COMMUNICATION, DOCUMENTATION, AND ACCOUNTABILITY

Hindsight is 20/20

Disclosure

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The Nurse Planner for this presentation reports no conflict of interest and no financial relationships with a commercial interest organization.
The views expressed are solely my own, and do not necessarily reflect those of Columbus Regional Health, or the State of Georgia, and are not intended to be nor are offered as legal advice.

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Course Objectives

- Understanding the importance of quality communication in the healthcare setting and its impact on patient safety, care outcomes, and litigation.
- Know how to effectively communicate pertinent, patient centered information.
- Chain of Command: understanding healthcare team responsibility and accountability to ensure patient safety.

Course Objectives (continued)

- Understanding nursing standard of care and practice.
- Understanding nursing negligence.
- Understanding the importance of consent forms and their impact on patient treatment and care.
- Understanding bad outcome requirements.

A Cautionary Tale

- 45 y/o patient presented to a clinic in California. He was seen by a physician assistant (PA) and informed her that he was suffering from multiple myeloma (MM) with bone pain. He asked for pain control, and was prescribed Hydrocodone Bitartrate 10 mg and acetaminophen 325 mg.
- The patient returned multiple times for refills of the opioids, but his condition did not deteriorate. The PA confronted the patient and he admitted he did not have MM.
- He insisted he needed to receive continued refills of his opioids to avoid withdrawal symptoms.
- It was determined that the patient could not receive opioids simply for the prevention of withdrawal and was referred to an addiction medicine specialist.

A Cautionary Tale (continued)

- The patient found an attorney to review his case who requested a copy of the medical records.
- The PA took the patient's history in good faith and could not have known that he was fabricating his history.
- Later, the plaintiff's attorney called for the medical records a second time and compared the two sets.
- He noted that the PA had changed the records without dating the change. In fact, she had added information to the record with a similar pen to make it appear that the entries were made on the original date.

A Cautionary Tale (continued)

- The PA felt she should have included more details and documented key aspects she had not included initially. She used a similar pen to add the missing details.
- She documented her discussion about the risks of opioids and questions regarding the patient's history of substance abuse which had not been included in the initial notes.
- She did not date or sign the addendum and the changes appeared as if they had been originally included in the record.
- Verdict: $1.5 million for falsification of medical records.

Documentation

I don’t have time! So, WHY should I document?

Because documentation is…

- the Standard of Care and Practice!
- required by federal and state regulations!
- required by professional organizations!
- required by hospital policies!
- written proof that something was done!
- your testimony!
- quality assurance!
- money – third party reimbursement!

Documentation bad = care bad?

- Documentation shows either a complete or incomplete record of all assessments and care provided.
- Documentation quality (accuracy) may influence the outcome of malpractice litigation > perception!
- One questionable entry can harm integrity of the entire record (i.e. copy/paste/template).
- Assessment (checklist) and nurses note (narrative) should always match.

Documentation

- If it wasn't charted, it wasn't done > true?
- Documentation does not only occur in the medical record. Is it evidence?
- Charting by exception – good practice?
- Care team documentation – who's on it?
- Multiple documentation systems
- Statue of Limitation(s) vs. trial > years down the road.

The medical record is a legal document!

- Documentation should be objective, factual, accurate, organized, inclusive, timely, legible, include only approved language/abbreviations, unaltered, and never copied and/or pasted.
- Documentation should reflect a clear and concise thought process.
- Documentation should include patient's own words.
- Documentation should utilize standardized terminology.
- Documentation should be done concurrently.

Documentation Examples

- Hand-off report (lunch, shift, transfer)
- ALL attempts to contact provider (pager, voicemail…)
- Any report to provider in details
- Any verbal reports or relevant discussions
- Interventions before and after provider notification
- Adverse events and outcomes
- Assessments
- Care plan changes/explanations
- Patient/family education/instructions
- Medications
- Discharge procedures/instructions

8 Common Charting Mistakes To Avoid

1. Failing to record pertinent health or drug information.
2. Failing to record nursing actions.
3. Failing to record that medications have been given/refused.
4. Recording on the wrong chart.
5. Failing to document a discontinued medication.
6. Failing to record drug reactions or changes in the patient's condition.
7. Transcribing orders improperly or transcribing improper orders.
8. Writing illegible or incomplete records.

by Marianne DeMilliano, BSN, JD

Documentation? We have a case for that!

