## OB Liability Overview

### Recent Large Obstetric Verdicts/Settlements

<table>
<thead>
<tr>
<th>DATE</th>
<th>LOCATION</th>
<th>FACTS</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/08</td>
<td>NEW YORK</td>
<td>IMPROPER USE OF FORCEPS</td>
<td>$19.6M (V)</td>
</tr>
<tr>
<td>7/08</td>
<td>WISCONSIN</td>
<td>IMPROPER MONITORING DELAY IN C-SECTION</td>
<td>$18.2M (S)</td>
</tr>
<tr>
<td>6/08</td>
<td>FLORIDA</td>
<td>NURSING DELAY IN CALLING THE OB</td>
<td>$35M (V)</td>
</tr>
<tr>
<td>5/08</td>
<td>OHIO</td>
<td>IMPROPER MONITORING BY NURSING STAFF</td>
<td>$10M (S)</td>
</tr>
<tr>
<td>5/08</td>
<td>OHIO</td>
<td>IMPROPER MANAGEMENT OF LABOR</td>
<td>$22.6M (V)</td>
</tr>
<tr>
<td>1/08</td>
<td>ILLINOIS</td>
<td>IMPROPER MONITORING BY THE OB AND NURSING STAFF</td>
<td>$21.5M (V)</td>
</tr>
<tr>
<td>9/07</td>
<td>IOWA</td>
<td>IMPROPER MONITORING DELAY IN C-SECTION</td>
<td>$13.5M (V)</td>
</tr>
<tr>
<td>4/07</td>
<td>ILLINOIS</td>
<td>IMPROPER MONITORING BY NURSING STAFF AND THE OB</td>
<td>$18M (S)</td>
</tr>
</tbody>
</table>

Source: [www.willis.com](http://www.willis.com), Healthtrek Newsletter, Sept. 2008
In short, six cases cost all of us 103.8 million dollars!

And that’s not to mention the emotional costs, not only to the families, but to the obstetric staff involved in these cases.

Are all of these just frivolous lawsuits brought by greedy attorneys and served up in front of juries that watch too much TV?

Let’s have a look at some recent data that provides at least part of the answer…. 
Recent Review
in Obstetrics & Gynecology

- Examined perinatal closed claims from a single insurer between 2000-2005
- 70% of OB claims involved substandard care, and these claims accounted for 79% of all costs
- 98% of claims settled prior to or during trial, only 2% went to verdict

Clark, et al; Obstet Gynecol 2008; 112:1279-83
The review concluded:

“Most money currently paid in conjunction with obstetric malpractice cases is a result of actual substandard care resulting in preventable injury”

Clark, et al; Obstet Gynecol 2008; 112:1279-83
The top case issues

1. EFM in non-VBAC patients
2. VBAC cases
3. Shoulder dystocia
4. Maternal injury

Clark, et al; Obstet Gynecol 2008; 112:1279-83
Specifically, EFM issues related to fetal hypoxia accounted for 34% of the closed claims, and 53% of the total dollars paid out.

Care was found to be substandard in 60% of the claims related to EFM/fetal hypoxia.

Clark, et al; Obstet Gynecol 2008; 112:1279-83
What Can We Do?
Impact of CRM Team Training
CRM = Crew Resource Management
Results from Beth Israel Deaconess, a tertiary care academic center doing 5000 births/yr.

