Documentation & Nursing

A Legal Perspective
Nursing & Documentation

Presentation Sponsored by the Registered Nurses Association of Ontario (RNAO)
Legal Assistance Program
Nursing & Documentation

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If you only take one thing from this presentation...

- IF IT IS NOT DOCUMENTED, IT DID NOT HAPPEN

- Important to have accurate and complete documentation

- NUMEROUS examples when you may need to look at your documentation at a later date
Multiple Accountabilities

- Nurses are accountable to a number of different groups:
  - Patients & their families
  - Employers
  - Colleagues
  - CNO
  - The Public

- Documentation can be crucial with respect to all of these accountabilities
Outline of Presentation

- The CNO and Documentation

- Nurses’ Notes in “litigation”
  - Generally
  - In criminal and civil matters
  - Other forums

- Charting-by-Exception
The CNO & Documentation

- The CNO’s Practice Standard on Documentation (Revised 2008)
  - Available on CNO Website
- Outlines three accountabilities for Nurses’ documentation:
“Nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client’s needs, the nurse’s interventions and the client’s outcome”
CNO Practice Standard on Documentation – Statement #1, Communication

- Documentation should be a complete record of nursing care – assessment, planning, intervention and evaluation

- Document objective and subjective data

- Ensure plan of care is clear, current, relevant and individualized to meet the client’s needs and wishes

- Minimize duplication of information in the health record

- Ensure that relevant client care information kept in temporary hard copy documents (such as kardex, shift reports or communication books) is captured in the permanent health record
CNO Practice Standard on Documentation – Statement #1, Communication

- Provide full signature or initials, and professional designation
- If handwritten – make sure it is legible and in permanent ink
- Use abbreviations and symbols appropriately
- Document informed consent
“Nurses are accountable for ensuring their documentation of client care is ACCURATE, TIMELY and COMPLETE
CNO Practice Standard on Documentation – Statement #2 - Accountability

- Complete documentation during or as soon as possible after the care or event

- Document date and time that care was provided and when recorded

- Document chronologically

- Clearly indicate if the entry is late

- Do not leave empty space for others to add information later
CNO Practice Standard on Documentation – Statement #2 - Accountability

- Correct errors and make sure original information is visible or retrievable
- Do not delete, alter or modify another person’s documentation
- Document if information for a specific time frame has been lost or cannot be recalled
- Ensure that documentation is completed by the individual who performed the action or observed the event
- Clearly identify the individual performing the assessment and/or intervention when documenting
“Nurses safeguard client health information by maintaining confidentiality and acting in accordance with information retention and destruction policies and procedures that are consistent with the standard(s) and legislation”
CNO Practice Standard on Documentation – Statement #3 – Security

- Ensure that relevant client care information is captured in a permanent record
- Maintain confidentiality of client health information, including passwords or information required to access the client record
- Understand and adhere to policies, standards and legislation related to confidentiality
CNO Practice Standard on Documentation – Statement #3 – Security

- Accessing only information for which the nurse has a professional need to provide care
- Maintain the confidentiality of other clients by using initials or codes when referring to another client in a health record
- Obtain informed consent to use and disclose information to others outside the circle of care
CNO Practice Standard on Documentation – Statement #3 – Security

- CNO Disciplinary Decision, Re Leroux (March 23, 2005)
- Allegation that a nurse accessed confidential information about a client on a hospital computer system
- The patient in question was a former colleague who had been admitted to the hospital
- The Nurse accessed her patient file/information
- Member was found by the Discipline Committee to have committed acts of professional misconduct
- Member received an oral reprimand, required to complete a professional ethics course, required to meet with a Practice Consultant, have in-service sessions regarding client confidentiality, and review the One is One Too Many program
Clinical Notes & Records at the CNO, In General

- Your notes are relevant at CNO in two respects:
  - If standard of documentation at issue
    - E.G. Narcotics cases
  - To give information on patient care or a complaint or matter of incapacity more generally

- One of the *first* things the CNO asks for in an investigation – ALL clinical notes/records regarding the care of a patient(s) at issue in a file
Notes in Court – Issues around Testimony and Liability

- Notes – In General
  - In “civil” court (e.g. lawsuits)
  - In Criminal Court
  - Other forums (e.g. Coroner’s Inquests)
Nurse’s Notes In Litigation – In General

- **Ares v. Venner** (Supreme Court of Canada, 1970)
- Nurses’ notes are admissible as *prima facie* proof of the truth of the facts and events that they recorded.

- Three conditions must be satisfied for the notes to be admitted for the truth of their contents. The notes must be made:
  - Contemporaneously;
  - By someone having personal knowledge of what’s being recorded; and
  - By someone under a duty of care to make the entry or record.

- If these conditions are satisfied the contents of the notes will be considered to be true unless the party challenging their accuracy can persuade the Court otherwise.

