

NURSING LAW IN VIRGINIA: THE ART OF DOCUMENTATION

I. The Importance of Complete Documentation

A. Sources of Standards for Charting

1. Statutory and Regulatory Requirements for Medical Record Charting

The health care industry is among the most highly regulated, including detailed requirements for medical record keeping.

The Virginia State Board of Health has issued rules and regulations for the licensure of hospitals and outpatient surgical facilities, 12 VAC 5-410, et seq. (amended August 10, 1995), including regulations governing medical records. 12 VAC 5-410-370. (Attachment A) A section of the regulations specifically delineates the minimum requirements for medical records in outpatient surgical facilities. 12 VAC 5-410-1260. (Attachment B) Other detailed record keeping requirements are scattered throughout the regulations:

- Each hospital must have an organized medical staff whose bylaws must include requirements regarding medical records. 12 VAC 5-410-210.
- Each surgical suite is required to be under the supervision of a registered professional nurse (12 VAC 5-410-420.C.1) and must maintain an OR register, including patient's name, pre- and post-op diagnoses, complications, name of surgeon and assistants, etc. (12 VAC 5-410-420.E), and the patient's medical chart is required to be available in the surgical suite at the time of surgery. 12 VAC 5-410-420.G.
- Policies and procedures required for OB units include those for the monitoring of patients at all times (12 VAC 5-410-430.C.4.a.(3)); documentation of administration of RH O(D) immunoglobulin (id. at C.4.a.(7)); defining vital signs, the intervals at which they must be taken, and requirements for documenting them (id. at C.4.b.(4)(a)); and the completion of medical records (id. at C.4.b.(9)). Similarly detailed regulations exist for other hospital units.

The State Board of Health has also published rules and regulations for nursing facilities (12 VAC 5-371 et seq.) which also include detailed requirements for nursing record keeping, including clinical records (12 VAC 5-371-360) (Attachment C), and use of restraints. 12 VAC 5-371-330 (Attachment D).

The Virginia Department of Health has issued similar regulations for hospice facilities (Virginia Department of Health, Rules and Regulation, Hospice, effective April 11, 1990) and home care organizations (Virginia Department of Health, Rules and Regulations, Home Care Organizations, effective April 11, 1990). The hospice regulations include specific requirements for medical records (Hospice Regulations, § 3.11) (Attachment E) and the duties of registered nurses in the hospice setting (id. at §§ 4.04 and .05) (Attachment F), including the requirement to prepare and coordinate clinical notes and progress notes on nursing services delivered. Id. at § 4.05.B.6. The HCO regulations contain similar provisions concerning medical record requirements and nursing duties. HCO Regulations, § 3.10, 5.01-.02) (Attachments G and H, respectively).

The BON regulations also require that any registered nurse delegating any nursing task or procedure to an unlicensed person must supervise the delegated task or procedure, including "[e]nsuring appropriate documentation." 18 VAC 90-20-430.B.2.

2. Professional Association and Accrediting Organization Standards

There are as many professional associations as there are specialty practice groups, and nearly all have published "position statements" or "guidelines" applicable to their particular specialty, including statements establishing standards for documentation within the specialty. For example, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has adopted the recommendation of the American College of Obstetricians and Gynecologists (ACOG) that:

"[T]he frequency of documentation of FHR auscultation for a low-risk intrapartum patient should be every 30 minutes during the active phase of the first stage of labor.

For the high-risk intrapartum patient, FHR auscultation should be performed and documented every 15 minutes during the active phase of the first stage of labor and every 5 minutes during the second stage of labor."

AWHONN Position Statement on Fetal Assessment (April 2000), citing ACOG Technical Bulletin No. 207, Fetal Heart Rate Patterns: Monitoring, Interpretation, and Management (1995).

As a further example, the well known Guidelines for Perinatal Care, published jointly by the American Academy of Pediatrics and ACOG, contain many detailed requirements for documenting medical and nursing care both prenatally, in the L&D unit, postpartum, in the nursery and upon transfer of any patient. Similarly, the American Association of Nurse Anesthetists (AANA) has published detailed record keeping requirements in its Scope and Standards for Nurse Anesthesia Practice.

Many of the organizations publish these statements as "guidelines" in an effort to avoid their use as evidence of an explicit "standard of care" which, if violated, would serve as a basis for a finding of malpractice. As a practical matter, these statements will often be admitted (though generally not by Virginia state courts) as evidence of the applicable standard of care.

Most institutions incorporate these standards into their own policies and procedures and record keeping forms. Any failure to do so creates an argument that care is not being appropriately documented. It is important to be aware of any such standards applicable to the specific area of one's own practice, both for patient quality of care reasons as well as professional liability concerns.