From left: Dennis S. O’Leary, Ronald Marcus, Robert Hanscom (in back), Mary Salisbury, Penny Greenberg, Stephen Pratt (in back), Barbara Stabile, Benjamin Sachs, Susan Mann, and Janet Corrigan.
<table>
<thead>
<tr>
<th>Module</th>
<th>Skill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td><strong>SEAR</strong></td>
<td>Structured technique for presentation of relevant patient information.</td>
</tr>
<tr>
<td></td>
<td><strong>DESC</strong></td>
<td>Structured technique for conflict resolution.</td>
</tr>
<tr>
<td></td>
<td>2-Challenge</td>
<td>Concept that patient safety concern must be verbalized at least twice if it is not corrected.</td>
</tr>
<tr>
<td></td>
<td>Check Back</td>
<td>Orders and clinician needs must be repeated back to the sender to ensure that the receiver has understood the message correctly.</td>
</tr>
<tr>
<td></td>
<td>Call Out</td>
<td>Important events are called aloud, especially during rapidly changing situations. Facilitates anticipation of next steps.</td>
</tr>
<tr>
<td></td>
<td>&quot;Stop the Line&quot; Phrase</td>
<td>A word or phrase understood by all to indicate a significant safety concern. It can be spoken in front of awake patients.</td>
</tr>
<tr>
<td>Situation Monitoring</td>
<td><strong>Situation Monitoring</strong></td>
<td>Actively scanning the unit to assess patients and their plans of care, team member performance, and the environment, looking for potential errors.</td>
</tr>
<tr>
<td></td>
<td>Shared Mental Model</td>
<td>When caregivers are aware of the same information, and are thus able to plan and problem solve together.</td>
</tr>
<tr>
<td></td>
<td>Situation Awareness</td>
<td>The state of knowing one’s surroundings and work condition.</td>
</tr>
<tr>
<td>Mutual Support</td>
<td>Feedback</td>
<td>A form of verbal support that help colleagues to improve their teamwork.</td>
</tr>
<tr>
<td></td>
<td>Advocacy</td>
<td>A form of verbal support that requires staff to advocate for patient safety.</td>
</tr>
<tr>
<td></td>
<td>Task Assistance</td>
<td>Asking for or offering assistance when one team member is overworked or attempting to do something beyond their skill set.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Resource Management</td>
<td>Appropriately re-allocating resources or work load to ensure that no patient is at risk due to overworked staff.</td>
</tr>
<tr>
<td></td>
<td>Conflict Resolution</td>
<td>Leaders help resolve interpersonal or medical conflicts using structured language and a chain of command.</td>
</tr>
<tr>
<td></td>
<td>Teamwork Behaviors</td>
<td>The leader ensures that team meetings, briefings, debriefings, and other teamwork behaviors occur.</td>
</tr>
<tr>
<td></td>
<td>Role Clarity</td>
<td>The leader is responsible for ensuring that team members know their roles and responsibilities.</td>
</tr>
</tbody>
</table>

SEAR, Situation-Background-Assessment-Recommendation; DESC, Describe, Explain, Suggest, Consequences.
The concepts can be summed up by the Circle of Safety schematic…
The Key Components

- Clinical Comprehension
  - What’s our knowledge base?
  - What information do we have/need?
- Communication
  - SBAR, DESC, 5-step assertiveness
  - Listening skills, Crucial Conversations
- Collaboration
  - Developing & instituting a clear plan of care that includes *all* team members
And for EFM, that collaborative plan of care is delineated by the intrapartum application of the Standardized Management Model.

Let’s refresh our memories…”
Intrapartum FHR Monitoring Management Decision Model

**Confirm FHR and uterine activity**
- Is there an indication for immediate intervention? (for example, prolonged deceleration without recovery, persistent sinusoidal pattern, hemorrhage, HELLP syndrome)
  - If so, manage according to specific indication
- Are all 5 FHR components normal?
  - Normal baseline rate (110-160 bpm)
  - Moderate variability (6-25 bpm)
  - Accelerations present (fetal stimulation if needed)
  - Decelerations absent
  - No significant changes or trends over time
  - Yes
  - Low probability of evolving metabolic acidemia
    - Is there another reason to review the FHR tracing more frequently than usual? (for example, fetal growth restriction or preeclampsia)
      - Yes
      - Reassess the above at least every 30 minutes in the 1st stage of labor and at least every 15 minutes in the 2nd stage. Deliver for usual obstetric indications.
      - No
      - Reassess the above at least every 15 minutes in the 1st stage of labor and at least every 5 minutes in the 2nd stage. Deliver for usual obstetric indications.
      - Yes
      - Recurrent decelerations? or
        - Minimal-absent variability and absent accelerations?
          - Yes
          - No
          - “C” - Clear obstacles to rapid delivery
          - “D” - Determine decision to delivery time
          - Is vaginal delivery likely to occur before the onset of metabolic acidemia and potential injury?
            - Yes
            - ROUTINE INTRAPARTUM SURVEILLANCE
            - Heightened intrapartum surveillance
            - Offer operative delivery
  - No
  - “ABCD”
    - “A” - Assess oxygen pathway and consider other causes of FHR changes
    - “B” - Begin corrective measures if indicated and reassess FHR
### "ABCD"

