COLLEGE OF
LICENSED PRACTICAL NURSES
OF ALBERTA

Nursing Documentation 101

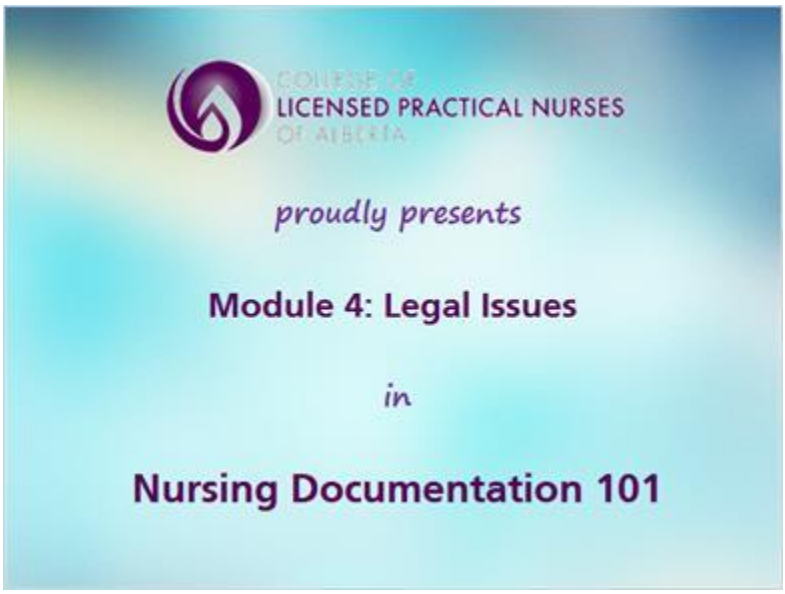
Module 4: Legal Issues

Handout

Module 4 – Legal Issues

1. Introduction

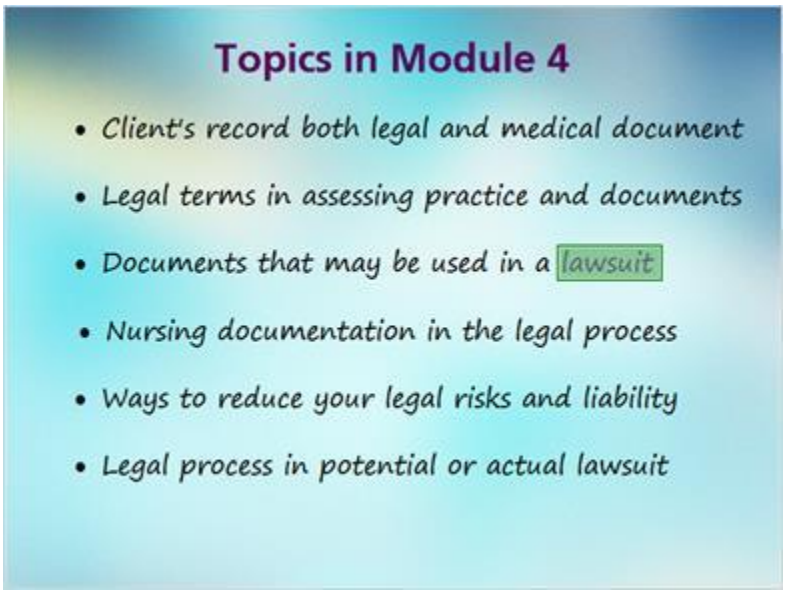
1.1 Welcome



Narration

No narration, only music.

1.2 Topics



Narration

JILL: Hi … I'm Jill and with me is Mark. Welcome to the Legal Issues module in this nursing documentation course.

MARK: Hi Jill. Oh, this is the module where we get to play pretend lawyers, right?

JILL: Well, not quite. However, we will discuss an overview of the legal process. The topics we'll cover include … why's the client's record is a legal as well as medical document … common legal terms … the medical documents that may be used in a lawsuit … nursing documents that may be involved in the legal process … ways to reduce legal risks … and how the legal process works in a lawsuit.

MARK: Since we are talking about legal things, I suppose we better make a disclaimer that this module is NOT a substitute for professional legal advice, nor does it necessarily reflect legal practices across all jurisdictions. It is intended only as a broad overview of the legal process and its impact on our documentation practices.

