HEALTH LAW

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RECORD KEEPING FOR MENTAL HEALTH NURSES

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PRESENTATION OVERVIEW

1. Charts and Records
    a) Purpose
    b) Legal Uses of Nursing Records

2. Standards of Record Keeping Practice
    a) Professional Misconduct and Records
    b) College of Nursing Record Keeping Guidelines
    c) Common Law

PRESENTATION OVERVIEW

3. Confidentiality of Medical Records
    a) Basic Duty
    b) Mandatory Reporting
    c) Duty to Warn
    d) Patient's Right to their Medical Records

4. Summoned to Appear in Court

5. Other Topics and Questions

1. CHARTS AND RECORDS

1A. PURPOSE OF CHARTS

According to Ontario College of Nurses Guideline on Documentation ("Guideline"), Purposes for Documenting Patient Encounters Include:

- Communication
- Accountability
- Legislative Requirements
- Quality Improvement
- Research
- Funding and Resource Management Decisions

1B. Legal Uses of Nursing Records

Civil lawsuits

- Malpractice against hospital, doctors and nurses
- Personal injury lawsuits
- Insurance disputes

College Investigations and hearings

- Charges of Professional Misconduct
- Discipline Hearings
- Quality Management assessments

Coroner's Investigations and Inquests

Criminal trials

2. STANDARDS OF RECORD KEEPING PRACTICE

2. STANDARDS OF RECORD KEEPING PRACTICE

Who sets the record-keeping requirements?

- Statutes (i.e. *Nursing Act, 1991*)
- College decisions (Complaints investigations and Discipline Hearings)
- College of Nursing Guidelines
- Common Law (Experts retained in legal proceedings and Judges)

2a. PROFESSIONAL MISCONDUCT AND RECORDS

Nursing Act, 1991 – Regulation on Professional Misconduct:

Definition of Professional Misconduct (pertaining to records) includes:

- Failing to keep records as required
- Falsifying a record relating to the member's practice
- Signing or issuing, in the member's professional capacity, a document that the member knows or ought to know contains a false or misleading statement

2a. PROFESSIONAL MISCONDUCT AND RECORDS

College Decisions

- Numerous College cases involving “Failure to Document”
- Failure routinely involves lack of documentation pertaining to:
  - Ongoing care and assessment
  - Medications administered
  - Inaccurate charting
  - Omitted entries

2a. PROFESSIONAL MISCONDUCT AND RECORDS

College of Nurses of Ontario and Rita Roy, R.N. (2003)

Facts:

Full time RN working in Neurotrauma Intensive Care unit (NICU) of large hospital (17 bed level one trauma care centre).

Member was treating a patient (chronic alcoholic suffering from alcohol withdrawal) who suffered multiple injuries due to a fall - injuries sustained in fall included fractures (lumbar-spinal fracture and stable pelvic fracture), scalp lacerations and internal bleeding.

Nurse began to notice that patient began to experience symptoms of alcohol withdrawal (tachycardic, very agitated, uncooperative, hallucinatory, etc.).

2a. PROFESSIONAL MISCONDUCT AND RECORDS

College of Nurses of Ontario and Rita Roy, R.N. (2003)

Facts:

Nurse reported condition to staff anaesthetist who verbally ordered nurse to administer 10 mg Valium (IM) initially and additional Valium prn (IV) as required.

Both nurse and anaesthetist failed to document orders with regard to amount, frequency and maximum amount to be administered.

During a radiology session, nurse administered 35 mg Valium IV on the basis of anaesthetist's previous verbal prn order. Radiology resident was present during administration.

In total, nurse administered 65 mg Valium (10 mg IM and 55 mg IV) between 0800h and 1230h (with no documented written orders to do so).

2a. PROFESSIONAL MISCONDUCT AND RECORDS

College of Nurses of Ontario and Rita Roy, R.N. (2003)

Facts:

Nurse failed to document Valium administered / vital signs while in Radiology, but did made a "block entry" later in the day stating:

> 1300h: Procedure completed – Pt received Valium 35 mg I/V gradually in several doses as needed & asked by [the resident] to give. Pt's HR most @ 120-130/min range. When brought up to unit – pt more drowsy progressively. [Anaesthetist] on hand.

Later the same day, the patient began to experience respiratory distress and became comatose and required emergency intervention.

2a. PROFESSIONAL MISCONDUCT AND RECORDS

College of Nurses of Ontario and Rita Roy, R.N. (2003)

Facts:

Administration of Valium antagonist (due to Valium overdose) was given and patient also required intubation for 7 days.