Consider these steps and implement if clinically indicated

<table>
<thead>
<tr>
<th></th>
<th>“A”</th>
<th>“B”</th>
<th>“C”</th>
<th>“D”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assess Oxygen Pathway</td>
<td>Begin Corrective Measures</td>
<td>Clear for Delivery</td>
<td>Decision to Delivery Time</td>
</tr>
<tr>
<td>Lungs</td>
<td>Airway and breathing</td>
<td>Supplemental oxygen</td>
<td>OR availability</td>
<td>Realistic estimate of facility response time</td>
</tr>
<tr>
<td></td>
<td>Pulse oximetry or ABG</td>
<td>Treat pulmonary disorders</td>
<td>Instruments</td>
<td>Equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>After breathing technique</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>Heart rate and rhythm</td>
<td>Intravenous fluid bolus</td>
<td>Notify:</td>
<td>Availability</td>
</tr>
<tr>
<td></td>
<td>Cardiac output</td>
<td>Treat arrhythmia</td>
<td>Obstetrician</td>
<td>Training</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Surgical assistant</td>
<td>Experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anesthesiologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neonatologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pediatrician</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing staff</td>
<td></td>
</tr>
<tr>
<td>Vasculature</td>
<td>Blood pressure</td>
<td>Maternal position changes</td>
<td>Informed consent</td>
<td>Surgical considerations</td>
</tr>
<tr>
<td></td>
<td>Volume status</td>
<td>Correct hypotension</td>
<td>Anesthesia options</td>
<td>(prior abdominal or uterine surgery, uterine fibroids)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Laboratory tests</td>
<td>Medical considerations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Blood products</td>
<td>(clefts, hypertension, diabetes, SLE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>IV access</td>
<td>Obstetric considerations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Urinary catheter</td>
<td>(parity, pelvimetry, placental location, preeclampsia)</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td>Abdominal prep</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Transfer to OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterus</td>
<td>Contraction strength</td>
<td>Stop or reduce uterine stimulants</td>
<td>Confirm</td>
<td>Consider factors such as:</td>
</tr>
<tr>
<td></td>
<td>Contraction frequency</td>
<td>Uterine relaxants if needed</td>
<td>Fetal heart rate</td>
<td>Baseline FHR changes</td>
</tr>
<tr>
<td></td>
<td>Baseline uterine tone</td>
<td>Consider IUPC</td>
<td>Estimated weight</td>
<td>Loss of variability</td>
</tr>
<tr>
<td></td>
<td>Exclude uterine rupture</td>
<td>Alter pushing technique</td>
<td>Gestational age</td>
<td>Loss of accelerations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Presentation</td>
<td>Recurrent decelerations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Position</td>
<td>Growth restriction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Macrosomia</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Presentation, position</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Prematurity, infection</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Meconium</td>
</tr>
<tr>
<td>Placenta</td>
<td>Placental separation</td>
<td>Rapid delivery if indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bleeding vasa previa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cord</td>
<td>Vaginal exam</td>
<td>Consider amnioinfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exclude cord prolapse</td>
<td>Consider elevating fetal head</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor</td>
<td>Consider tocolytic</td>
<td>Consider IUPC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© David A. Miller, M.B.
Note to instructors:
Case studies may be utilized here before proceeding to the deposition process
Depositions in Perinatal Cases

- Remember the purposes of the deposition, it is certainly not limited to “fact-finding”
- Perhaps the best way to get a handle on depositions is to review some actual deposition testimony
- First we’ll look at some of my favorite expert excerpts
- Next, we’ll take a look at the answers given by defendant doctors, midwives, and nurses. During this portion I’ll be asking for audience suggestions – in other words, how would YOU answer?
Q. So the FHR tracing can detect brain damage?
A. Yes, in this case I can see the brain damage evolving as the tracing continues.