JILL: I'm glad you made that point.

1.3 Introduction

Narration

JILL: By way of introduction … A client's health record is the main communication tool that the healthcare team uses; it is also a medical and legal document.

As you have already mentioned Mark, this module is an overview only, and is not intended to be legal advice.

In Canada, lawsuits are generally initiated within two years of an adverse event, except in the case of a child or minor. However, the lawsuit may drag on for years, until a trial occurs.

1.4 Documents in Legal Process

Narration

JILL: Mark, why don't you talk about the documents in the legal process?

MARK: Sure. A health record tells the story of the client's situation and it enables others to understand the treatments and care that the client did or did not receive. From a legal standpoint, the client's record becomes the evidence if a lawsuit is initiated.

Documented care is just as important as the actual care. The legal system assumes that care was NOT done if it has not been documented. This implies that failure to document care means that there was failure to provide care.

Therefore, your documentation practices can make the difference between positive and negative legal outcomes. According to lawyers, "good notes will save you and no notes can destroy you".

Because your documentation is a legal necessity, your documentation may also be used to investigate a complaint to your regulatory College or it may be used in a coroner's inquest.

JILL: You can see why it is so important to document all the relevant details in a client's health record.

1.5 Types of Evidence

Narration

MARK: So what documents may be used as evidence in a lawsuit … is it only the client's health record?

JILL: Documents investigated not only include the client's full record, but also includes medication records … dispensing records … professional responsibility forms and … incident reports.

1.6 Other Documents

Narration

JILL: As well, other documents that may be investigated include work schedules … number of clients on a given unit … shift trades … staff on vacation, sick days and those who are on their days off. Physician appointment documents and credentials may also be examined.

MARK: Wow … I had no idea that ALL that information could be used in a court case.

JILL: Wait … we are not done yet!

1.7 Other Information

Narration

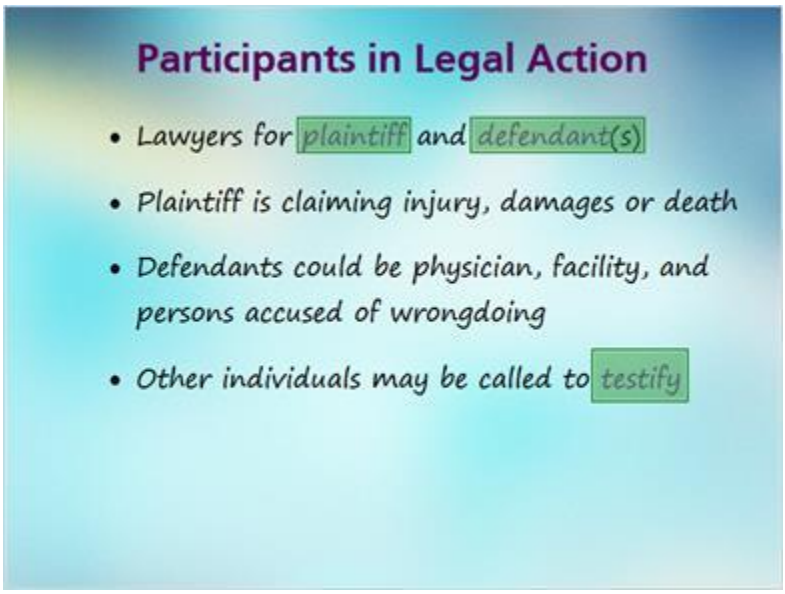
JILL: Here is a list of other documents that may be examined. Human resources files or pertinent employment files that contain performance reviews, family complaints, and interpersonal memos regarding the incident may be examined. Lawyers may even go as far back as requesting the academic grades of a care provider and whether this individual has engaged in professional development activities as part of fulfilling their professional responsibilities. There may be a review of mandatory education and training records. Policies and procedures of the employer may be examined to ensure that the employer expectations are clear for care providers.

Although incident reports are generally confidential, they are always reproducible should a legal issue arise. Although e-mails may be deleted from a computer, they are reproducible and may be used as evidence. Personal notes, sticky notes or a journal of a serious client issue that has been kept privately by care providers may also be demanded by the legal system.

MARK: So no document is safe from the prying eyes of the law, huh?

JILL: That's right Mark. Everything can be scrutinized when it comes to a lawsuit.

