whether a patient’s injury was an unfortunate and unavoidable accident or the result of a nurse’s negligence, inadequate skill, or poor judgment.

STANDARDS OF CARE

So how does a jury determine whether an accused nurse was practicing according to the standards of care?

According to Aiken in Legal Nurse Consulting: Principles and Practice, “Standard of care” is a term used to designate what is accepted as ‘reasonable’ under the circumstances.” It refers to “that degree of skill, care, and judgment used by an ordinary prudent health care provider under similar circumstances.” Nurses are expected to meet the standard of care for every nursing task they perform; standards of care are determined by state nurse practice acts, state and federal regulatory agencies, oversight agencies (such as the Joint Commission), policy and position statements by specialty societies, health care institutions and organizations, current nursing literature, and job descriptions, among other sources.

In determining whether standards of care have been met, juries consider the testimony of health care professionals and are also likely to review the medical records. The American Nurses Association (ANA) highlighted the legal status of documentation by stating: “Patient-related reports and clinical records are legal documents that can be used as evidence in courts of law and provide another reflection of how well nurses, and the institutions that employ them, perform professionally.” (Of course, there are also good clinical reasons for nurses to clearly record the care they provide. Documentation enhances continuity of care, for example, and helps a team of providers coordinate assessment and treatment.)

CASE STUDY

The following account of litigation, in which I served as a legal nurse consultant, demonstrates how a failure to follow current standards of care and document the care provided led to patient

Overview: Properly documenting care in a patient’s medical records is essential and, in the event of a lawsuit, provides evidence that the care that was provided met professional standards. Even nurses who meet the standards of care must document that care fully and accurately to avoid being vulnerable to accusations of malpractice that may result in costly jury verdicts and court decisions.

Conventional wisdom raised in discussions of the legal aspects of nursing says that “documentation of care is synonymous with care itself.” This equivalence might not be obvious to patients and families, but jurors serving on nursing malpractice cases may have little more than documentation to evaluate. Thorough documentation in the medical record may be the best evidence that appropriate care has been provided. And according to Iyer and Camp in Nursing Documentation: A Nursing Process Approach, “Timely, accurate, and complete charting helps the patient secure better care and protects the nurse, physicians, and hospital from litigation.”

Although all nursing school students learn about documentation from the first day until graduation, on the job they may find themselves tired, busy, or unsure of how and what to chart and therefore overlook this critical step. But in our litigious times, nurses would do well to ask themselves how a jury would decide

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injury. The patient and facility aren’t identified, but the clinical facts are accurate.

A 70-year-old man suffered a stroke after undergoing coronary artery bypass grafting surgery. Subsequently, he required a permanent percutaneous endoscopic gastrostomy (PEG) tube for feedings. The standard of care for such a patient calls for the feeding tube to be checked for residual feeding formula and flushed every four hours. Tube feeding was begun with Jevity Plus at 25 mL/hr and was to increase gradually to 75 mL/hr if the patient was tolerating it. On three consecutive days the nurses documented that tube feeding had to be turned off for short periods because residual formula aspirated from the stomach exceeded the normal limit.

The patient’s condition stabilized, and he was moved to a transitional care unit for further evaluation and nursing care prior to discharge. Admission orders to the transition care unit included administering Jevity Plus at 65 mL/hr by PEG tube, keeping the head of the bed elevated at 30° to 45° at all times, and recording vital signs every six hours.

Late in the afternoon the patient was transferred to the transitional care unit. A nursing admission form was completed, but no vital signs or assessment of the tube feeding were recorded. Nursing notes stated that at 10 PM the head of the bed was elevated to 45° and that Jevity Plus was infusing at 55 mL/hr. There was no documentation of checking for residual formula and patency of the tube, calls to the physician, or new orders for a different infusion rate, nor was there an explanation of why the infusion rate was 55 mL/hr instead of the rate ordered.

The nursing staff documented that at 1 AM they heard the patient coughing. The patient was ashen and had vomit on his face; he had aspirated the Jevity Plus formula. Although he was transferred to the ICU and intubated, the patient died later that morning as a result of aspiration pneumonia.

The patient’s family filed a negligence claim against the hospital and members of the nursing staff. There was no documentation to show that the nursing standards of care for assessment, planning, implementation, and evaluation had been met. The hospital and the patient’s family agreed to a confidential settlement.