Q. What type of decels are those?
A. Those are late envelope decelerations.

Q. So you are saying a base deficit of 9 is consistent with a metabolic acidemia, right?
A. Well, a mild metabolic acidemia, I would say.
Nurse’s answer, follow-up to questions regarding “hypoxia”

Q. It can also lead to acidosis?
   A. Yes, I guess so.

Q. You know what acidosis is of course?
   A. I don't know the exact definition but yes.

Q. You know the general?
   A. Yes.

Q. You know it as a problem?
   A. Yes.
Follow-up to nurse’s definition of normal intrapartum strip as “BL 120-160 with good variability & accels when baby moves”

Q. Can you tell me any recognized nursing literature or fetal monitor literature that has been published in this country in the last 20 years that supports your definition?
A. No, I don’t read journals.

Q. Do you read anything in fetal monitoring?
A. No.
Questions nurse re: engagement of fetal head in labor

Q. Can the head be engaged at a minus 4 station?
   A. No.

Q. Can it be engaged at a minus 3?
   A. I am not the expert on that. I believe yes.

Q. Can you tell me what that means?
   A. It means the head is in the pelvis and when you do a vaginal exam you are unable to move the head; the baby's head has come down and is sitting in the pelvis and not moving.
Different nurse, but same case, and same questions related to the engagement of fetal head

Q. Is there any station that indicates the head is engaged?
A. Usually minus 3, minus 4.

Q. Is that your opinion, as a nurse practicing over 10 years in labor & delivery?
A. If it’s not ballotable, yes.
Q. Variability is a kind of sawtooth, up & down thing?
A. Well, to me moderate is like hills & valleys and short-term is like trees on the hill.
Q. And the variability in the deceleration is what you found reassuring, correct?
A. Yes, as long as there is variability within the decel, baby is OK and we can wait.
10 Deposition Survival Tips

1. Be prepared...early on!
2. Be involved actively with your defense.
3. Learn to be a literal thinker and use this skill in listening.
4. Take your time.
5. Think about your presentation, don’t personalize the deposition.
6. Do not volunteer information.
7. Pay attention to your attorney.
8. Know the medicine (or midwifery or nursing) behind the issues.
9. Realize that “I don’t know” and I don’t recall” are acceptable, yet distinctly different answers.
10. Use the “KISS” vs. the “Kiss off” approach.
Documentation:

Are We Charting Too Much?
Purposes of documentation

- Facilitate communication among & between caregivers
- Promote improved quality of care by encouraging assessment and reevaluation of progress and clinical plans
- Meet professional and legal standards
Charting & Documentation

- JCAHO report noted that a staff RN spends up to 50% of an 8-hour shift with charting and administrative duties!
- Many documentation protocols are onerous, and can actually create liability issues for staff rather than prevent them
- But many documentation protocols will not be changed until certain myths are exposed and critical thinking is employed
To fully understand the role of documentation, as well as its limitations, we must understand the “big picture”.
Critical thinking reveals…

Assessment
  Encompasses everything
Communication
  What I tell others
Documentation
  What is recorded
Truth or consequences?

The old adage “If it wasn’t charted, it wasn’t done” is cited frequently by both lawyers and nursing/managerial personnel as if it were the 11th commandment.

Many clinicians believe that although this is obviously not clinically true, it is legally true. Unfortunately, this myth can cause quite a few problems for clinicians.
Evidence 101 for clinicians

Offers of proof at trial may include:

- The medical record and other notes
- Specific recollections of clinicians
- The family's story
- Standard and routine practices

But remember, although all of these may be available at deposition or trial, the plaintiff's attorney and his/her reviewers only have two things to rely on: the medical record...
Let’s have a look at a sample, and somewhat generic, documentation protocol that I think is fairly representative of many; and see what we want to change and what we might want to add for a perinatal unit…

Documentation of nursing care is to be pertinent, concise, and will reflect the patient’s status.