1.8 Participants



Narration

JILL: Mark, why don't you remind us who the participants in a legal action are?

MARK: Okay. In a potential lawsuit, there are lawyers who act on behalf of the plaintiff. This is the person who initiates or begins the lawsuit and claims injury or death or damages.

There are also lawyers who act on behalf of the defendant(s). The defendants could be a physician, facility or agency and the person or persons who are accused of wrongdoing.

Although you may never be named as a defendant in legal case, you may be called to testify at a discovery or during a trial. You will no doubt depend on your documentation and NOT your memory to respond to questions regarding client care.

1.9 Use of Documents 1

Narration

JILL: Let's now take a look at how the medical documents are used by the legal system.

Because the client chart has the most comprehensive record of care, it is used to establish the events and has the facts of what occurred. Since the legal system ultimately wants to prove cause and effect of damages or injuries, the court accepts the actions and the communications in the client record as proof that these events did occur. The court relies heavily on the client record to reconstruct events.

MARK: So, the lawyers for the plaintiff use documentation to prove that the standard of care was breached or not met. The client record is inspected to see that the care was competent, safe and appropriate, as well as completed. The plaintiff's lawyer is looking for lapses in charting, errors, amendments, deletions, inconsistencies and vague entries.

1.10 Use of Documents 2

Narration

JILL: That's correct Mark. The plaintiff's lawyer is trying to draw inferences of sub-standard practices and that standards of care were NOT met. If documentation was done before the care was completed, a plaintiff's lawyer could argue that the care was never done. Likewise, if the care was completed after the fact and documentation did not indicate a late entry, a plaintiff's lawyer could argue that the care was altered. Late entries after a serious incident involving death or injury may be viewed with suspicion.

MARK: And the lawyer for the defense will try and prove the opposite – that the care the client received was up to standard.

1.11 Use of Documents 3

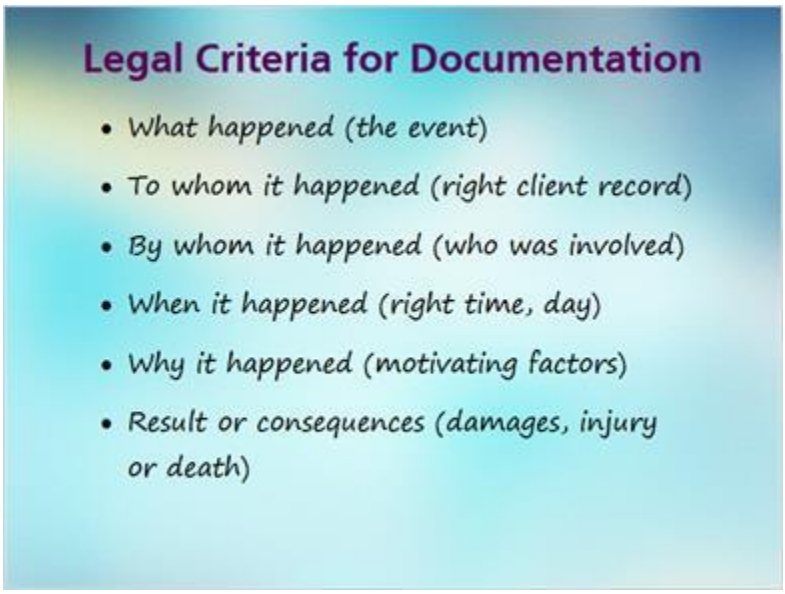
Narration

JILL: Yes Mark. The defendants are attempting to prove that the standard of care was met and that the care was safe, timely and appropriate for the client. The defendant's lawyer is trying to prove that the actions of the care provider are prudent, reasonable and that there is no causal link between the actions of the care provider and the client's injury or death. He is attempting to show that there were no lapses in the documentation, errors, inconsistencies or vague entries. Sometimes, an unbiased, health care expert is hired to verify that the defendant's documentation and actions did not breach the standard of care.

MARK: Okay, now I am beginning to understand why documentation … from a legal perspective … is so important. The quality of the documentation will determine whether we win or lose the lawsuit!

JILL: Yes, that is why this is so important to remember when you document every day.

