Nurse Spotlight: Documentation

Nurses Service Organization (NSO), in collaboration with CNA, has published our **Nurse Professional Liability Claim Report: 5th Edition**. It includes statistical data and case scenarios from CNA closed claim files, as well as risk management recommendations designed to help nurses reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.nso.com/nurseclaimreport.

This Nurse Spotlight focuses on our analysis and risk recommendations regarding one of the most significant topics in the report: **Documentation: Complying with Healthcare Information Record Requirements**.

In the dataset used for the *Nurse Professional Liability Claim Report: 5th Edition*, documentation deficiencies were often identified as contributing to risk exposure and its defense. This underscores the significant role documentation deficiencies present in both nurse professional liability cases and license protection matters.

In many of the closed claims and matters reviewed in the 2025 dataset, the outcome of the legal proceeding could have been more favorable for the insured nurse if the healthcare information record had provided clear, comprehensive evidence that appropriate nursing care was provided. Many healthcare providers have heard of the old adage, '*if it is not documented, it was not done*.' This adage is a mistaken belief based on unsound, unrealistic healthcare practices. Nurses cannot create a healthcare record entry for every nuance encounter with a patient, and it is impossible to create a perfect healthcare record of every nurse-patient interaction (Sullivan, 2012, pp. 1–2). However, similar to other aphorisms, the principle behind the phrase remains relevant-especially given that there can be several years between when an incident occurs to when it becomes a lawsuit.

The time from when an incident occurs to when a claim or lawsuit is closed varies depending upon multiple factors including, but not limited to, the applicable statute of limitations, court calendars and the complexity of the matter. A professional liability claim in which an indemnity payment is made may take, on average, 4.2 years to close, as seen in **Figure 3 below**. This underscores the importance of comprehensive documentation to preserve relevant patient information. Documentation of the nursing assessment, care plan, and response to nursing interventions are integral in demonstrating that the standard of care was met. Concise and thorough documentation is also critical in defending license protection matters and/or preparing the insured for a deposition.

The Importance of Documentation

The healthcare record is a legal document. A well documented record can:

1. **Provide an accurate reflection** of nursing assessments, changes in clinical state, and care provided.
2. **Guard against miscommunication and misunderstanding** among the interdisciplinary patient care team.
3. **Demonstrate your competence as a provider** and help to bolster your credibility.
4. **May help guard** against a lengthy litigation process.

3 Closed Claims by Coverage Category

	Average Total Incurred	Average Years to Close
Professional liability, indemnity (≥ $10,000) and expense	$236,749	4.2 yrs
Professional liability, expense only (≥ $ 1)	$17,915	4.4 yrs
License protection (≥ $1)	$6,304	2.3 yrs

Below is an example of a professional liability claim that was difficult to defend due to the lack of thorough documentation:

A 65-year-old female patient was taken to the emergency department (ED) after suffering a fall at home. Her husband had been away from the house for several hours, and when he returned home he found her on the floor. The patient was confused, and no one was able to ascertain how long she had been lying on the floor.

She was taken to the ED with complaints of weakness, confusion and right lower leg and foot pain. Her past medical history included Parkinson's disease, mild dementia, hypothyroidism and anxiety.

The radiology results revealed an open displaced fracture of the right tibia and fibula. An orthopedic surgeon requested the patient be prepped for surgery. However, the patient's surgery was delayed by over four hours due to multiple factors.

The patient underwent an intramedullary (IM) nailing procedure which lasted approximately three hours. After the procedure, the patient was admitted to the orthopedic floor with orders to follow the post IM nailing procedure standing protocol. In the intraoperative nursing (pre-operative and post-operative) assessment, documentation regarding skin integrity was incomplete as well as documentation of the positioning aids.

