3. truthful – document only what you actually observe
4. appropriate – make documentation that you would allow the public to see and do not use judgmental language
5. Safe - Document safety precautions implemented.

Examples of Illegal Tampering With Medical Records
1. Adding to another person’s note
2. Destroying the patient’s chart
3. Not recording important details
4. Recording false information
5. Writing an inaccurate date or time
6. Adding to previous notes without indicating that the note is a late entry
7. Charting in advance medication administration, dressing changes or other treatments constitute falsification of records.

When Charting by exception (CBE) take extra precautions. CBE documentation does not give a clear, accurate description of the patient’s condition; therefore the nurse needs to write the patient's condition out in a narrative note to allow the reconstruction of an accurate picture of the patient’s condition in the future. In addition anything out of the ordinary needs to be written in a narrative note.

Describing a patient’s behavior as uncooperative, difficult, manipulative, or referring to the patient in a sarcastic manner alerts the patient’s lawyers that a nurse did not respect or value the patient, therefore make descriptions only by giving factual and impartial descriptions without additional commentary.

Recognize and respond to complications. Assess and monitor patients regularly and report a significant change in a patient’s condition to physician. Nurses should report situations in which a patient’s condition undergoes
1. rapid change, especially after surgery or labor
2. after patient suffers injury in the hospital facility
3. when the patient have self-destructive tendency.

Documenting in Emergencies Make sure your documentation addresses these issues:
1. The patient's condition before the emergency
2. The patient's condition when the emergency began
3. When the emergency occurred
4. When the physician was notified
5. What interventions were used and when they were started
6. How the patient responded to the interventions
If, in your professional judgment, you consider the physician orders placing the patient in jeopardy, you must intervene on the behalf of the patient and clarify the treatment plan or verify the medication with the physician. The nurse must be persistent in an attempt to notify and convince the physician of the seriousness of the situation.

If a change in a patient’s status warrants notifying the physician and a potential change in the treatment or medication, the nurse must be able to communicate essential information in a clear and logical manner that expedites understanding and intervention.¹³⁶

Organizing Your Reporting Data⁴

1. Patient’s history: present illness or surgery, medications, significant comorbidities
2. Assessment:
   a. Complete set of vital signs
   b. Change in level of consciousness
   c. Changes in perfusion as indicated by skin color, oxygen saturation and urine output
   d. Pain out of proportion to the diagnosis or procedure
   e. Unusual behavior — irritability, hallucinations, agitation, sense of impending doom
   f. Change in a wound or drainage status
   g. Relevant diagnostic test results

Document each time you phone a physician.⁴ Chart the details of your message and the physician’s response.⁴⁶ Specify the details you reported, the time you called, the new orders or no orders received and additional actions you take.⁴ Always note in the chart the specific change in the patient’s condition or diagnostic test result that prompted your call to the physician.

Documentation that reflects the nursing process, including

1. competent assessment,
2. frequent observation,
3. timely and accurate reporting, and the
4. use of the chain of command, if necessary, often will protect the nurse from accusations of negligence — even when there is a poor outcome.¹⁰

Legally credible documentation provides an accurate written record of the care your patient received and evidence that you met an acceptable standard of care. Let your charting tell others that you did all you were expected to do in providing your patient with quality nursing care.⁴⁶
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Reference:

3. Hudson K. Legal documentation. 2nd ed. Dynamic Nursing Education.com Web site. 