Meek v. Southern Baptist Hospital of Florida, Inc. d/b/a Baptist MC

- The patient was admitted for a hysterectomy and developed bleeding after surgery. She was admitted to the radiology unit for uterine artery embolization (UAE) to stop the bleeding.
- The physician ordered frequent leg examinations to mitigate the risk of diminished blood flow and nerve injury (a known complication of UAE).
- The patient sustained nerve damage after a massive clot was removed in the external iliac artery.
- The patient claimed the exams were not performed and based on the lack of documentation the claim could not be disproven.
- Verdict : $1.5 million

Documentation…the timing matters!

- Metadata – data about data (i.e. audit reports).
- Computer Forensics – from the Electronic Medical Record (EMR) to Facebook.
- Metadata generated by the EMR can show who accessed a record when, where, for how long, what part, at what time…endless possibilities.
- Metadata can show modifications to a record. If the modification occurred at an inappropriate time, questions about falsification of records may arise, even in the absence of any wrongdoing.
- Be aware of the time/signature stamp.
- Identify your late entry (paper chart or EMR).

Timing? We have a case for that!

- A patient with a catastrophic operative outcome sued hospital for negligence.
- Metadata showed the anesthesiologist wrote his post-op note minutes after the operation began.
- The hospital later discovered that its anesthesiologists commonly recorded standard notes, such as their presence at the patient's emergence from anesthesia, during less hectic parts of the procedure, thereby documenting in the future.
- Verdict: unknown settlement

Communication

I don’t have much time, so

WHY should I communicate?

Communication

- The quality of communication directly influences patient safety and care outcomes!
- Applies to all types of communication:
  - Staff to Patient - Patient to Staff (language, situation…)
  - Staff to Staff - Nurse, MA, Tech, RT…(shift/unit transfer)
  - Staff to Provider - Provider to Staff (emergency…)
- Greatest point of vulnerability > Hand-Off!
- TJC Sentinel Event Alert Issue #58 (published 09/12/2017)
- Know your facility's policies/procedures (fall, critical results…)

Communication (continued)

The goal is to create a clear picture of the situation:

SBAR: Situation (what is going on), Background (key info), Assessment (what do I think the problem is), Recommendation (what do I want)

- Be direct in your communication, close the loop (R&V)!
- If you know what you want > ask for it!
- Use standardized language, if applicable.
- Take out “the middle man”, if possible.
- Make a list before you call, if necessary.
- Middle of the night – oh joy!
- Emergency – rapid decision making communication.

Communication Barriers

- Disruptive behaviors
- 'Rivalries' (unit to unit, day/night shift, old/new staff, staff/student)
- Intimidation - Bullying
- Hierarchy
- Complexity of care (too much going on, priorities)
- Inexperience (don't know what to say, feeling overwhelmed)
- Personal values and/or prejudice

Communication Tips

- Practice makes perfect – drills
- New employee orientation classes
- Nice people rarely get sued
- Maintain confidentiality
- Be aware – you could be recorded
- Don’t criticize others or their actions in front of the patient
- Don’t offer medical opinions
- Include the patient and the family
- Don’t use medical jargon

Communication? We have cases for that!

Healthcare Auth. for Baptist Health v. Davis (2013)

- Patient went to ER after a fall at home. After x-rays came back negative, she mentioned she had a sore throat, and the ER physician ordered a test for streptococcus. The patient was sent home.
- The culture showed the presence of methicillin-resistant staphylococcus aureus (MRSA). The lab recorded the results in the electronic medical record, but the results were never reported to the treating physician. The patient died 2 months later.
- Verdict: $3.2 million

Costly Communication Error

Busta v. Columbus Hospital Corporation (1996)

- A postoperative patient died from injuries sustained in a fall from his third-floor window when he tried to climb down on an improvised rope.
- Nurse testified the patient had experienced an episode of tachycardia, hypertension and had behaved atypically, desiring isolation and refusing all nursing care.
- His prescribed medications were known to have adverse effects, including confusion, anxiety, and psychosis.

Costly Communication Error (continued)

- Nurse did not reassess patient's VS during the night because he appeared to be sleeping.
- The nurse did not report the symptoms and the change in behavior to the physician.
- The nurse was negligent in failing to adequately monitor the patient, and in failing to report the collection of signs and symptoms to the surgeon.
- Verdict: $560,000

Discharged Without Heparin Order

- Patient suffered a right ankle fracture when a vehicle ran over his foot and he underwent orthopedic and vascular surgery.
- He needed subsequent surgeries for wound debridement, grafts, and placement of VAC dressings. He was placed on heparin to prevent blood clots.
- The heparin was administered for a week, but an evening dose was refused. The next morning's dose was also refused. The records did not indicate the patient was informed of the risks of refusing the heparin, nor was the plastic surgeon informed of the heparin refusal.
- Additionally, the discharge report did not include the order to continue heparin.
- Patient died of bilateral PE due to deep vein thrombosis.
- Verdict: $750,000

Chain of Command (COC)

Don't know what to do?

