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Documentation Myths In Litigation

Defense lawyers, as well as caregivers, should not allow normal gaps and errors in resident charting to be equated with poor care in court.

She's out there somewhere: the nursing instructor who first used that foolish saying, "If it wasn't charted, it wasn't done." Sure, it's a cute teaching tool; it's dramatic and memorable. But like many overblown catchphrases, its absolute nature makes it inaccurate and misleading out in the real world. When moved to the artificial setting of litigation, it becomes destructive. Good documentation is important—and helpful in litigation—but documentation is not care, and poor documentation does not mean poor care. It's important for long term care professionals, and the lawyers who represent them, to understand both sides of that equation.

Charting Is Not Care

First and foremost, no piece of paper ever took care of a patient. Charting is not care. Thus, lack of charting or poor charting is not poor care. The "standard of care" in nursing facility litigation is, basically, "reasonable care under the circumstances." A caregiver who puts patients over paperwork is meeting the standard of care.

Everyone who has worked in a nursing facility knows that the best nurses are often not the best charters, and the best charters are often not the best nurses.

When a nurse or certified nurse assistant (CNA) picks up a chart outside one patient's room to begin writing, but then sees a call light go on at the other end of the hall, what should he or she do? The profession needs caregivers who put people over paperwork, who will put the chart down and respond to the patient first—hoping to be able to finish the paperwork later.

Complete Does Not Mean Absolute

The law requires that nursing facilities maintain "complete" clinical records on each resident, "in accordance with accepted professional standards and practices." So the question is: Is the documentation complete enough to meet that goal? Nothing in the law requires health care professionals to document everything they do or say. That would be impossible. Yet, in litigation, plaintiff lawyers hire people to go through the chart with a microscope to find the inevitable "gaps" and then use those to claim the chart was not "complete," and therefore the care was not given.

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The battle lines are clear. In a case brought by the family of a deceased resident—like virtually every such case—there were "gaps" in the chart. In doing *voir dire*—the questioning of potential jurors at the start of the trial—the plaintiff's lawyer found a doctor in the group who, with the lawyer's prompting, treated everyone to a tirade on how important charting was, how terrible it was for nurses not to chart everything, and how gaps in the chart put patients at risk. There was the plaintiff's argument, for all to hear.

Fortunately for the defense, there was also a CNA among the potential jurors. With the defense's prompting, she talked about how busy she was all day, how important the work was, and how much she loved spending time with her patients. By the time she was asked, "Do you stop and write down everything you do?" the answer was obvious. She laughed and responded, "Lord no, if I did that, I wouldn't have time to help my patients." The other potential jurors laughed with her, and the point was made.

The chart is a helpful tool. It is good for it to be as complete as possible in important areas. But the notion that it can or should be absolute and gap-free is absurd.

Accurate Does Not Mean Perfect

Nurses and CNAs are not robots. They are caring human beings, dedicated to their patients. Like all humans, even lawyers, when they are distracted, tired, or just busy, they may make mistakes. That does not mean that care wasn't

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provided, or that the chart is a fraud. It just means that someone made an honest mistake. Plaintiff attorneys have someone take all the time they need to comb through the chart in hindsight, hunting for mistakes. Caregivers don't have that luxury and have better priorities: giving care.

So the battle is joined in litigation: Are errors in the chart proof of negligence or proof of humanity? In that context, it is worth taking a brief look at some of the most common types of "mistakes:"

There is nothing fradulent, or even unusual, about getting a date or time wrong.

■ *Wrong date or time.* Every year, well into February and March, many people still write the prior year on checks. Are they doing something evil, or just careless? There is nothing fraudulent, or even unusual, about getting a date or time wrong. It is not what caregivers want to do, particularly when it ends up contradicting other evidence, such as the caregiver or patient being out of the facility, for example. But witnesses should acknowledge the mistake, clarify it, and then move on and not be defensive about it.

■ *Wrong indicator.* The chart does not change reality. If the wound was undeniably on the right side, and someone got confused or forgot, and wrote "left," it is an honest mistake. Any mistake like this is a problem only if the defense allows the other side to make it so. A witness should clarify it, explain it, positively and politely, and move on.

■ *Late entry.* A late entry properly done is not an error, it is simply a late entry. There will be times when staff cannot—and should not—drop what they're doing to write in the chart. In such circumstances, if it can be done carefully and within a reasonable time, a late entry that identifies itself as such, including when it was written, is an honest and appropriate approach. In its role as a resource, a late entry is certainly better than no entry at all.

In a recent deposition, when the director of nursing was being pressed by counsel about problems in a patient's chart, she responded, "This is nothing: I was in a facility years ago where we had three residents named Garcia—you should have seen that mess!" Judges and jurors understand that in a busy facility, things get misplaced or misfiled.

Care may have been properly given and properly charted, but the chart document simply was placed in the wrong file or place.

A few years ago, in a case brought by a nursing facility resident's family where rehab was a key issue, there were no rehab records in the chart. Staff insisted it was done, but they could not be found. The plaintiff argued, naturally, "If it wasn't charted, it wasn't done." The facility failed to provide rehab care. On the Friday before a Monday trial, someone was cleaning in the facility's basement and discovered a notebook on a shelf: the rehab records! Apparently, years before, someone had tried an experiment of keeping rehab records in a separate, centralized notebook—not in the chart. It hadn't lasted long, and the experiment and the notebook were long forgotten, until that day.

Plaintiff's lawyer moved to suppress, screaming bloody murder: Deceit, fraud, violation of discovery rules. There was a long, tough hearing, in which an angry judge agreed with many of plaintiff's complaints. They had repeatedly asked for these documents and the defense had failed to provide them. This last-minute miracle unfairly pulled the rug out from under a key contention. But the judge could not agree with the remedy. He said that this case shows that "if it wasn't charted, it wasn't done" is a difficult presumption in any case. To suppress these documents would allow plaintiff to go forward on that theory, knowing that it was a lie. The motion was denied, and the case was settled.

Finally, charting is not just a one-way communication to a doctor or other provider. It should also be a way of trying to record things that give a fuller picture of the care, and even things that help everyone understand that care. Things caregivers should document more, and more often, include: admission assessments, successful interventions, compliance or non-compliance, and family issues—good and bad.

Charting Is Not One-Directional

Charting is a difficult balance: Having good documentation may at times be helpful to care, while creating it may be distracting from care. Much as plaintiff lawyers may try to draw inferences, there are no easy conclusions to draw. "If it wasn't charted, it wasn't charted," is the best we can do. Long term care caregivers, as well as counsel, should not allow anyone to equate the normal gaps, errors, and disorganization of caring for human beings with poor care. After all, when that call light goes on, no piece of paper responds. ■