However, Nurse also failed to document level of consciousness / respiratory functions during emergency intervention.

2a. PROFESSIONAL MISCONDUCT AND RECORDS

Discipline Committee's Review of Nurse's Records:

College of Nurses of Ontario and Rita Roy, R.N. (2003)

- Nurse failed to document orders with regard to amount, frequency and maximum amount of Valium to be administered
- No contemporaneous chart entries of drugs administered / vital signs made by nurse during administration of Valium in period of 0900h to 1300h
- During period of administration of 55 mg Valium (0900h to 1300h), nurse only recorded heart rate every hour and failed to record any assessment of the client's level of consciousness
- No record of assessment of patient's level of consciousness or respiratory function during initial resuscitative attempts

2a. PROFESSIONAL MISCONDUCT AND RECORDS

Discipline Committee's Review of Nurse's Records:

College of Nurses of Ontario and Rita Roy, R.N. (2003)

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2a. PROFESSIONAL MISCONDUCT AND RECORDS

Discipline Committee Decision

College of Nurses of Ontario and Rita Roy, R.N. (2003)

- Member guilty of professional misconduct
- Member failed to adequately assess and evaluate the patient's medical condition during and after the administration of Valium
- The member failed to document and properly chart the ongoing assessment and patient condition during the administration of Valium

2a. PROFESSIONAL MISCONDUCT AND RECORDS

Discipline Committee Penalty:

- One month suspension of certificate of registration
- Member to appear before Discipline Committee for an official reprimand
- Member ordered to complete course in Nursing Skills
- Member's practice restricted to certain areas
- Member must provide employer with copy of penalty order from College

2a. PROFESSIONAL MISCONDUCT AND RECORDS

Lessons Learned

- College extremely concerned that nurse administered excessive amounts of Valium without proper orders OR administered same amounts without documenting verbal orders
- Nurse's defence that she was doing what the doctors told her to do was not accepted by the College
- College charting standards are very high and deviation from acceptable standards will not be tolerated
- Omissions as well as errors are serious

Always follow acceptable standards, even if the doctors do not!

2b. COLLEGE OF NURSING RECORD KEEPING GUIDELINES

Specific Standards

1. Timing of Entries
    - Entries made on a chronological basis
    - Include date and time of care / event
    - Contemporaneous entries are preferred
2. Legibility
    - All entries must be legible, non-erasable and permanently written
3. Abbreviations
    - Widely used and “known” abbreviations are suitable
    - Lesser known abbreviations can be used if spell out meaning immediately after first appearance in entry

2b. COLLEGE OF NURSING RECORD KEEPING GUIDELINES

Specific Standards

4. Forgotten / Late / Omitted Entries

- Allowed to make "subsequent" entries if information is accurate and complete
- Must state in such an entry that it is forgotten / late or was originally omitted
- Subsequent entry must be dated on date it is actually made and placed in chart in proper chronological location of chart for this date
- Must sign entry
- Subsequent entry refers back to the date of the original entry

5. "Corrections" to Entries

- Must not obliterate original entry
- Can make correction by using single line crossing out original entry and by initialing and dating correction

2b. COLLEGE OF NURSING RECORD KEEPING GUIDELINES

Specific Standards

6. Identifying Entries
    - Must note who provided care by signature next to entry
    - Initials are sufficient if master list maintained
    - Must note professional designation
    - RN, RPN, RN(EC), etc.
7. Documented Informed Consent
    - Must document informed consent if nurse proposes treatment or intervention
8. Content of Records
    - Records must document:
        - Assessment of patient's health status
        - Implementation of treatment
        - Observations; and
        - Treatment outcome

2b. COLLEGE OF NURSING RECORD KEEPING GUIDELINES

Documentation Forms

Many forms of documentation are acceptable including:

- Worksheets
- Kardexes
- Care Plans
- Flow Sheets
- Checklists
- Monitoring Steps
- Narrative Documentation

Regardless of the form used, must adhere to the basic and specific recognized standards.