- This places a heavy and difficult burden of proof on the party trying to discredit nurses’ notes.
Nurse’s Notes In Litigation – In General

- **Joseph Brant Memorial Hospital v. Koziol** (Supreme Court of Canada, 1978)
  - Nursing notes were introduced as evidence at trial
  - With respect to the absence of entries the court inferred that “nothing was charted because nothing was done”
Nurse’s Notes In Litigation – In General

- *Ferguson vs. Hamilton* (Ont. High Court of Justice, 1985)
  - The court rejected that the absence of any nurse’s entry is an indication of failure in care on the part of the nurse(s).
  - Court concluded that the fact that there was nothing in the nurses’ notes during a period of time did not necessarily mean nothing was done, provided:
    - There was evidence to the contrary
    - AND
    - The usual practice was not to chart.
Nurse’s Notes In Litigation – In General

- And *Ferguson* is balanced a bit by:

- Here, the court held that the absence of contemporary documentation of *important* events in the care of a patient gives rise to the inference that the events simply never happened
Civil Liability & Nurses’ Notes – Case Study: Sozonchuk

- Sozonchuk v. [“Nurse A”] (Ont. Sup. Ct., 2012)
- Negligence claim against “Nurse A” brought by patient’s family
- Patient, as result of allegedly inadequate care, was left with severe functional limitations
- At issue was the standard of care the nurse provided to the patient
Civil Liability & Nurses’ Notes – Case Study: Sozonchuk

- “Nurse A’s” notes, or lack thereof, proved crucial to the outcome.

- Excerpts from judgment:
Civil Liability & Nurses’ Notes – Case Study: Sozonchuk

“Nurse [“A”] did not document any of her discussion with Nurse B in the medical records” (p. 7).
“Nurse [“A”] testified that she assessed Mr. Sozenchuk again at 8:30am. There is no documentation of the assessment” (p. 7).
“Although [Nurse A] testified that she had a number of concerns… there is no medical record that reflects the concerns she testified to” (p. 7).
“At 10:30am Nurse [“A”] said she asked whether a doctor had responded to the page… Once again, there is no documentation of this discussion” (p. 8).
“Nurse [“A”] said that she assessed [the patient] again at 12:15pm and bathed him... The assessment is not documented” (p. 8)
Civil Liability & Nurses’ Notes – Case Study: Sozonchuk

- The judge’s conclusions as a result:
  - “[Nurse A] admits in her evidence that some of the times she noted are not accurate” (p. 12).
  - “It is also clear, based on [Nurse “A’s”] own evidence, that some of her entries were not timely and were made after events took place” (p. 12).
“Clearly not every interaction between the primary nurse and the charge nurse during the shift need be documented. However, in circumstances where there is a concern about a patient’s condition, discussions about it, confirmation of assessments and the plan of care should be [documented]” (p. 13).
Civil Liability & Nurses’ Notes – Case Study: Sozonchuk

- The judge’s most telling statement re documentation:
  - “I ALSO DO NOT CONSIDER NURSE [“A’S”] EVIDENCE AT TRIAL TO BE RELIABLE GIVEN THAT IN MANY CASES SHE FAILED TO MAKE ANY RECORD OF EVENTS SHE WAS TESTIFYING TO” (p. 12-13).
Civil Liability & Nurses’ Notes – Case Study: Sozonchuk

- Nurse A lost – found to be negligent

- She was ordered to pay to the hospital 50% of the amount the hospital paid to settle the lawsuit

- The settlement amount was not disclosed but it could have been tens, or hundreds of thousands of dollars

- IN PART DUE TO HER POOR NOTE-TAKING
Nurse’s Notes in Criminal Court

- Rules of evidence already reviewed apply to criminal court as well
  - Notes admissible for proof of their contents provided certain conditions met
  - Nurse’s notes come up frequently in criminal matters
Nurse’s Notes in Criminal Court – Case Study – *R. v. E.S.* (Ont., 2011)

- Allegation/charge: attempted sexual assault
- Accused was found guilty and convicted at trial
- Appealed decision to Superior Court
- One of the defences raised in the case:
  - Honest but mistaken belief in consent
- Judge ignored a nurse’s note/record in finding the accused guilty
Nurse’s Notes in Criminal Court – Case Study – *R. v. E.S.* (Ont., 2011)

- After incident, Complainant went to a women’s sexual assault clinic and saw a nurse
- Nurse’s notes recorded that complainant said she had been “fooling around” with the accused
- Judge ignored this – held it did not matter
- On appeal, accused argues it is relevant to honest but mistaken belief in consent
Nurse’s Notes in Criminal Court – Case Study – *R. v. E.S.* (Ont., 2011)

- Court agrees on appeal, orders a new trial

- “[T]he factual content of medical records (such as medical observations or dosages) is admissible for the truth of such contents, but this does not apply to the content of statements of patients…”
“However… the accuracy of a direct quote in a medical record must be regarded as high, as the recorders of that record are required to create a true record so the institution can act upon that information… Further, nurses are highly trained medical professionals and have both statutory and professional duties in regard to patient care and record keeping: See section 19-25, O. Reg 965… and the Practice Standards of the [CNO] (Documentation, Revised 2008)”.
Nurse’s Notes in Criminal Court – Case Study – *R. v. E.S.* (Ont., 2011)

- “This court is troubled by the manner in which the issue of the notes and the statement that the complainant made to the intake nurse unfolded during the trial…

“On this basis alone, the conviction should be set aside and a new trial should take place.”
Nurse’s Notes & Employment Issues

- In a 2004 labour arbitration case, a Nurse was fired for failure to properly document client interactions, and her attempt to falsify records.