IGNORANCE IS NO EXCUSE

When a nurse is accused of negligence, ignorance of the standards of nursing care does not serve as a viable legal defense. The eighth of the ANA’s Standards of Professional Performance states: “The registered nurse attains knowledge and competency that reflects current nursing practice.” Staying current in clinical practice is considered so important that it is a condition of maintaining a license. There are many ways to achieve this—for example, by attending hospital in-service sessions and continuing education programs, reading nursing journals, and participating in specialty nursing conferences.

If there’s no documentation, there’s no evidence. Jurors cannot assume that a patient received care if a nurse failed to document it. If a patient falls or experiences an adverse event, the standards of care require nurses to document the patient’s condition before and immediately after the incident, as well as the time that the physician was notified of the patient’s condition. The documentation must also include the physician’s response and any new orders. (While each facility should have a policy for completing an adverse-event form, this document is usually filed in the hospital’s risk-management department and isn’t part of the medical record; therefore, the nursing response to an adverse event must also be documented in the patient’s record.)

In my own practice as a legal nurse consultant, nurses have told me that they’ve failed to document the facts surrounding patients’ falls for fear of losing their jobs. But unless nurses record the facts in the medical record, including their own response to the fall, there will be no evidence to support the claim that they acted within the standards of care, leaving them vulnerable if a lawsuit is filed.

Brown v. DeKalb Medical Center, a case that came before the Georgia Court of Appeals, illustrates this point. In that case, the estate of a deceased patient claimed that pressure ulcers, allegedly acquired at DeKalb’s skilled nursing facility, had led to a below-the-knee amputation of the patient’s left leg.

The patient had spent a month at the skilled nursing facility after having a stroke. The medical record showed that, at admission and again at discharge, the skin over her sacrum was reddened, but there was no documentation of the condition of the patient’s heels at discharge.

The patient had a home health care nurse who examined her the day after she returned home, the patient had “blood blisters” on her heels. While a family member and the home health care nurse later disagreed about the condition of the ulcers
at that time, the estate’s expert nurse witness testified that, in her opinion, the ulcers had formed at the skilled nursing facility. Although some of them healed, new ulcers developed on the left foot and lower leg, making amputation necessary.

The nurse expert testified that, although the sacral ulcer had become no worse during the patient’s stay at the facility, indicating that that ulcer had been treated properly, the patient’s medical record didn’t show that steps had been taken to prevent pressure ulcers from forming on the heels. The DeKalb nurses testified that it wasn’t their practice to document normal findings; therefore, there was no documentation of a heel lesion because there had not been one while the patient was at their facility.

The court rejected this rationale. The nurses’ failure to document meant that DeKalb couldn’t demonstrate that adequate care had been provided. The jury determined that the absence of documentation of a pressure ulcer was not the same as documentation of a thorough skin assessment. Therefore, they found in favor of the patient’s estate and awarded damages.

Jurors and attorneys usually view the medical record as the best evidence of what really happened to a patient. When a patient or a family member seeks legal advice about a possible claim of nursing negligence, the attorney scrutinizes the patient’s medical record first to determine how well the nurse met the standards of care. Except on special units or unless a physician orders otherwise, nurses routinely assess patients every two to four hours; in the case of an unstable patient, a diligent nurse assesses the patient even more frequently. Therefore, any gap in nursing documentation of several hours or more can be a red flag to a jury. The standards of nursing care include documenting the patient’s condition at the time of each assessment, even if it’s unchanged or stable.

The record must be specific in its documentation of who did what, when, and how. A lack of specificity can be costly when defending against a lawsuit. For example, consider Griffin v. Methodist Hospital, a case involving a patient who developed foot drop after a prolonged period of immobility. The foot drop was due to contracture of the Achilles tendon, a complication that can be expected if nursing measures are not adequate to compensate for the patient’s prolonged immobility, according to an opinion handed down by the Court of Appeals of Texas.

**Malpractice vs. Negligence**

Negligence committed by a professional is malpractice, but not all malpractice is negligence.