There is a process for that!

Chain of Command (COC)

- A conflict resolution process.
- Used to address unresolved patient care or administrative issues and following is not optional.
- Considered the minimum standards of care.
- If you don't get what your patient needs, you have a duty to activate the Chain of Command to prevent patient harm!
- There is a difference – Nursing/Provider COC.
- You should always inform provider of intention.
- Know your facility's policies/procedures!

COC? We have a case for that!

- 24 y/o patient was diagnosed with swelling of the brain r/t an intracranial aneurysm and scheduled for neurosurgery the next morning.
- During the night the NP assessed the right pupil as fixed and dilated and called the neurosurgeon at home. The physician thanked the NP and hung up the phone.
- The scheduled surgery the next morning included a partial lobotomy, but the patient died.
- The NP correctly identified the problem, documented it, and contacted the physician. However, she failed to initiate the COC when it became clear the physician did not come in.
- NP failed to react to the emergency of the situation.
- Verdict: $2.5 million

Negligence

- **Failure** to act as an ordinary prudent person would act.
- **Failure** to provide such care as a reasonable and prudent person would under same or similar circumstances.
- Four elements are required to prove negligence:
  - Duty (to provide reasonable care to avoid patient harm)
  - Breach of Duty
  - Causation
  - Damages

DON'T make an F

Some of the most important nursing tasks include monitoring and the administration of meds. Negligence may include any of the following:

- Failure to monitor a patient properly
- Failure to assess a patient properly
- Failure to take a patient's vital signs at the proper times
- Forget to take an important vital sign
- Failure to administer the right type of medication
- Failure to administer the right amount of medication
- Failure to administer the medication at the right time
- Failure to check a bedridden patient for bed sores

DON'T make an F (continued)

If the nurse is an employee of the hospital, the nurse's negligence constitutes the hospital's negligence as well.

- Failure to respond to a patient's call quickly enough
- Failure to report suspicious symptoms and complaints to the physician in charge.
- Failure to communicate
- Failure to document
- Failure to follow standard or protocol
- Failure to initiate the chain of command
- Failure to use equipment properly
- Failure to act as patient advocate

Negligence? We have cases for that!

Neuen v. Primecare Medical Inc. (2011)

- Prisoner who suffered vascular disease in leg claimed prison's nurses ignored circulatory problem that led to amputation. Defense contended amputation couldn't have been avoided. ($850,000)

Estate of Williams v. Marworth

- Rehab facility's patient wandered off of grounds and died. Suit alleged nurses didn't watch him and allowed him to leave three other times. Defense noted decedent was a voluntary patient. ($1.6 million)

Negligence? We have cases for that!

Messina v. Deblasi (2011)

- Patient claimed nurse ignored bedsore, leading to infection and hip problem that necessitates his use of a wheelchair. Defense blamed infection on patient's comorbidities. ($5,402,748)

Steen v. USMD Hospital (2011)

- Patient alleged nurses used wrong catheter on surgical patient's bladder, tearing urethra and necessitating more surgeries. Defense contended correct catheter wasn't in operating room. ($850,000)

Standard of Care & Practice

Nurses are held accountable for their professional actions based on the standard of practice and standard of professional performance.

- Standards reflect the values and priorities of the nursing profession.
- Standards provide direction and guidance.
- Standards provide a framework for evaluating nursing practice.
- Standards are a benchmark for evaluation and assessment of quality nursing practice.

Standard of Care & Practice (continued)

Where can you find it?

- Professional organizations (ANA, AWHONN, ACOG…)
- State and Federal Rules and Regulations
- The Joint Commission/CMS/FDA/CDC Standards
- Facility Policies and Procedures
- Job Descriptions
- Educational Programs (Tailored to Clientele, Disease Process, Continuing Education, Specialty, Certification ...)
- Licensing Boards
- Other professional and regulatory bodies

Rules and Regulations of the State of Georgia

What is Unprofessional Conduct?

