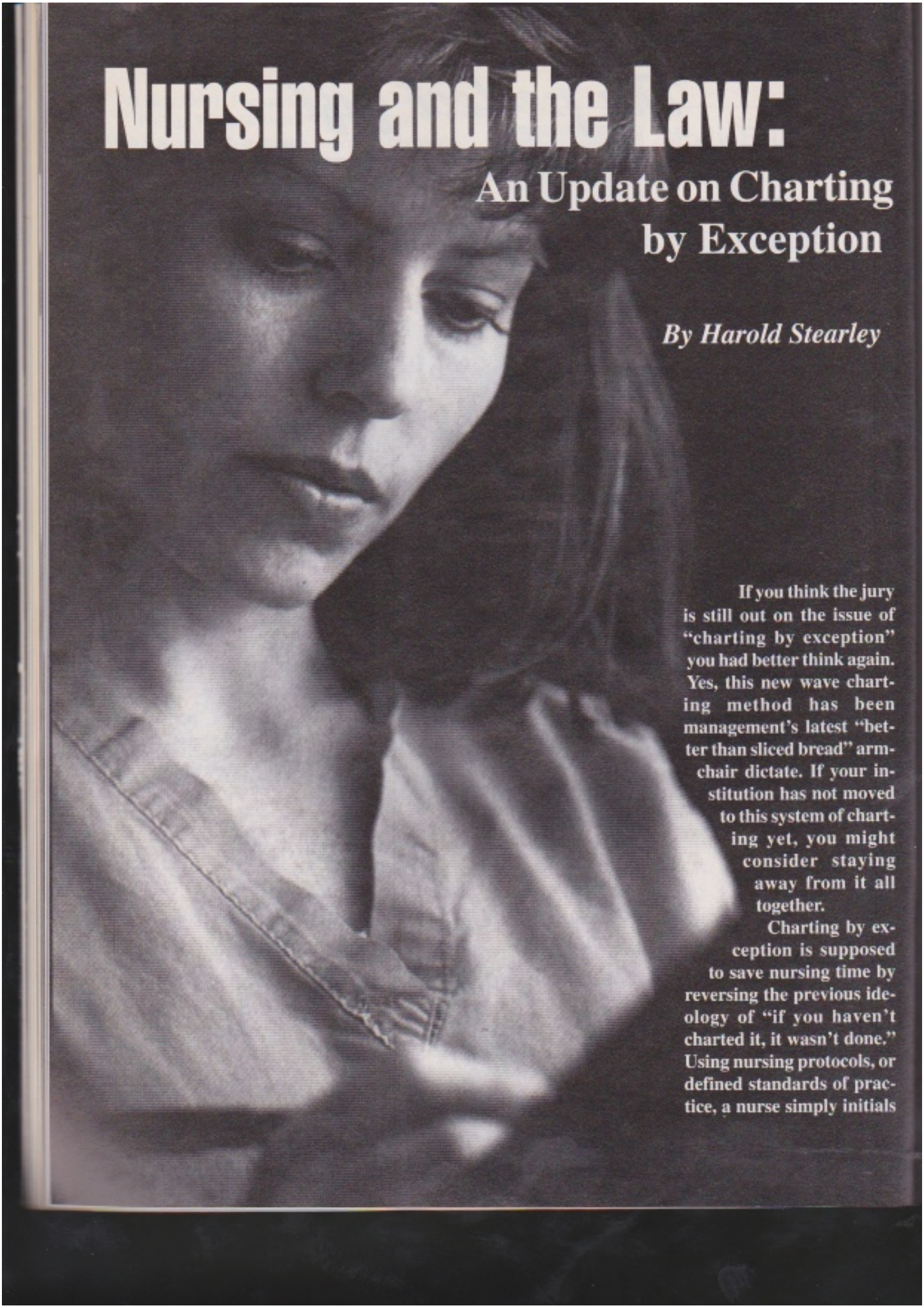

Nursing and the Law:

An Update on Charting by Exception

By Harold Stearley

If you think the jury is still out on the issue of "charting by exception" you had better think again. Yes, this new wave charting method has been management's latest "better than sliced bread" armchair dictate. If your institution has not moved to this system of charting yet, you might consider staying away from it all together.

Charting by exception is supposed to save nursing time by reversing the previous ideology of "if you haven't charted it, it wasn't done." Using nursing protocols, or defined standards of practice, a nurse simply initials

a flow sheet and off she can go to the bedside. These protocols can cover any number of basic, or advanced, nursing care procedures such as catheter care, NG maintenance, trach care, hemodynamics, or even advanced cardiac life support (ACLS). Rather than charting all of the individual steps of your nursing care, you initiate the necessary protocols, and your initials indicate that you performed all of the required interventions, in the required way. Narrative notes are reserved only for deviations, or exceptions, to the predefined norms.