Even more important are the documentation standards mandated by accrediting organizations, including, particularly, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). While the JCAHO Hospital Accreditation Standards (2000) include record keeping requirements for specific functions throughout the standards, the section dealing directly with information management is explicit and detailed, setting forth requirements that are familiar and generally incorporated in health care practice as a matter of second nature, including:

- A medical record is initiated and maintained on every patient. (IM.7.1)
- Only authorized individuals make entries in the record. (IM.7.1.1)
- Operative reports are entered in the record immediately after surgery (IM.7.3.2) or at least a surgeon progress note pending the formal report. (IM 7.3.2.2)
- Verbal orders are accepted and transcribed by qualified personnel as identified by title or category in the medical staff rules and regulations. (IM.7.7)
- Every medical record entry is dated, its author identified, and, when necessary, authenticated. (IM.7.8)

The standards with respect to patient-specific data (IM.7 - IM.7.9) require documentation of virtually every aspect of patient care in the hospital and that this be done in a timely manner.

3. Institutional Standards

- Medical Staff Bylaws and Rules and Regulations, Clinical Service Rules and Regulations, Department Policies and Procedures

Most hospitals incorporate record keeping requirements in the Medical Staff bylaws as well as the medical staff rules and regulations and provide for oversight through a medical records committee which includes representatives of the nursing service to assure that an adequate medical record is maintained for every person admitted to the hospital.

Each clinical service or department within the hospital generally adopts its own rules, regulations, and policies and procedures containing provisions specific to the record keeping function. These may impose duties on the nursing staff.

For example, an OB Service's rules may require the nurse to contact an attending physician for admitting orders if there is any delay in receipt of orders and to document appropriate monitoring in the labor room. (Attachment I) An Emergency Medicine Department's policies and procedures may delineate record keeping requirements for general nursing care of patients in the ER (Attachment J), or for specific presenting symptoms or findings (Attachment K), or transport of patients from the ER to a clinical unit. (Attachment L)

- Nursing Policies and Procedures

Policy and procedure manuals abound on hospital nursing units. They are often not read, or were last reviewed long ago, by members of the nursing staff. Detailed record keeping requirements are pervasive in these manuals. In Virginia, there is a split among the circuit courts as to whether these manuals are either discoverable or admissible in evidence as proof of the applicable standard of care. Familiarity with and adherence to the requirements in relevant the policy and procedure manuals is recommended.

4. Case Specific Standards

- The Expert Witness Standard:

Expert witness testimony is generally required to establish the applicable standard of care. The standard is whatever the expert says it is.

"If you didn't write it down you didn't do it." NOT! Your actual recollection is important. The role of "custom, habit and practice" evidence is also important.

- Admissions by a party or witness:

The applicable standard of care can be established by your own testimony or that of other nurses, particularly those in managerial positions, within your organization, either on deposition or at trial.

B. Clinical Considerations

Little comment is necessary. The record keeping standards derived from all the sources identified (with the possible exception of the plaintiff's expert witness) are designed to contribute to quality patient care, a desirable goal.

C. Professional Licensing and Professional Liability Considerations

The Virginia Board of Nursing Regulations, 18 VAC 90-20-10, et seq. (effective April 12, 2000), provide that the Board may deny, revoke or suspend a license, or otherwise discipline a licensee for violating any of the provisions of the Code of Virginia, § 54.1-3007, including a prohibition against "unprofessional conduct." The regulations then define unprofessional conduct as including, but not limited to, falsifying or otherwise altering patient or employer records.

It is well established that nurses and their employers are liable for acts of professional negligence. *Jenkins v. Payne*, 251 Va. 122 (1996) (nurse practitioner liable, along with physicians, for failure to diagnose patient's breast cancer); *Stuart Circle Hospital v. Curry*, 173 Va. 136 (1939). See generally *Anno: Nurse's Liability for Her Own Negligence or Malpractice*, 51 A.L.R. 2d 970. This includes harm sustained by patients as a result of errors in charting. See, e.g. *St. Germain v. Pfeifer*, 418 Mass. 511, 637 N.E.2d 848 (1994) (nurse may be held liable for taking off physician orders without implementing orders appropriately or communicating them to others); *Green v. Berrien General Hosp. Auxiliary, Inc.*, 437 Mich. 1, 464 N.W.2d 703 (1990) (in malpractice action by parents of seven-year-old boy who died when endotracheal tube airway failed, nurse could be held liable for failing to observe and document breathing sounds and to complete a specific nursing plan for the child's care consistent with maintaining his airway).

II. Critical Elements in Charting

A. The Obvious Factors

1. Legibility, Completeness, Timeliness

Entries must be legible to meet minimum requirements for record keeping purposes.

Completeness of entries is a recurring problem, including:

- Failure to date and time entries when clearly required by preprinted forms (whether take off of physician orders, nursing progress notes, witness signature on informed consent forms, etc.);
- Failure to check or mark each box on preprinted forms or to fill in all the blanks.
- Failure to record all the information you are given by a patient (including drug allergies, diseases).
- Failure to document all medications given, including dose, route and time.
- Failure to record a discontinued medication.
- Failure to record drug reactions or medication errors.
- Failure to record changes in a patient's condition.