The Definition of The State of Georgia

Nursing conduct failing to meet the minimal standards of acceptable and prevailing nursing practice, which could jeopardize the health, safety, and welfare of the public, shall constitute unprofessional conduct.

Source: Ga. Comp. R. & Regs. R. 410-10-.03
Authority: O.C.G.A. §§ 43-1-25, 43-1-27, 43-26-2, 43-26-3, 43-26-5, 43-26-10, 43-26-11, 43-26-40, 43-26-42, and 43-26-51.
History. Original Rule entitled "Definition of Unprofessional Conduct" adopted. F. Aug. 24, 2015; eff. Sep. 13, 2015.

The Definition of the State of Georgia (continued)

This conduct shall include, but not be limited to, the following:

- Failing to take appropriate action to safeguard a patient's welfare. *(i.e. Chain of Command)*
- Using inappropriate or unsafe judgment, technical skill or interpersonal behaviors in providing nursing care.
- Assuming patient care responsibilities that the nurse lacks the education to perform, for which the nurse has failed to maintain nursing competence, or that are outside the scope of practice of the nurse. (i.e. expired courses)
- Failing to maintain a patient record that accurately reflects the nursing assessment, care, treatment, and other nursing services provided to the patient. (i.e. documentation)

Standard of Care/Practice? We have a case for that!

- In cases of advanced practice nurses such as a certified RN anesthetist (CRNA) or nurse practitioner (NP), the standard of care would be for a CRNA or NP.
- The legal standard of care for an advanced practice nurse would be that of an average and reasonable advanced practice nurse.

Ordonez v. Bayonne Medical Center (2011)

- Infant's brain damage blamed on delivery room nurses' failure to act after detecting severe drop in heart rate of fetus. Defense contended placental infection caused brain damage.
- Verdict: $8.5 million

Consents

Informed Consent

- NOT a nursing function!
- Must be obtained before the procedure!
- Must be dated, timed, and signed by the provider!

Consent to Treat

- Emergency – does it apply?
- Minor vs. adult – don't forget about DFCS!
- Psychiatric 1013 – NOT an order to treat!

Valuables Consent

- Nurses have a duty to guard patient belongings according to the GA Nursing Rules and Regulations.

Consents

DNR/Medical Power of Attorney

- Provider responsibilities
- Nursing responsibilities
- Witness – who can sign?
- Telephone consent
- Know your facility's policy

ALL Consents – must be dated, timed, and signed by all responsible parties (nurse, physician, patient, witness…)

Abortion Consent

- Know the Woman's Right To Know (WRTK) Act
- Difference between medical emergency (mother) and medical futile (fetus)

<u>Medical Emergency (mother)</u>

- Applies to any phase of the pregnancy
- No second opinion necessary
- 24 hour waiting period does not apply
- WRTK packet does not apply
- Informed consent for a medical procedure applies, depending on the emergency

Abortion Consent (continued)

Medically futile (fetus)

- Applies to any phase of the pregnancy.
- Two medical opinions are necessary
- 24 hour waiting period must be observed
- WRTK packet must be given to the patient
- WRTK consent form must be completed
- Informed consent for a medical procedure applies

Mandatory: State Report

Consents? We have a case for that!

Sanchez-Scott v. Alza Pharmaceuticals (2001)

- The drug company wanted drug salesmen to better understand medical practice, and encouraged physicians to let drug salesmen watch the physician.
- Plaintiff had been treated for breast cancer and went to the oncologist for a follow-up examination.
- The physician told the patient the salesman's name, but did not indicate that she had the right to exclude him from the exam.
- The patient was examined with the salesman present and later filed a law suit for invasion of privacy.

Bad Outcome – now what?

First steps – what to do:

- Know your facility's policies for adverse outcomes!
- Enter an occurrence/variance report - why is that so important?
- Inform your COC – day shift/night shift
- Notify the Risk/Legal Department – insurance carrier notification.
- Complete all documentation in a timely manner according to your facility's policies.

Bad Outcome – now what? (continued)

First steps – what to do:

- Secure all evidence – beware of spoliation laws (i.e. fetal strip, IV fluid bag, unit census log…)
- Disclose the event according to your facility's policies
- Reportable Event – mandatory state reporting vs. voluntary disclosure (there is a deadline)
- Debriefing – but don't talk about it
- Staff support – counseling

Bad Outcome – now what? (continued)

First steps – what NOT to do:

- Do NOT try to cover up the event!
- Do NOT destroy evidence (fetal strip, logs, meds…)!
- Do NOT falsify the medical record!
- Do NOT talk to the patient/family about the event without permission!
- Do NOT post on Social Media!
- Do NOT befriend your patient on Social Media!