While this seems to be an efficient method of recording quantitative data, in flow sheet form, it lacks the element of qualifying patient response. The legal pitfalls include: if you fail to perform even one step of your protocol then you are guilty of falsifying the patient record by having initialed it; if you fail to perform that one item of care then you are guilty of failing to meet this newly defined institutional standard of care; and any additions to charting are usually regarded with suspicion in court rooms—you will be defending yourself against the charge of tampering with the evidence. All of the literature I reviewed indicated that you must implement charting by exception correctly to meet legal requirements—but none of the authors defined the correct way to implement this shaky concept which leaves one asking, is there a correct way? In fact, Anne Grant, who was the only nurse attorney writing on this subject, ended her article with the disclaimer that she was only providing information—not legal advice.

So where have the courts come into play on this issue? Well the original inference that "if it wasn't charted, it wasn't done" stemmed from the case "Kolesar and Jefferies" ruled on by the Supreme Court of Canada. A patient aspirated and died while on a Stryker Frame, and there was no documentation of events surrounding the incident. This case set the precedent which has been traditionally followed in malpractice claims.

Deficient charting has since been a cornerstone in many court cases, as is illustrated in the "Ramsey versus Memorial Hospital" case. In this instance a nurse failed to document, or communicate in any way, vital information concerning a child's tick bite. The physician misdiagnosed the child, failed to treat him for his true condition (Rocky Mountain Spotted Fever), and the child died. The nurse was held liable for failure to communicate this pertinent information in her charting. It is required, by law, that charting serves to communicate patient information in a clear manner. So back to charting by exception....

With initialed protocols, do you really think that physicians, or any other health care professionals, can have a clear communication of the patient's condition? Do you really think that physicians know the intricacies of nursing duties and protocols? Some of these protocols are ten pages long with over 150 steps, and we simply initial a flow sheet! Here is what the first court ruling states; "charting by exception policy is negligent." End of story.

In the case of "Lama versus Borras", 16F.2d 473 PR (1994), the United States First Circuit Court of Appeals upheld the ruling of the lower court's jury that the hospital was negligent in maintaining a "charting by exception" policy. Mr. Lama developed an infection after undergoing surgery to remove a herniated disk. Despite the fact that his symptoms of drainage, bleeding, and persistent pain were present, not enough qualitative information was charted— it was not required per institutional policy. Important changes in the patient's condition were chronicled in the chart, however, the Department of Health required qualitative notes be written for each shift regardless of changes, or no changes, in patient condition. It was determined that not enough information was charted, under this system, to adequately document, and communicate, information important to the diagnosis of the patient's infection. An example of this inadequacy was no record of pain was maintained unless narcotic analgesics were administered. Due to the delay in detecting the patient's discitis, he suffered a prolonged hospital stay and very painful complication.

This particular case only addresses one aspect of the pitfalls of charting by exception, and sets the precedent of all other cases involving this type of charting. As I mentioned earlier, there are still the issues of failure to meet the newly defined standards of care, falsifying charting by initialling multi-step protocols, and failure to communicate adequately to other members of the health care team due to their lack of specific knowledge of nursing procedures.

I would have to conclude that the only reason which management is cramming this charting method down our throats is that it may relieve them of their legal concept of "respondent superior." Respondent superior states that the employer is responsible for the actions of its workers, however, if we, as nurses, initial these nurisng "standards of care" then we assuming all of the responsibility of following through on the delivery of that standard. Heaven help us if a "routine day" (do those exist in nursing?) is disrupted, and we miss even one step of these lengthy protocols.

Apparently, refusing to particiapte in a hospital's charting by exception policy is not adequate to protect RNs. One legal expert which I consulted stated that simply the existence of a protocol in your institution makes you legally responsible to carry it out. Charting by exception appears to be just another form of "nurse abuse." See you in court.....

References

Comstock, L.G. & Moll, T.E. (1991). Cost-Effective, Time Efficient Charting. *Nursing Management*, 22 (7), 44-48.

Fiesta, J. (1991) If It Wasn't Charted, It Wasn't Done. *Nursing Management*, 22 (8), 17.

Grant, A. (1994). Charting By Exception. *Canadian Nurse*, 90 (2), 49.

Murphy, J. & Burke, L. J. (1990). Charting By Exception: A More Efficient Way To Document. *Nursing*, 20, (5), 65, 68-69.

Tammelleo, A.D. (ed.) (1989). Deficient Charting: Weak Link in Evidence. *The Regan Report on Nursing Law*, 29 (12), 2.

Tammelleo, A.D. (ed.) (1994). Court Holds "Charting By Exception" Policy Negligent. *The Regan Report on Nursing Law*, 34 (12), 2.

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FALL 1997 art 5 text

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