1.12 Legal Criteria



Narration

JILL: According to legal experts, no matter what method of documentation is used, the client record should be able to determine the following:

- What happened or a description of the event
- To whom it happened or the right client record
- By whom it happened or who was involved
- When it happened, that is the right time and date
- Why it happened or motivating factors
- The result of what happened or the damages, injury or death

MARK: So if any of these are missing or done poorly, we are going to have a difficult time proving our case in court.

JILL: Yes, we will.

1.13 Problem Areas

Narration

JILL: Here is a bit of really useful information. It is the problem areas in documentation that lawyers see.

MARK: So if any of these are missing or described inaccurately, we will know what we need to fix and pay attention to!

JILL: Correct. Let's do this one together. I will start. *Not recording at the time of the event* – long delays in documentation create negative impressions of the care provider.

MARK: *Recording someone else's actions* – you record only what YOU saw, heard or did.

JILL: *Recording out of chronological order* – this is confusing to understand the care provided; you need to be careful with late entries.

MARK: *Not recording concisely, factually, and clearly* – have you provided significant details on client care and adverse events? Is your documentation objective? Is your writing legible?

JILL: *Recording infrequently* – recording is to be done promptly with the changing condition of the client and according to facility or agency policy; frequent documentation prevents charges that nothing was done or inadequate care was provided. For example, since post-surgical cases are considered higher risks, it is generally facility policy to monitor vital signs every fifteen minutes or as per physician orders.

MARK: *Not recording corrections clearly* – these need to be timely, honest and forthright and according to employer policies and procedures. You need to document corrections in such a manner to avoid implications that there is something to hide. When correcting a late entry, you need to state the date, time, reason and your signature. The incorrect information must still be legible. Forensic hand writing specialists have methods of detecting changes to incorrect information.

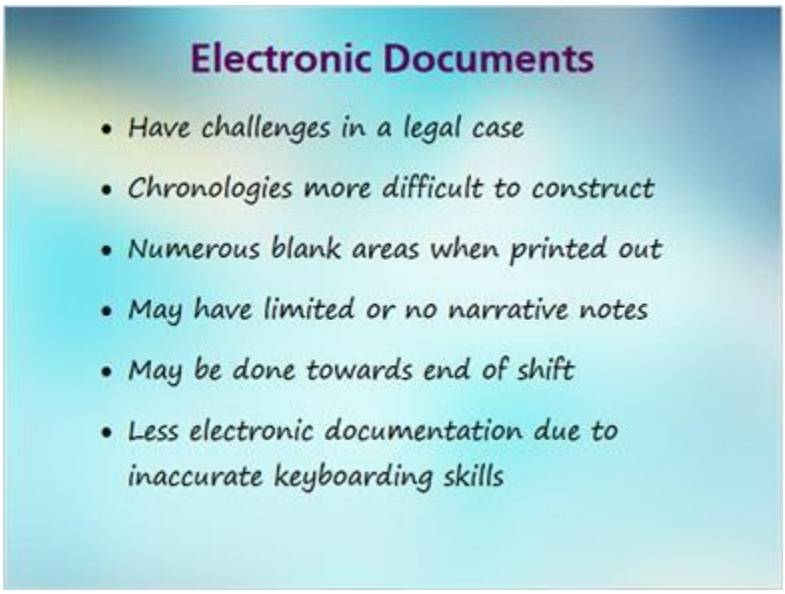
JILL: *Recording inaccurately and incompletely* – The client record should contain assessments, identification of health issues, plan of care, implementation of care and the evaluation of care. Remember that time and details matter.

MARK: *Facility or agency policies that are not realistic* – A care provider may need to address these with administration if documentation or other polices relating to documentation are not realistic or require updating. Ensure each department has reasonable policies that have clear standards of acceptable practice and policies that are agreeable to all.

JILL: Everything mentioned here, except for agency policies, are totally under our control. So we all have it in our power to make sure that our documentation can pass the legal test.

MARK: I fully agree with that!

1.14 Electronic Documents



Narration

JILL: Electronic client documents have some unique challenges in the legal sense.

MARK: What do you mean, Jill?

JILL: Chronologies are much more difficult to construct. Because of templates with most electronic systems, there are numerous blank areas when an electronic record of care is printed out. Some systems have no or limited narrative notes which are very important to reconstruct client events.