- In upholding the employer’s decision to terminate her employment, the Arbitrator said this:
  - “I adopt the generally accepted arbitral view that employees in the health care field are held to a high standard of care. Errors can have potentially serious consequences.”
Nurse’s Notes in other Legal Forums

- There are innumerable forums and legal proceedings where Nurses notes may become relevant
  - CPSO matters
  - Child custody matters
  - Civil suits between third parties (e.g. disability claims, personal injury)
  - Coroner’s Inquests
  - WSIB claims

- General legal principles reviewed thus far generally apply to these other forums
Charting by Exception

- Neither the courts nor the CNO have “rejected” charting-by-exception nor advised against its use.

- BUT – has caused issues around memory/recall in several cases and raised questions about what assessments/interventions were, or were not done.
Charting by Exception

- *Re Leroux*, CNO Discipline Committee
- Nurse accused of:
  - Sexually assaulting a client
  - Failure to document supposed “accidental” physical contact with same client
- Manager had advised Nurse that the client had accused the nurse of sexual abuse
- Nurse denied abuse, said client’s hand “brushed” against him (Nurse)
  - He did not chart this “accidental” contact
Charting by Exception

- *Re Leroux*, continued
  - “…[E]ach and every panel member expressed concern that given the circumstances of the allegation, any reasonable nurse would have documented even the most incidental physical contact with the [client] regardless of hospital policy. The Member did not. Despite being advised by [Nurse B] to go make complete documentation, the Member did nothing, and said nothing until his meeting with [an investigating manager] more than three weeks later… [T]he Member was specifically advised by [Nurse B] to document because an “exceptional circumstance” had occurred in that [the Client] had accused him of sexually assaulting [the Client]. If that doesn’t represent an exception that should be charted, then the panel is uncertain what would.”
Charting by Exception

- In another case, the CNO’s Discipline Committee commented as follows regarding charting by exception:
  - “The panel found that the charting used by the Facility presented some challenges in providing a clear understanding of some of the sequences of events. There was a lack of information found on the Flow Sheet in relation to the timing of events and assessments. The Flow Sheet did not easily distinguish between initial charting and subsequent event charting, as often there is no time indication. The progress notes did not seem very thorough because of the practice of charting by exception. This complicated factual matters such as the Member’s claim that he performed a second bladder scan but did not chart it because there was no catheterization required or done” (College of Nurses of Ontario v Member, May 23, 2014, 2014 CanLII 97526 (ON CNO)).
Charting by Exception

- In several cases before the Courts, judges have expressed reservations regarding the “charting-by-exception” method
Charting by Exception

“The difficulty with charting by exception on a flow chart or graph is that when there are holes and blanks in the information, it leaves another observer wondering whether the observations were made, but not charted, or not made at all… In my view, a better practice would be (on documentation such as flow charts) for all of the observations made at intervals to be documented on the chart to establish, if the chart is accepted, that the measurements were made and what they were.”

- Skeels Estate v. Iwashkiw, 2006 ABQB 335, Alberta Court of Queen's Bench.
Charting by Exception

- **Jackson v. Kelowna General Hospital 2006 BCSC 279** (British Columbia Supreme Court)

- “It is safe to say that the charting performed by the nurses...does not inspire confidence. It is clear from the evidence before me that it is critical that patient's hospital charts be fully maintained and that they accurately document the care provided to the patient. This is particularly the case, in my view, on a ward which employs team nursing. Each patient's hospital chart is an important method of communication between nurses and other health care professionals with respect to the patient.”
Charting by Exception

- *Jackson v. Kelowna General Hospital* 2006 BCSC 279 (British Columbia Supreme Court)

- “In this case, it is clear that there was insufficient charting... It is incomprehensible that something as important as doctor ordered vital sign monitoring would not be charted.”

- “Similarly, as a result of the lack of charting, the evidence of the defendants [Nurses] is unconvincing with respect to when, and indeed whether, hourly rounds were done on that shift, prior to the rounds done by Ms. Hunt at midnight. No notes were made with respect to the periodic assessments, formal or informal, of the plaintiff's pain level, sedation level or nausea level.”

- “While I heard much evidence about "charting by exception", which involves the practice of making no chart notes unless something abnormal is noted, it seems contrary to good practice, in my view, to not at least note that rounds were performed or informal assessments were made, even if no abnormal findings were noted.

- “I am satisfied that the charting performed by the defendant nurses failed to meet the standard expected of reasonable and prudent nurses.”
CNO Resources

- Practice Standard: Confidentiality and Privacy – Personal Health Information
- Practice Standard: Documentation
Conclusions, Q&A

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