Only current hospital-approved forms will be used.

Entries will be legible, neat, and concise with correct spelling and punctuation using black ink.

Each Registered Nurse (RN) and Licensed Practical Nurse (LPN) will document the care he or she gives.

Exception: Patient Care Attendants (PCAs) and Patient Care Specialists (PCS’s) may document the care they give on specific flowsheets as identified in related nursing procedures.

Signatures:

a. On any document without an initial/signature section, the entries will be signed as the nurse’s name appears on his/her nursing license. In the case of multiple names, first initial and last full name may be used.

b. Entries may be signed with the nurse’s initials, where documentation forms provide “initials/signature” boxes to identify the writer.

c. If there is space between the last word of the entry and the signature, the writer will draw a line to fill blank space prior to signature.

Information will be documented as the shift progresses (no-advance charting).

Information will be entered on the correct chart. All forms will be labeled with the correct patient information using the patient labeling system.
This seems quite broad, doesn’t it?

And what exactly does this mean?

Why put this into the protocol? Could it be worded differently?

Isn’t number 8 included here?

And why is this here? Is this really needed?

8. Actions or interventions performed, appropriate observations, services performed, or other pertinent information will be documented.

9. Reported symptoms will be described accurately.

10. Document nursing action taken following an indication of a need for action.

11. Information will be written so that there are no lines left between entries.

12. The “Do not Use” abbreviation list will be followed for manual documentation.

13. The use of the word “apparently” and “appears to be” should be avoided.

14. Information pertinent to the established medical and interdisciplinary plan of care, including identified problems, progress toward goals, interventions, patient responses and progress, and patient/family education will be documented.

15. Nursing will maintain all patient information in a strictly confidential manner.
Documentation protocols *should* be simple, concise and clear. Taking a look at your own protocols with a critical eye is a good exercise and can help you work toward creating useful and unambiguous protocols.

After all, you’ll be the one in the deposition answering questions about them!
EFM & documentation issues

- Use of NICHD terminology
- Use of non-NICHD terms and concepts
- Nurse vs. provider charting
  - variances in style & type
  - conflicts in the record
- Late entries vs. spoliation issues
Use of NICHD terminology

- Published originally in 1997, the NICHD nomenclature was adopted by all professional organizations in 2005-6.
- In 2008, a new NICHD panel was convened and the definitions for FHR terminology were once again reiterated, with clarifications regarding baseline and sinusoidal pattern.
- In addition, the committee addressed uterine activity and created a three-tier classification system to replace the use of non-specific terms like “reassuring” and nonreassuring.”
2008 NICHD FHR Tracing Evaluation

Must include a description of:

- Uterine contractions*
- Baseline rate
- Baseline variability
- Presence of accelerations
- Periodic or episodic decelerations
- Changes or trends over time
Note that it specifically states *contractions*, not *activity*, so specifics are better than summary terms and in keeping with the NICHD panel’s discussion of the clinical evaluation of uterine activity.
2008 NICHD Update – Uterine Activity

- 2008 NICHD panel states uterine contractions are now “quantified as the number of contractions present in a 10-minute window, averaged over 30 minutes”

- Notes the importance of duration, intensity and relaxation time in clinical practice

- Normal is \( \leq 5 \) contractions in 10 minutes, averaged over a 30 minute window
2008 NICHD Update – Uterine Activity

- Tachysystole is >5 contractions in 10 minutes, averaged over a 30 minute window, and includes both spontaneous and stimulated labor
- Tachysystole should be further qualified as to the presence or absence of decelerations
- Specifically excludes the use of the terms hyperstimulation and hypercontractility
Documentation of decels

- NICHD states decelerations *may* be further quantified by the depth of the nadir in BPM and the duration in minutes/seconds from onset to offset.
- But must we document this with every single deceleration? And how do we chart when we are dealing with documenting decelerations that vary over time?
- The answer lies in understanding standard of care, which is based on *reasonableness*.
The NICHD nomenclature provides us with standard definitions that accurately describe the different types of decels, therefore further quantification is optional when it comes to documentation, but may be quite significant to include when communicating decels to the MD/CNM. Every institution will need to decide what is “reasonable” re: documentation.