Because care providers may complete electronic documentation toward the end of their shift, this may create an inference that the client was not actually monitored. Staff who have inadequate keyboarding skills may do less electronic documentation. This may suggest that the client was not monitored routinely.

MARK: Ah, I see.

1.15 Legal Precautions

Narration

JILL: Let's now discuss a few additional tips for improving the legal status of your documentation.

MARK: Sounds good to me. What do we need to do?

JILL: First, develop your own practice statement to rely on if your memory fails. For example, it should be your usual practice to shred draft client notes each day; to talk in person to the receiving care providers using SBAR – Situation, Background, Assessments, Recommendations. These personal practice statements will protect you in the legal process.

Second, incident reports are used as evidence first by the agency or facility in internal investigations. Be careful of the language and terms you use when completing these. You do not want to use the terms "mistake" or "error". These words can be used to determine that something you did or did not do was your fault. Remember to write about facts only, be objective and do not write accusations or blame.

Finally, if you keep personal notes that are laden with opinions and accusations, be prepared to share these with both legal teams. It is generally not in your best interests to keep private files and notes on client care events.

MARK: Thanks Jill. These are really good points to remember … especially the ones about private files.

1.16 Lawsuit Process

Narration

JILL: The final topic to cover in this module is an overview of what happens when a lawsuit goes ahead. Why don't we do this one together? Mark, you start.

MARK: Okay. A facility has immediate involvement when an incident or adverse event that involves serious client injury or death has occurred. At this point the client record and all other reports and documents that are related … even in a small way to the case … are examined by the agency's legal team.

JILL: The plaintiff files a statement of claim that he was injured or harmed by the defendant(s) who could be physicians, care providers or a facility or an agency. The details surrounding the harm or injuries that the client experienced are presented.

MARK: The incident or adverse event is investigated by lawyers and facility's risk managers. Interviews are conducted using the client's documents.

JILL: The defendant, sometimes represented by the facility's lawyer, makes a statement in response to the plaintiff's statement of claim.

MARK: In the disclosure phase, lawyers will examine all relevant documents and will decide which ones are significant to use in the case.

JILL: The next step is Oral Discovery also known as Examinations for Discovery. A representative from the agency or facility is produced to answer questions. All named individuals in the statement of claim may be examined or questioned by the plaintiff's lawyer. If you are questioned, your statements may be used if a trial goes ahead. Your documentation and your practice will be scrutinized in much detail. It may be sent to unbiased care experts to see if you met the standards of care by what you documented. This is because judges and juries are not qualified to know if the standard of care was met or not.

MARK: A pre-court settlement between the opposing parties may be made at this point. If agreements cannot be reached, then a trial date is set. This process may take years. Although a lawsuit may span years, the good news is that very few lawsuits go to trial.

JILL: I think that most health care providers would prefer to have to never go to court. Their work is stressful enough as it is!

MARK: I agree! Unfortunately court cases do happen! All we can do is make sure that we do our job well so that legal intervention is not necessary!

1.17 Key Points

Narration

JILL: This brings us to the end of this module on legal issues. Care to summarize Mark?

MARK: Okay. A client's health record is both a legal and medical document – the facility or agency owns the record, however the client owns the information in it.

Your memory can fade with time, but your documentation lives forever.

Accurate documentation ensures compliance with the legal requirements of provincial legislation, employer by-laws, policies and procedures, College standards of a profession and practice guidelines.

Lawyers have the authority to request all types of client records, hospital records, and staffing records and schedules. They may even request records of a care provider's work history and education credentials.

No matter how skilled a care provider you are, gaps and inconsistencies in your documentation will undermine your credibility. Discrepancies and inaccuracies discredit the care provider.

Not documented means that the care was not done.

Timely, clear, concise and comprehensive documentation portrays quality care.

Your College may examine your documentation to determine your competence, observance to standards of care, and to see if you followed your employer's policies and procedures.

JILL: Very good Mark. We covered a lot of information in this module.

MARK: Yes, we did, but I feel it is information all healthcare providers must know about the legal implications of their work.

1.18 Reflection

Narration

JILL: Before you finish, take some time to reflect on these questions about some of the legal issues we have covered in this module. When you are finished thinking, click NEXT to continue.

That's it for us. I'm Jill along with Mark. We will see you again soon.

MARK: Goodbye for now.

1.19 The End

Narration

No narration … music only.