2b. College of Nursing Record Keeping Guidelines

Documentation Systems

1. Charting by Exception
   - Patient evaluated against well-defined standards, norms and outcomes and differences from the norm are noted
   - Record analysis of any differences noted in the narrative
   - Consistency - Must ensure that all health care providers on health care team are using this system

2. Care Mapping
   - Also known as Critical Path and Variance Analysis
   - Similar to charting by exception
   - Catered to patient's specific needs
   - Any variance from expected outcome is documented along with the suspected reasons and action plan

2b. College of Nursing Record Keeping Guidelines

Documentation Systems

3. Focus Charting
   - Documentation based on a client's concern or behaviour identified during assessment (i.e. decreased urinary output)
   - Notes are organized under
   - Data (Subjective and objective information)
   - Action; and
   - Response
4. SOAP
   - Problem-oriented approach
   - Nurse identifies and lists clients problems
   - Data organized into "S" "O" "A" "P"

2b. College of Nursing Record Keeping Guidelines

SOAP

Subjective data

Patient's chief complaint and patient's description of symptoms

Objective Data

- Results of physical exam
- Relevant vital signs

Assessment

Impression and assessment of patient's current situation

Plan

Are changes to the recommended treatment plan required

Re-evaluate

Must re-evaluate any intervention performed and revise as required

2c. Standards of Record Keeping Practice

Common Law

Children's Aid Society of Toronto v. D.H. [1999] O.J. No. 5495 (O.C.J.)

1. Admissibility of Nursing Records in Court Cases

    - "Usually" considered "business records" under *Evidence Act*
    - Memory of person making record must be relatively fresh about event, therefore records should be made contemporaneously
    - Records must have been made in the ordinary course of business

If he records the comments about an earth quake in a hospital record, it is probably not going to be very accurate; but if they are recording the temperature of a patient taken by a nurse and she is presumed to be competent, probably, it is going to be reasonably accurate.

2c. Standards of Record Keeping Practice

Common Law

Children's Aid Society of Toronto v. D.H. [1999] O.J. No. 5495 (O.C.J.)

2. Reliability of Nursing Records in Court Cases

- Hospital records must be an honest and true reflection of the events that occurred

  …the requirement that the person making the notation be under a duty to make it is to discourage or to prevent gratuitous comments, self-serving evidence, et cetera, to be inserted in hospital records.

  … presumably there is someone to enforce the duty and so the records will be subject to scrutiny from time to time to see if, in fact, the duty is being performed satisfactorily

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Case Overview:

In-patient at General hospital (known risk of suicide) seriously injured self by running through plate glass window and then running into traffic suffering serious injuries. Patient was under care of nurses and psychiatrists at the time. Hospital, nurses and doctors all successfully sued by patient's family.

Nursing staff was singled out for negligence for failing to chart all relevant information concerning the patient's condition.

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Facts:

Patient was a 20 year old male who was a good student and was attending University. Patient however demonstrated “perfectionist” behaviour and was never satisfied with his academic performance and was also overly concerned with his accent (Dutch extraction) and appearance (acne).

Mother increasingly noted signs of change in patient, mostly manifested as disproportionate worrying and “depression”. Patient’s symptoms worsened and his family doctor diagnosed him with anxiety with depressive reaction in first year university.

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Facts:

Soon after, the patient developed suicidal ideation and as a result, the doctor prescribed anti-depressant meds (150 mg of Norpramin daily). At follow-up, family doctor noted drastic mood swings and believed that patient may be suffering from manic depressive disorder, therefore doctor referred patient to psychiatrist at Owen Sound General Hospital.

However, patient's symptoms worsened to extent that he required hospital admission prior to appointment with psychiatrist.

Patient was admitted to hospital on an involuntary basis under Form 1.

Patient spent a total of 40 days in hospital over two separate admissions.

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Facts:

Significant highlights from initial admitting form.

> Suicidal thoughts began about three months ago at exam time…felt a failure because did not achieve as well he did at Grey highlands Gr. 13 … only 2-3 hrs. sleep, appetite, energy, poor concentration, thought of electrocuting self with – hydro wire…suicidal ideation.

However, patient showed signs of significant improvement after 36 days in hospital and was discharged on August 15, 1984 with instructions for close observation and follow-up.

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Facts:

Soon after, on August 21, 1984 (6 days later), the patient "decompensated" and was readmitted with the main issue being suicidal ideation. The readmission note stated:

> Very depressed – suicidal ruminations, sleeplessness.
> Has not slept for several nights.

Subsequently, over the next four days, the patient repeatedly expressed his suicidal ideation and remained extremely depressed and agitated and had trouble sleeping. Was given meds (liquid C.P.Z.) during this time.