This must be considered in light of the type of records the institution uses (computer, paper, flowsheet, etc.)
New Classification System

- 2008 NICHD panel recommended a new three-tier classification system, *the terms “Reassuring” & Nonreassuring” are not used*

- **Category I** tracings are considered “**normal**” and include all of the following:
  - Baseline rate between 110-160
  - Moderate variability of baseline
  - Late or variable decelerations: absent
  - Early decelerations: present or absent
  - Accelerations: present or absent
New Classification System

- Category II tracings are considered “indeterminate”, are not predictive of abnormal fetal acid-base status, and require evaluation that includes clinical context.

- Examples of Category II include:
  - Bradycardia without absent variability, Tachycardia
  - Minimal or marked variability
  - Absent variability without recurrent decelerations
  - Absent accelerations following stimulation
  - Recurrent variables with minimal or moderate variability, or variables with other characteristics
  - Prolonged decelerations
  - Recurrent late decelerations with moderate variability
Category III tracings are “abnormal”, they are considered predictive of abnormal fetal acid-base status at the time of observation, and require prompt evaluation that includes intrauterine resuscitation.

Category III tracings include either:
- Absent variability and any of the following:
  - Recurrent late decelerations
  - Recurrent variable decelerations
  - Bradycardia
- Sinusoidal pattern
New Classification System

- All FHR tracings that do not fit into Category I or III are to be included in Category II.
- Of interest is the return of the terms “shoulders” and “overshoot” in relation to variable decelerations, albeit without any definitions of these two terms provided, and used only in Category II.
- No specific management guidelines were presented, other than the recommendations for continued surveillance and reevaluation with Category II tracings, and the use of intrauterine resuscitation for Category III.
Non-NICHD terminology

- Using non-NICHD terminology in 2009 creates the potential for a claim that you are not operating within the standard of care.
- Any FHR pattern that does not fit the standardized NICHD definitions should simply be charted descriptively.
Non-NICHD terminology

For a more detailed review of terms that are commonly used but not NICHD compliant, along with a discussion of the related evidence, see the 6th edition of Mosby’s Pocket Guide to Fetal Monitoring.
Nursing vs. Provider Charting

- Flowsheets are more commonly used by nurses, while CNMs, NPs/PAs, and MDs will more often utilize progress notes.
- Standardized delivery notes, especially in shoulder dystocia cases, can be very helpful.
- The key consideration is to avoid conflict in the record by ensuring that everyone, including the patient, is on the same page regarding the plan of management.
- And the most important caveat in charting, regardless of the initials after your name, is simply this...
Common Charting Errors

- Failure to record pertinent health info (allergies, medical history, chief complaint)
- Failure to record nursing actions, or a clear plan of care if you are the provider
- Failure to record meds given or meds discontinued
- Writing on the wrong chart
- Problems with transcribing or writing orders
- Illegibility
- Incomplete records
Spoliation is a legal term that refers to intentional alterations or falsification of records to avoid liability.

Although appropriate late entries can be your best friend, “buffing” the chart is not only unethical, it immediate makes you a “liar” instead of a defendant nurse, midwife or doctor.

Whether you use paper records or electronic records, plaintiff’s attorneys will spend the money to find out when the entries were actually made...
ESDA & Audit Trails

- Electrostatic Detection Apparatus (ESDA) will show latent impressions, or indentations, on underlying paper. This test can help determine when particular notes were originally written.
- Electronic systems, if not transparent, can be checked by requesting a history or audit trail that will show keystroke entry times for each note.
- In short, if you do not identify an entry as a late entry, you run the risk of being accused of record falsification.