Bad Outcomes? We have too many cases for that!

Kopishke v. Noorchashm (2011)

- Nurse gave surgical patient 1,000 times the prescribed dose of blood-pressure booster. Defendant debated whether overdose caused stroke, respiratory problems. ($875,000)

Gastard v. Paoli Hospital (2011)

- Neurobiologist sustained nerve damage in hand as a result of nurse's improper insertion of IV catheter. Defense disputed plaintiff's claim that she can't pursue medical research career. ($927,000)

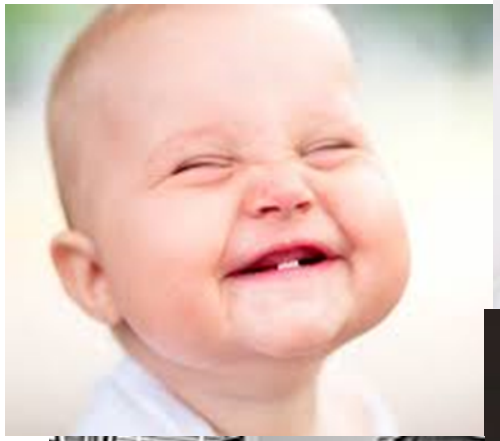
Kerley v. Tri-City Healthcare District (2011)

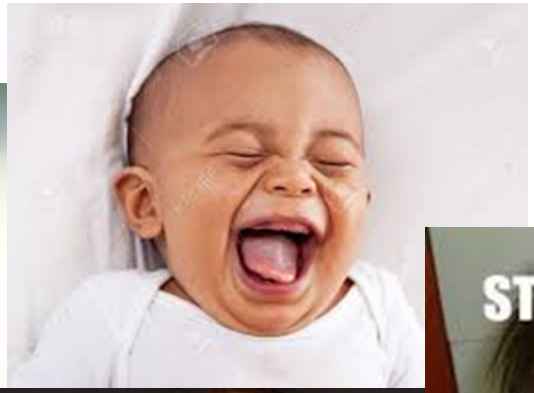
- Nurse sued for not watching patient with seizure disorder. Patient suffered seizure, fell off gurney and broke hip. Nurse claimed she didn't know patient hadn't taken her seizure medication. ($ undisclosed)

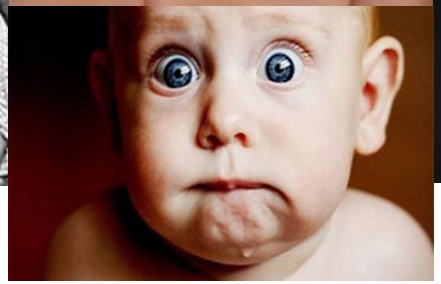
Takeaway

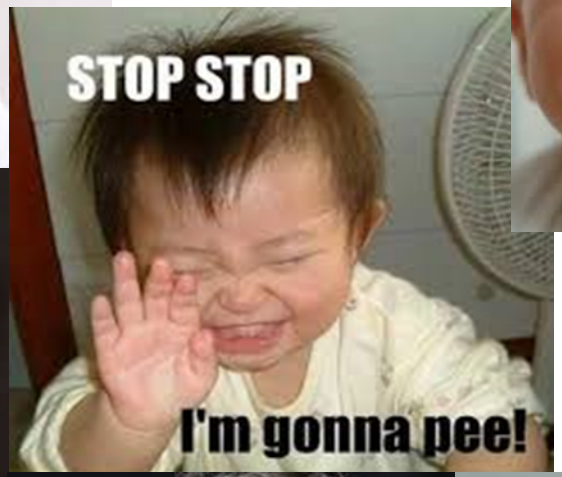
- Know your nursing standards of care and practice!
- Know your facility's policies and procedures!
- Know your chain of command!
- No matter who you are on the healthcare team; high-quality communication and documentation may save a life…and a license!

Let's End On A Funny Note…









Bloopers In The Pursuit Of Care

- She has no shaking chills, but her husband states she was very hot in bed last night.
- Patient has two teenage children, but no other abnormalities.
- Social history reveals this 1 year old patient does not smoke or drink and is presently unemployed.
- The patient refused an autopsy.
- His prognosis was poor, having a massive cerebral hemorrhoid.

The End

Questions?

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