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Facts:

On evening of August 23, 1984 (Day before suicide attempt) Nurse Oberle was assigned to patient and noted in chart the following:

- Patient was silent all evening
- Was not responding to questions (silent), but did eventually form a sentence concerning his medication
- Plan: Conference in a.m., more involvement with ward activities, maintain close observation and continue to assess

Problem: Above charting was not contemporaneous and was completed after suicide attempt on August 28, 1984

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Facts:

Evidence at Trial revealed the following facts concerning the events of August 24, 1984 leading up to and including the suicide attempt:

- Patient verbally unresponsive before dinner
- Nurse heard a loud crashing sound and went to investigate and saw patient repeatedly throw his body against window with a lot of force and eventually break through inner pane of window (not safety glass) causing bleeding all over his arms
- Nurse tried to get him to stop, but patient continued to ram body into glass despite nurse's repeated attempts to control him
- Patient eventually broke through outer pane and ran through window and onto road, and was struck by car, suffering serious injuries (Patient died 2-3 years after trial)

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Judgment:

- Court found the hospital, doctors and nurses all negligent
- Nurse held to be negligent. Her failure to chart according to standards was determinative for the judge in finding that she breached her duty of care owed to her patient

Notable Quote:

Nurse Oberle's charting for that final shift on August 23, 1984 was not done until the weekend immediately following the plaintiff's escape and injury, following a request of Nurse Oberle by the hospital for a recounting of the events of that shift. By all accounts, there were significant items of information contained in Nurse Oberle's charting that bore upon the presentation of the plaintiff; information that was necessary to inform the clinical judgments of those team members who followed her

2c. Negligence Standard with Regard to Charting

DeJong (Litigation guardian of) v. Owen Sound General [1996] O.J. No. 809 (O.C.J. Gen. Div.)

Judgment:

- This decision emphasizes the importance of charting and how other members of the health care team rely on proper records to inform themselves of the patient's condition
- The failure by the nursing staff to have crucial information documented and available for other members of the health care team in a timely manner was deemed to be negligence that resulted in the plaintiff's injuries

3. CONFIDENTIALITY (OF MEDICAL RECORDS)

3. Confidentiality (of Medical Records)

A patient's right to confidentiality is based on:

- Charter of Rights and Freedom
- Hippocratic oath
- College policy
- Statutes (Federal and Provincial)
- Common law
    - Fiduciary duty and tort of breach of confidentiality

3a. Basic Duty - Statute

Nursing Act, 1991 – Regulation on Professional Misconduct:

Definition of Professional Misconduct (pertaining to confidentiality):

Giving information about a client to a person other than the client or his or her authorized representative except:

- with the consent of the patient or his or her authorized representative; or
- as required by law

3a. Basic Duty - College of Nurse's Position

- The duty to keep client information confidential is not restricted to health information but relates to any client information obtained as part of the nursing relationship;
- The duty of confidentiality outlives the professional relationship
- The duty does not restrict the ability to contact other healthcare professionals to ensure continuity of care and care within a multidisciplinary setting

3a. Basic Duty - As required by Law

When is a Nurse or other health care provider allowed to breach confidentiality and disclose content of health care records

- College investigation, hearing, etc.
- Civil litigation
- Coroner's inquest
- Court order
- Search warrant
- Mandatory Reporting
- Duty to Warn

3b. Mandatory Reporting

Common statutory reporting obligations that a nurse would encounter in practice, are found within the following Acts:

- Child and Family Services Act
- Health Protection and Promotion Act
- Health Professions Procedural Code
- Mandatory Gunshot Wounds Reporting Act, 2005

3b. Mandatory Reporting

Child and Family Services Act

If a nurse has reasonable grounds to suspect physical, mental or sexual abuse of a child, he or she shall immediately report the suspicion and the information on which it is based to a Children's Aid Society.

Health Protection and Promotion Act

A nurse who is of the opinion that a person has or may have a reportable disease or is or may be infected with an agent of a communicable disease, shall, as soon as possible, report to the medical officer of health of the health unit in which the professional services are provided.

3b. Mandatory Reporting

Health Professions Procedural Code

A member shall file a report, if he or she has reasonable grounds, obtained in the course of practicing the profession, to believe that another member of the same or different College has sexually abused a patient ("Whistle Blower" provision).

Mandatory Gunshot Wounds Reporting Act, 2005

Every facility that treats a person for a gunshot wound shall disclose to the municipal police, regional police or OPP The name (if known) of a person being treated for a gunshot wound and the location of the facility.

"Facility" currently is defined only as a Hospital, but it may be expanded by Regulations to include a clinic or a doctor's office.

3c. Duty to warn

Smith v. Jones [1999] (S.C.C.)

Court held that confidentiality should be violated if all of the following factors are present:

1. Information disclosed by patient indicates that there is a a clear and immediate risk to an identifiable person or group of people;
2. Information discloses a risk of serious bodily harm, that the person must be capable of carrying out;
3. The danger identified must be imminent and not at some unidentified time in the future

3d. Patient's Right to their Medical Records

McInerney v. MacDonald [1992] 2 S.C.R. 138 (S.C.C.)