When the patient arrived at the orthopedic unit she was placed on the IM nailing surgery protocol. The protocol included comprehensive orders for vital signs, pain control, nutrition, hydration, mobilization, and skin integrity prevention measures. The admitting nurse assessed the patient's skin and documented a risk score of 14 according to the Braden Scale® (the lower the number, the higher the risk of developing pressure injury). The hospital's "Alteration in Skin Integrity" protocol required an air mattress for any patient with a score of less than 18.

Although the admitting nurse ordered a medical air mattress overlay for the patient, the hospital did not have one available. A request for a mattress was placed with an outside vendor, but, since it was a holiday weekend, the delivery of the mattress would take at least eight hours. The following day (post-operative day one), the day shift nurse assessed the patient and documented a skin assessment score of 20.

Skin assessments and repositioning documentation were missing on several shifts, despite hospital policy requiring skin checks once a shift and repositioning every two hours.

On post-operative day three, the night shift nurse reported the presence of a purple localized area of discolored intact skin on the patient's sacrum. However, it wasn't until the night nurse returned to work the following night that the patient was finally placed on an air mattress. On post-operative day five, the patient was discharged to a local skilled nursing facility. The patient's admitting diagnosis to the skilled facility was written as "status-post IM nailing, Parkinson's disease, mild dementia, hypothyroidism, anxiety, anemia, and Stage IV pressure injury."

Nursing Scope and Standards of Practice

According to the American Nurses Association (ANA), documentation represents a critical competency of all nursing processes and standards of practice *(ANA Nursing Scope and Standards of Practice 4th Edition, 2021).*

The ANA Standards of Practice Competencies include the following criteria for appropriate documentation:

- Documents data accurately and makes accessible to the interprofessional team in a timely manner (*ANA Standards of Practice*, Standard 1. Assessment).
- Documents diagnosis, problems, strengths, and issues in a manner that facilitates the development of the expected outcomes and collaborative plan *(ANA Standards of Practice*, Standard 2. Diagnosis).
- Documents expected patient outcomes as measurable goals *(ANA Standards of Practice*, Standard 3. Outcomes Identification).
- Documents the patient's plan of care using standardized language or recognized terminology *(ANA Standards of Practice*, Standard 4. Planning).
- Documents implementation and any modifications, including changes or omissions, of the identified plan *(ANA Standards of Practice*, Standard 5. Implementation).
- Documents the coordination of care *(ANA Standards of Practice*, Standard 5A. Coordination of Care).
- Documents the results of the evaluation *(ANA Standards of Practice*, Standard 6. Evaluation).
- Documents nursing practice in a manner that supports quality and performance improvement initiatives *(ANA Standards of Practice*, Standard 15. Quality of Practice).

Over the next nine months, the patient suffered from infections and anemia and underwent several debridement procedures to the sacral area due to the pressure injury. At one point, the size of the pressure injury was 8.5 cm in length, 7cm in width, and 4 cm in diameter. To prevent further infections, the patient underwent a sigmoid loop colostomy, a sacral osteotomy and a second bilateral gluteal flap repair for the non-healing pressure ulcer. A urinary catheter was used to prevent further skin breakdown, and, since the patient struggled with malnutrition due to infection, a gastrostomy tube was inserted during one of her hospitalizations.

The patient died 10 months after her fall. The family (plaintiff) of the deceased filed a professional malpractice claim against the hospital and seven registered nurses (individually) involved in the patient's care related to her hip surgery.

Five of the seven nurses were NSO/CNA insureds. The five nurses included:

- The circulating nurse (assisting the orthopedic surgeon during the IM nailing)
- The registered nurse first assist (assisting the orthopedic surgeon during the IM nailing)
- The day shift nurse (post-operative days one and two)
- The day shift nurse (post-operative days three and four)
- The night shift nurse (post-operative days one and two)

The plaintiff opined that the care provided by the nursing staff fell below the accepted standard of care, which included:

- Skin assessments were not documented while the patient was in the ED.
- The operating room skin assessments were incomplete as well as any documentation of the positioning aids.
- The hospital's Alteration in Skin Integrity Protocol was not implemented after surgery.
- The nursing assessment flow sheets were incomplete.
- A specialty bed/mattress was ordered but not provided to the patient until the breakdown was at Stage 4.
- The surgical unit nurses failed to turn and reposition every two hours throughout the patient's hospitalization.