Timeliness of entries is equally important. Problems can arise with charting right at the change of shift.

III. Preventative Measures to Decrease Liability Risks

A. Monitor Your Own Charting

Take the time to review your own charting practices.

B. Keep Privileged Documents Out of the Clinical Chart

Do not allow incident reports, quality assurance or peer review documents to become part of a patient's clinical record.

C. No Finger Pointing

Do not put comments on the clinical record more appropriately reserved for QA activities.

D. Review Earlier Entries and Follow Up as Necessary

Plaintiff's expert will testify that you should have reviewed earlier nursing notes. If there is an entry that cries for follow up, but none is documented and you are the subsequent nurse, the omission becomes your responsibility to correct.

E. Record Alteration and Destruction (Appropriate and Inappropriate)

Make "corrections" appropriately.

- Draw a single line through the entry to be corrected so that the original entry remains legible.
- Write a brief explanation of the reason for the correction ("Error" or "Incorrect Chart")
- Write the corrected information in the nearest available space.
- Date, time and initial the corrected entry.

Make "late entries" appropriately (assuming a "late entry" is a more detailed note than a "correction" concerning an event as to which there was no time to make the entry at the time of the event, or subsequent events have suggested the need for additional clarifying information and the entry is being made within a reasonable time after the event occurred):

- Do not alter the original entry in any fashion.
- Make the "late entry" at the next available space on the chart for the type of entry involved. Late entries generally should be made in the progress note portion of the chart.

The late entry should be made at the next available space after the last progress note then on the chart

- Date and time the entry as of the time it is being made, begin the narrative portion of the note "Late Entry" and then proceed to explain both what happened and why the entry is being made at the later time.
- Sign the entry.

Record destruction: Never, under any circumstances, no exceptions.

G. "Pre-Charting"

This should not be done. If care that is pre-charted does not get done, for whatever reason, a patient's health may be jeopardized. A false record has been created.

H. Consult with Risk Management or Counsel

If there is doubt about specific charting requirements or appropriate action, it is probably because the situation is (1) not routine, and (2) somewhat worrisome. That is reason enough to consult with the institution's risk manager or legal counsel.

I. Do Not Keep Your "Own Record"

Resist the temptation to document an event for your own future personal use in a record to be kept at home. There is no privilege that attaches to such a document, and the creation of the document alone will be used as evidence of guilty knowledge. Again, consult risk management or legal counsel. There are a legitimate ways to assure that information will be retained if a need should arise years later to explain or defend a specific event.

J. Incident Reports

Whether incident reports are discoverable and can be used against a health care provider is the subject of disagreement among Virginia Circuit Courts. If completed correctly, an Incident Report ought not to serve as a significant piece of evidence against a health care provider. Limit information to "just the facts" - date, time, place, who was there (all involved persons and witnesses), a brief factual statement of what happened, and any actions taken. (This is the same information that a claimant would get in any event through depositions of witnesses in a lawsuit.) Do not include in an Incident Report any opinions, assumptions, speculations, comments on why something happened, statements affixing "blame" or recommendations for change or remedial action. Speak to the institution's risk manager or quality assurance department on how to communicate recommendations for change or improvement.

K. Fully Document "AMA" Departures

Patients have a right to refuse medical treatment. It is important to document fully, however, the fact that a patient is leaving the health care facility "against medical advice." Be sure to complete the standard "AMA" form and ask the patient to sign. If the patient refuses, document that fact as well and try to have at least one other provider serve as an additional witness. Place the form in the clinical chart and then document in the chart the details of what happened, including the circumstances regarding the patient's decision to leave, the discussion with the patient about the risks of leaving and any alternatives to leaving, and the details of the patient's departure.

L. Privacy

1. Virginia Code § 32.1-127.1:03

Fairfax Hospital v. Curtis, 1997 Va. LEXIS 122, holding that a patient has a cause of action against a hospital for the voluntary disclosure of her confidential medical records without the patient's authorization.

2. HIPAA (Health Insurance Portability and Accountability Act of 1996) Regulation

This massive new federal regulation was scheduled to take effect on February 26, 2003, but has now been postponed for a further public comment and review process. The regulation forbids disclosure of patient medical records without patient consent and provides penalties for violations ranging from not more than \$100 per person per violation to a fine of not more than \$250,000 and/or imprisonment of not more than 10 years if the violation is with intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm. Equally important is carefully guarding against verbal disclosure of sensitive patient information, either at the work site (nursing station, hallways, cafeteria, elevators - any place where unauthorized third parties may overhear what is being said) or in casual conversation with spouses, significant others, friends, or anyone else who does not have a legitimate basis to know what is in the medical record.