

THE PITFALLS OF MEDICAL RECORD CHARTING

By: Leonard H. Kunka

In an increasingly litigious society, the importance of proper patient charting for hospital staff cannot be underestimated. However, a difficulty arises when the hospital's standard for patient charting comes in conflict with the legal standard imposed by litigators who attack the charting practices used in a particular case, and Judges who must decide whether a health care practitioner has fallen below the "standard of care" expected for that practitioner.

Each hospital develops its own standard of charting practice, usually by taking into account the requirements set by the associations which govern health care professionals in that community. A major tension which develops is the apparent need to "document everything" in order to protect against lawsuits, and the fact that such documentation can be used by a skilled lawyer to attack virtually any health care professional. Equally problematic are hospital policies which have adopted charting protocols, such as the form of charting known as "charting by exception" (CBE) or "variance charting". These policies are potentially the biggest area of risk for hospitals and their staff, as they provide ample and futile ground for attack by experienced counsel.

CHARTING BY EXCEPTION (CBE) OR VARIANCE CHARTING:

Because this charting protocol is the basis for many claims against hospitals and nurses, this paper will focus in some detail on the reasons why this charting method creates such risk for hospitals.

This method of charting documents the progression of a disease or illness based on a pre-established nursing care plan. This plan documents standard patient

management and delivery of care guidelines based on established protocols and procedures, with spaces for health care professionals to check off and initial normal or expected developments in a patient's condition. When a patient's condition deviates from the care plan and significant findings or unanticipated responses are observed then additional narrative notes or documentation should be added to the chart by the health care professional.

It is argued that a major advantage of this type of charting system is an alleged enhancement in the consistency of charting, (due to the elimination of individual differences in charting practice by different health care professionals). Additional benefits are said to include the reduction of confusing or redundant charting; a clearer definition of abnormalities requiring attention or intervention, and clearer measurement of patient outcomes.

This CBE protocol was developed to deal with the concern of health care professionals that in a courtroom, lawyers would take the position that "if it was not charted then it was not done". The CBE protocol attempts to replace this legal belief with a new premise, namely "all standards have be met within the normal or expected response outlined in the care plan, unless otherwise noted.

Where the chart does not contain an entry and simply a check mark, the assumption is that the patient's condition is "normal", but therein lies the difficulty with this method of charting, and this becomes the focal point for cross-examination by experienced counsel. This charting protocol creates a self-perpetuating defence to a claim in negligence by suggesting that all standards have been met. However, in a situation where a patient's condition did deteriorate, or where complications arise, this method of charting can provide an easy avenue of attack for experienced counsel. The nurse or other health care professional who charted and is being cross-examined on the chart, will be forced to admit, by the absence of any further charting documentation, that either she or he did not observe any abnormalities in the patient's condition, or that they

believed from their observation of the patient, that the patient's condition was "normal" or at least expected for that stage of their recovery. The response to any attack on the absence of documentation will inevitably be, "If I observed or found any abnormality in the patient, I would have charted it". Counsel cross-examining the health care professional will then get them to admit that the absence of any further documentation in the chart means that the patient's condition was therefore "normal" or as expected, in the opinion of that health care professional. The cross-examiner will then set up the nurse or other health care professional to admit that if the Court finds the patient was exhibiting other symptoms which did not appear in the chart, the nurse or other health care practitioner must have fallen below the standard of care by either failing to observe those symptoms, or alternatively, they fell below the standard of care by failing to follow the hospital's protocol to document those abnormal symptoms in the chart.

Counsel will then generally lead other evidence, such as evidence of family members or friends who were visiting the patient, to show that the patient was exhibiting various symptoms which should have been observed and recorded in the chart. The lawyer will then argue that those symptoms should have been interpreted as an indication of a patient's deteriorating condition, or an indication of some other serious complication which had developed.

While redundancy of charting may be eliminated using the charting by exception protocol, often the repetition of a particular symptom by different nurses or health care practitioners who are attending to the patient, becomes the triggering mechanism for concerns about the patient's condition, which may in turn lead to earlier intervention.

It is therefore quite easy to understand how variance charting may create enormous risk to hospitals and their staff in the context of a negligence action.

OTHER FORMS OF CHARTING:**A) The Written Narrative:**

This is still the most widely used form of charting, and it is often used in conjunction with other styles of charting. This style of charting offers space for the nurse to document information not captured elsewhere in the health record, (such as in the flow sheets, operative records, emergency record etc.). This style of charting is most effective when the complexity of required care requires a detailed written chronology.

It goes without saying that this style of charting is only as good as the entries made. The entries must be clear, concise and legible.

Where entries are unclear, vague or so difficult to read that they cannot be understood, this creates a further avenue for attack in a negligence claim.

B) Flow Sheets:

Flow sheets are standardized forms, usually are arranged in pattern which allows visual comparison of data, treatment or symptoms across a period of time.

Flow sheets enhance the continuity of care by providing an easy ability to compare data from period to period.

One major shortfall of flow sheets is that where a patient's symptoms are not changing, sometimes the flow sheets are not completed by the nurse or other health care professional. The effect is that critical data can sometimes be missed or alternatively, the data which would help support the nurse's or doctor's decisions or treatment will be absent. This makes it difficult for the hospital to

defend a claim in negligence, particularly where the hospital needs to show the reasonableness of a nurse's or doctor's decision not to intervene and provide other treatment or care.