The healthcare organization that owned the hospital and the leadership team were held vicariously liable for the substandard care.

Risk Management Comments

Wound care nursing experts for the defense opined that the pressure injury likely occurred during ambulance transport while the patient was on a backboard and the timeframe that she was immobile in the ED.

Two of the insured nurses were dismissed early in the case. However, the circulating nurse, registered nurse, first assistant and the day shift nurse (post-operative days one and two) remained in the case, and an indemnity payment was made on their behalf based upon the defense challenges associated with the lack of documentation regarding pressure injury prevention interventions. Each of the three nurses appeared defensive during their depositions which further challenged the defense of this case.

Defense counsel was concerned that the apparent defensiveness would anger a jury if this case went to trial. Despite defense expert opinions on the cause of the pressure injury, the professional liability claim was difficult to defend.

Total Incurred: Greater than $203,000 for all three insured nurses that remained in the case.
(Note: Amounts paid on behalf of other co-defendant(s) named in the case are not available.)

Documentation: Minimizing Risks, Maximizing Benefits

Proper documentation is a key element in avoiding adverse legal action and licensing board complaints. A complete and accurate healthcare information record presents a strong defense against any legal or licensing board action. While there is not a one-size-fits-all healthcare documentation tool, the *American Nurses Association (ANA) Nursing Scope and Standards of Practice* identifies essential principles to guide nurses on documentation.

The healthcare information record is a legal document that is an essential tool to:

- Document the services provided regarding the patient's illness or injury, response to treatment, and caregiver decisions;
- Communicate information about the patient's plan of care and outcomes to the healthcare team;
- Communicate information to other nursing professionals and healthcare providers using standardized communication techniques, such as Situation, Background, Assessment Recommendation/Request (SBAR);
- Support the appropriate information for billing; and
- Serve as the organization's business and legal record.

Because complete, accurate, and legible healthcare records constitute an essential risk management measure, nurses should maintain proper documentation practices and follow facility policies and procedures governing appropriate and comprehensive records documentation. The organization's documentation policies and procedures should address, at a minimum:

- Correcting documentation errors
- Delineating appropriate use of the copy and paste function in the electronic healthcare record
- Documenting practices during electronic system failures or outages ("down-time")
- Maintaining patient confidentiality
- Releasing patient healthcare information records and auditing practices
- Noting late or delayed entries

Risk management recommendations designed to assist nurses in evaluating their current documentation practices can be found below.

Risk Management Recommendations

Maintaining a consistent, professional patient healthcare information record is integral to providing quality patient care, ensuring consistent communication among all professionals caring for the patient, documenting patient care outcomes and responses and establishing the basis for an effective defense in the event of litigation. The following guidelines can help reduce risk:

Documentation – Clinical Content

- **Document nursing actions in accordance with the organization's policy requirements and frequency appropriate to** patient needs, capturing the following information as clinically indicated:
  - results of each nursing assessment, which may include an initial and ongoing skin assessment
  - pertinent nursing observations
  - patient complaints or concerns
  - significant changes in the patient's condition
  - any change in the patient's care plan
  - relevant monitoring findings, treatment or episode of care, as well as the patient's response to that care
  - facts relating to a patient incident, including evidence of injury, parties notified, nursing care provided and the patient's condition after care is rendered
  - laboratory and diagnostic test results, especially those that are abnormal and require provider notification and/or intervention
  - referral and consultation requests and results
  - telephone, face-to-face and electronic contacts with patients and other members of the healthcare team, including the content of discussions and agreed-upon follow-up.
- **Document discussions with the patient** about medical or medication issues that require additional explanation by healthcare practitioners and provider(s).
- **Record medications administered,** including injections, ointments and infusions, as well as a description of the patient's response as necessary. Also record self-administered medications.
- **Detail nursing observations** during patient contacts.
- **Specify patient's questions and answers given** regarding the nursing care/medications/service plan, as well as the goals and methods of treatment.
- **Describe the patient's response** to nursing care. If educating or teaching patients or family members on a treatment plan of care or medication, utilize the teach-back method to confirm that information was understood.
- **Note the review of current problems** and plan of care.
- **Assess skin and wound condition,** including clinical findings and observations initially and ongoing per facility protocol, as well as interventions, the nursing care/service plan and the patient's response to treatment.
- **Document provider notification of a change in condition,** symptoms or patient concerns and document the provider's response and/or orders, as well as any changes in the treatment plan.
- **Summarize communications with providers,** including those via telephone, facsimile and e-mail, text messages and patient portal communications, and note any subsequent orders and nursing interventions.
- **Note use of an interpreter,** including the interpreter's contact information. The use of family members as interpreters is generally discouraged due to the risks of miscommunication, lack of impartiality, and potential for errors. Instead, hospital staff should obtain a professional, qualified interpreter.

Documentation – Medications and Prescriptions

- **Review and update the current medication list** and patient's reported adherence to prescribing orders. The list should detail both prescribed and over-the-counter medications, including supplements and holistic/alternative remedies.
- **Collect and document the appropriate medication history as an essential component of the medication reconciliation process** following patient admission, changes in care or treatment, transfer from one service to another (e.g., after surgery or delivery), or post-discharge return to care.
- **Clearly describe patient responses to medications,** expected and unexpected. Utilize the teach-back method to correct any missed communication the patient or family may relay.

Nurse Spotlights

For risk control strategies related to:

- Defending Your License
- Communication
- Liabillity for Nurse Managers
- Home Care
- Medication Administration
- Depositions

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- **Document signs or symptoms of adverse drug reactions,** notifications made to providers and subsequent follow-up. Based on facility policies and procedures, contact with the patient's pharmacy as well as the facility's pharmacy may be warranted.
- In the case of a verbal order, document that the order was read back and verified.

Documentation – Diagnostic Tests, Referrals, Consultations

- **Contact the patient's healthcare provider** to report abnormal test results. Document any provider orders for additional testing or follow-up.
- **In cases of a non-response/delay or urgent/ emergent consultation, contact the consulting provider** to confirm that they were notified of the consultation request and to facilitate the timely provision of the consultation and receipt of the results, as needed. Document these actions in the patient's healthcare information record.
- **Utilize the chain of command to report abnormal laboratory results and the results of consultations** if the ordering/primary care provider (physician, APRN, PA) is not available or does not respond to messages. Invoke the chain of command to ensure timely patient care. Steps may include escalating to the supervisor/nurse manager, administrators, attending or covering physician, licensed independent practitioner and/or medical staff leadership until the abnormal result is addressed.

Documentation – Patient Education

- **Describe patient and family healthcare education encounters,** listing the name of participating family members and their relationship with the patient.
- **Document an assessment of the patient's ability to comprehend and repeat information provided using a "teach-back"** approach, both immediately and after a few minutes have elapsed to test accurate recall.
- **Provide a written assessment of the patient's appropriate demonstration of procedures/taught tasks, such as blood glucose testing or application of dressings.**
- **Maintain a copy of written materials provided** and document references to standard educational tools.
- **Retain patient-signed receipts** for any educational materials provided. If a family member or friend receives the education materials due to the patient's cognitive abilities, reflect a note in the healthcare information record to that effect. The family member's or friend's name should be documented as the person that received the materials.
- **Document the use of interpreters**, if needed, and include the interpreter's contact information.

References and Resources

- American Nurses Association. (2021). Nursing scope and standards of practice (4th Ed.) Silver Springs, MD: ANA.
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This information is designed to help nurses evaluate risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.

This information was excerpted from NSO and CNA's full report, *Nurse Professional Liability Exposure Claim Report: 5th Edition.*

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