The Joint Commission defines negligence as “failure to use such care as a reasonably prudent and careful person would use under similar circumstances” and malpractice as “improper or unethical conduct or unreasonable lack of skill by a holder of a professional or official position; often applied to physicians, dentists, lawyers, and public officers to denote negligent or unskilful performance of duties when professional skills are obligatory.” The commission’s definition further states: “Malpractice is a cause of action for which damages are allowed.”

Most lawsuits against nurses are for alleged violations of tort law. In general terms, a tort is an action or omission that harms someone. According to Nursing Malpractice: Sidestepping Legal Minefields, a tort is a civil wrong or injury resulting from a breach of legal duty that exists by virtue of society’s expectations regarding interpersonal conduct or by the assumption of a duty inherent in a professional relationship (as opposed to a legal duty that exists by virtue of a contractual relationship). . . . Malpractice refers to a tort committed by a professional acting in his professional capacity.

The law distinguishes between unintentional and intentional torts. An unintentional tort results from negligence. In order to prove negligence, a plaintiff must show each of the following:

- The defendant owed the plaintiff a specific duty (in nursing malpractice cases, the standard of care).
- The defendant breached this duty.
- The plaintiff was harmed.
- The breach of duty caused the harm.

In contrast, “an intentional tort is a deliberate invasion of someone’s legal right. In a malpractice case involving an intentional tort, the plaintiff doesn’t need to prove that you owed him a duty. The duty . . . is defined by law, and you’re presumed to owe him this duty.” In such a case, the plaintiff has to show only that the defendant breached her or his duty and that the breach caused the plaintiff harm. Examples of intentional torts include assault, battery, false imprisonment, invasion of privacy, and slander. (For more, see “Nurses, Negligence, and Malpractice,” September 2003.)—James M. Stubenrauch, senior editor

**REFERENCES**

Sometimes it isn’t possible until considerable time has passed to identify the cause of an injury or to discover that an injury has occurred.

The hospital and several health care providers, including RNs, physical therapists, and physicians, were named in a lawsuit filed by the patient and her husband, who alleged that all had been negligent in caring for the patient. The hospital retained a nurse and a physical therapist to review the medical records and submitted to the court their affidavits stating that the standards of care had been met in treating the patient. With regard to nursing care, the hospital’s affidavit stated: “the standard of care for treating a critical care patient . . . is (1) to assess the patient; (2) to implement and carry out the physician’s orders; and (3) to prioritize care and treatment objectives.” The affidavit further stated that the nurses “properly assessed [the patient’s] condition and charted her progress” from admission to discharge.

The lower court ruled that the nurses hadn’t been negligent, but an appeals court subsequently ruled that all of the defendants shared responsibility for the patient’s injury. The appeals court focused on a lack of specific notations regarding assessment or treatment of foot drop in the hospital’s affidavit, noting that “the lower court judge was in error for failing to recognize that the hospital’s affidavit . . . was purely conclusory . . . [and] overly generalized to the point it was completely useless to any court as the basis for ruling in favor of the hospital.”

Statutes of limitations establish time limits within which a patient (or someone acting on a patient’s behalf, such as a family member) must file a claim in response to an injury. These time limits are defined by state law and vary from state to state. In many states, the time limit is two years from the date of the injury or its discovery.

Sometimes it isn’t possible until considerable time has passed to identify the cause of an injury or to discover that an injury has occurred. In recognition of this, legislatures and courts have developed a series of rules to help determine when the actionable period, as defined by the statute of limitations, should properly begin. Depending on the circumstances, the time period may begin when the injury occurred, when it was first discovered, or at the end of treatment. But even after the time limit has passed, a patient’s attorney may file a claim in the expectation that the court will “toll”—delay or suspend—the statute of limitations. For example, in injuries that occur in childhood or during childbirth (which may result in motor deficits or developmental delays), the statute of limitations may be tolled until the injured person reaches “legal age” (also called “majority,” the age at which a person is legally accorded full civil rights and becomes responsible for her or his own actions according to the law). The legal age is also determined by state law. In most states the legal age is 18 years, but in others it is 19 or 21 years.

Considering that it may take years for a case to come to trial and that, in the interim, nurses may have cared for hundreds of other patients, they can’t rely on memory to summon every detail of a patient’s assessment, plan, implementation, and evaluation. Therefore, for nurses who find themselves named in lawsuits, accurate and complete documentation of the nursing process is the best evidence of the care they provided.

REFERENCES