C) *PROBLEM ORIENTED RECORD (POR):*

This form of charting gained popularity in the 1980's and focuses on recording patient outcomes in relation to a patient's problems. Once a problem is identified, it is recorded, as are the responses or outcomes in relation to the required interventions for that patient. Routine care events and interventions are not recorded in the POR.

At the present time, this form of charting is not regularly used.

GOOD CHARTING PRACTICES:

While the following is not an exhaustive list, it is an attempt to outline good charting practices, based on the areas where lawyers often look for omissions or problems in the chart. These omissions often form the basis for a claim that a health care practitioner fell below the standard of care in caring for or treating a patient:

- 1) Chart defensively, remembering that a judge or jury who cannot understand notations in a chart will tend to interpret them in a negative fashion against the health care practitioner.
- 2) Include all of your observations, including the date and time of each entry, and your signature
- 3) Include all your treatment or actions in a clear and concise fashion.

- 4) Record all of the patient's responses to treatment or therapy.
- 5) Do not avoid recording treatment which was missed or omitted, unusual incidents, mistakes or other errors.
- 6) Record all attempts to reach any physician who is treating the patient
- 7) When there are significant changes in a patient's condition, always alert a physician and document in the chart that you have done so.
- 8) From the standpoint of protecting the hospital from liability, nurses should record any concerns or reservations they may have about a physician's orders
- 9) Chart observable facts/findings and be accurate. Do not chart subjective opinions or hearsay information. Do not repeat as factual history in your charting information which you are not certain is reliable
- 10) Be contemporaneous in your charting. If you have to chart at a later time, indicate that when you are charting and when the actual observations were made
- 11) Document significant conversations with the patient or their family where appropriate
- 12) Chart non-compliant or risk taking behaviour of the patient (i.e. patient getting out of bed when not permitted, patient not following dietary restrictions, patient refusing medication etc.).

- 13) Where the patient has had an unanticipated/unexpected/abnormal development or incident, the chart should follow that event until resolution. Some hospitals have a separate procedure for documenting and following such events.

ITEMS NOT TO CHART:

- 1) Avoid labels to describe your patient's behaviour, and do not use subjective or insensitive statements pertaining to the patient. Be objective. To a cross-examining lawyer, a label describing your client's behaviour may be interpreted as a dislike of the patient which could lead to a suggestion that you provided substandard care to the patient. Similarly, do not make entries which reflect personality clashes rather than legitimate concerns about the patient's care.
- 2) Do not chart a symptom such as "complains of stabbing pain" without charting what you did about it.
- 3) Do not chart your concern that you were understaffed at a particular time. Avoid charting any other staffing problems. The hospital's procedure manual should explain how to deal with those types of concerns, and documenting them in the chart will provide ammunition for cross-examination.
- 4) Do not write imprecise descriptions such as a patient voided "a lot". Measure the amount and chart it.
- 5) Do not chart what others have told you. If you feel it is necessary to record something that someone else stated, ensure the chart reveals who told you what you are recording and when

- 6) Never try to cover up a mistake, or use the words “accidentally” or “somehow” to explain a mistake. Record the facts and let the facts speak for themselves. Attempting to cover up a mistake often leads to a finding of negligence against the nurse or other health care provider, and the hospital.
- 7) Do not chart in advance of care which is provided. Should you be unable to deliver the care and the chart reflects care which was not provided, this may be considered fraudulent.
- 8) Do not attempt to remove/obliterate or erase an entry if an error is made. Strike through the error with a single line which leaves the original text readable, and write “error” next to the incorrect entry and initial the strike-through.
- 9) Do not chart for others
- 10) Do not leave white space or blanks in the chart. This may allow others to add data within the parameters of your signature. If there is unused space, draw a line through it including your initials before and after the line to avoid this risk.
- 11) Avoid Abbreviations whenever possible (unless they are standardized abbreviations used consistently through the institution).
- 12) Do not refer to another patient by name. This violates that patient’s confidentiality. Use another description such as “patient in Bed 2 indicated...”

In a medical negligence case, lawyers will carefully review the hospital chart looking for the type of problems noted in this paper. The hospital chart is usually the first place a lawyer will look to attempt to build a case that a nurse, doctor or other health care professional fell below the standard of care in caring for or treating a patient.

Good charting practices reduce the opportunity for a lawyer to build upon inconsistencies or omissions in the chart, thereby making it more difficult to support an argument that the nurse, hospital or doctors fell below the standard of care.

An attempt to cover up a mistake is a red flag, and will often be used by a skilled lawyer as the focal point for a negligence claim against the hospital and its staff. While this comment seems self evident, it is shocking to see the number of times entries of various health care professionals are attempted to be altered. An attempt to cover up a mistake is almost always fatal to the hospital's ability to defend itself, and therefore must be avoided at all times.



Leonard H. Kunka, Partner

Thomson, Rogers
3100-390 Bay Street
Toronto, Ontario
M5H 1W2

(416) 868-3185

Email: lkunka@thomsonrogers.com