



Substandard Charting or Fraudulent Charting

Is the charting merely substandard? The attorney tells you she has a suspicion that the medical record has fraudulent charting. She thinks the medical documentation of healthcare providers may be incomplete, untimely, illegible, or incorrect.

I'm Pat Iyer and this is Iyer's Insights, one of two weekly Legal Nurse Podcast shows. I've found altered medical records and know there is a good chance you might also.

You know that *substandard* documentation may itself result in an untoward outcome for the patient and thus factor into a medical negligence suit. However, what makes it substandard is that it is due to a reason **other than** a desire deliberately to destroy, suppress, or otherwise tamper with medical records. In other words, it is the motive behind the charting that counts.

In podcast 344, Dr. Stephen Cohen spoke about some of the colorectal cases that stood out in his mind because of the failure to recognize complications. Suppose the healthcare provider went into the medical records after the fact and altered the information? That becomes fraudulent charting.

Incomplete charting may be substandard charting or fraudulent charting

Incomplete documentation might occur when a healthcare professional begins to document on a medical record and then is called away to do something else. A brief note written under the pressure of time may be interpreted as an inattentive interaction. Notes that are ambiguous or too brief include entries such as

- OK,
- looks fine, or
- review of systems within normal limits.

The incomplete notes may contribute to a negative clinical outcome when the missing information would have been important for others to know.

Untimely charting

Untimely documentation may result when the medical record is not available for charting, although this is less common now since more documentation is electronic. The dictation of a history and physical, operative report, consultation, or discharge summary might occur too long after the events in question. Sometimes the physician does not dictate the discharge summary within the required thirty-day timeframe because the hospitalization is lengthy, and it is difficult to set aside the time needed to perform this task. Hospital administration may suspend the admitting privileges of physicians if they are *habitually* late in completing discharge summaries.

Reports dictated too long after a complication lack credibility, whether the outcomes resulted from negligence.

Illegible handwriting

Illegible handwriting is a major source of frustration for all those who must rely on being able to read medical records. Although you see less of handwritten records in acute care, they are still prevalent in other settings such as long-term care.

Unreadable handwriting may affect the clinical care of the patient. Malpractice carriers report that illegible handwriting may lead to some of their most expensive and difficult to defend lawsuits.

Incorrect charting

Incorrect information may appear in medical records. Wrong information is entered into the medical record because of distractions, fatigue, or other factors.

Errors and inaccurate charting may result when the medical or nursing staff begins to document in a rote manner. For example, I read a chart of an elderly woman being treated for a hip fracture. A note written by a student nurse (and cosigned by her instructor) referred to the patient as a male intravenous drug abuser being treated with methadone!

Staff might incorrectly complete forms due to lack of education about the correct use of the form. Agency personnel or new employees may not have received education on the use of the documentation system. Supervisory staff is responsible

for overseeing the documentation of the workers to ensure that they are correctly using the forms. One of the responsibilities I had when I ran a hospital nursing staff development department was to teach new employees about the facility's documentation standards. Other healthcare providers who need this kind of orientation include temporary workers, rotating interns, residents, and so on.

Problems in charting develop

- when forms are used for the wrong reasons,
- introduced without education on the use of the form,
- are redundant with other documents in the medical record, or
- too complicated for the staff to use.

Incorrect charting also occurs when transcriptionists make errors and the physician does not take the time to review dictated reports. Some doctors ask a transcriptionist to stamp a report with the words “dictated but not read” in the belief that this disclaimer excuses them from correcting errors on transcribed reports. In fact, such a disclaimer may increase liability.

Suppose the doctor does not review a record that contains dictation errors. These errors injure the patient. The plaintiff attorney may assert the doctor was “too busy” or “too unconcerned” to ensure the accuracy of an operative report, history and physical, or consultation report.

Suspicious Charting

Healthcare providers may feel compelled to write detailed addenda to the medical record after they learned a patient was injured or was considering a malpractice claim. These notes, while probably accurate and legitimate, look suspicious and self-serving. Risk managers hate them! Often the late entries include more examination details, lengthier notes about treatment, discussions with the patient, and post-treatment advice than was originally documented in the record.

Risk managers call them *panic notes* because they are almost always written after the healthcare provider learns that there might be a lawsuit. They advise physicians to not give into the temptation to add to or subtract from the medical record.

Duplicate information

At times, information is charted in more than one place and is inconsistent. The inconsistency raises questions about which are the accurate data.

The legal nurse consultant's role is to spot inconsistencies, inaccuracies and other evidence of substandard, suspicious or altered medical records. The attorney's role is to determine the significance of these issues on the case.



Before we continue with the show, let me ask you a question:

The attorney called you about a nursing malpractice case. You have no firsthand experience in that clinical area and need to know enough to give the attorney proper guidance.

Where do you turn?

The fourth edition of *Nursing Malpractice* brings you a wealth of information and resources for your case. This extensively revised and updated edition covers the spectrum of the nursing process—from patient injury to lawsuit.

Packed with tips and techniques, these 2 volumes reveal a comprehensive overview of nursing responsibilities and standards of care.

I edited this text, along with my coeditors Barbara Levin, Kathleen Ashton, and Victoria Powell. Lawyers and Judges Publishing Company is the publisher.

These texts are an outstanding reference for the attorney, legal nurse consultant, insurance claim adjuster, healthcare risk manager, or healthcare facility leader involved in a nursing liability claim.

Order your copy at the show notes for this podcast at podcast.legalnursebusiness.com. Use the code listened to get a 25% discount.

Now let's return to the show.

In the first part of this podcast, I explained how you can spot substandard charting. Suspicious charting goes one step further to raise concern about the medical records.

Substandard Charting or Fraudulent Charting

Being detailed oriented pays off. A legal nurse consultant told me this week of a case in which a nursing home nurse rewrote an entire month worth of medication administration records. She signed her initials for all three shifts, all 30 days. No one noticed this except for the LNC.

In a California case, a woman claimed she specifically stated she did not want instruments, such as a vacuum, used during delivery. The obstetrician used a vacuum to deliver the baby's head during the cesarean section. The child suffered intracranial hemorrhaging, severe brain damage, and blindness. He will probably never speak or walk.

The obstetrician amended his dictated operative note by hand and then again by dictation to reflect the use of the vacuum and what he believed to have been the pressure used. The labor nurse amended the mother's chart and labor and delivery record to reflect the use of the vacuum.

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The labor nurse noted *higher* pressure settings than did the physician's report. The hospital reached a \$3.5 million settlement prior to trial. A defense verdict was reached on behalf of the physician. (1)

Substandard charting or fraudulent charting greatly complicates defending a medical malpractice case.

Always let the attorney know if you see suspicious charting. No one likes to be surprised by his or her adversary – give your client forewarning and encourage an investigation into your concerns.

Be sure to include the invaluable textbook, *Nursing Malpractice*, in your library for instant help with nursing malpractice cases. Order this book at the show notes for this podcast by going to podcast.legalnursebusiness.com and save a whopping 25% by using the code *Listened* in the coupon box at check out.

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