- Medical Records are the property of the Patient – not the Physician
- Default Rule: Patient has access to their medical records
- Therapeutic Privilege - Only in certain circumstances can a patient be denied access to their own medical records
- Access can be denied if disclosure will cause the patient harm to learn such information

4. SUMMONED TO APPEAR IN COURT

4. Summoned to Appear in Court

- Summons or subpoena is a legal document compelling a person to attend before a judicial body
- May compel nurse to attend with medical records
- Do not disclose any information until compelled to disclose information only to judicial body or other named and trusted individual as ordered by a court of law or other tribunal
- Confidentiality concerns should be raised “on the record”
- Unauthorized disclosure can result in professional discipline charges or a civil lawsuit

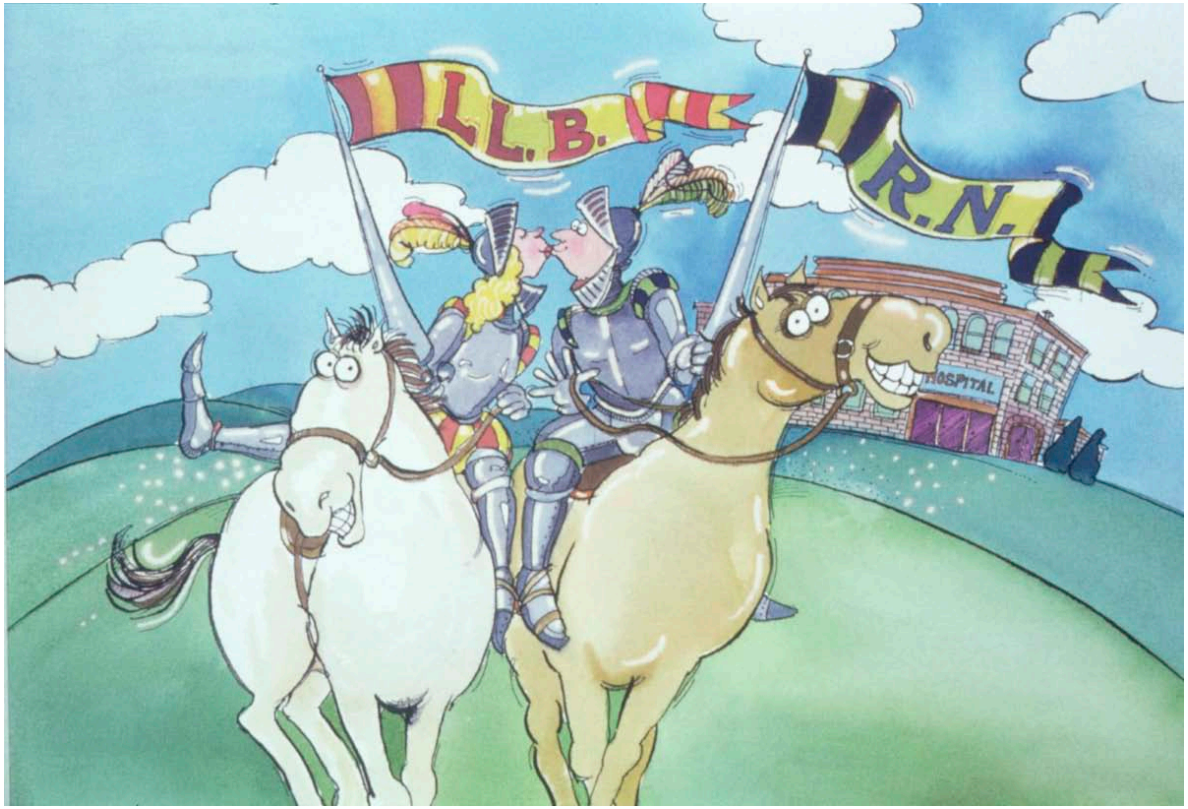
5. OTHER TOPICS AND QUESTIONS

5. Other Topics and Questions

- Using patient's exact words in records (i.e. profanities)
  - Yes. If relevant to entry use exact words used by patient and ok to spell out.

- Keeping copies of notes without a patient's name on it for future use
  - Credibility of notes may be questioned on basis that notes should have been made AND entered into chart at time of event

- Will detailed charting protect a nurse during litigation
  - If detailed charting made contemporaneously, it will be given high credibility by the Court and its contents will be considered as an accurate reflection of the facts / events that occurred
  - If charting is inadequate, this may be taken to be negligence (DeJong)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