Purpose/Objectives: To focus on nursing documentation and how it can lead to a malpractice lawsuit.
Data Sources: Nursing, non-nursing healthcare and legal journals, case law, and related Internet sources.
Data Synthesis: To avoid liability for inadequate or inaccurate documentation, nurses must be aware of how their documentation can either lead to a malpractice claim or actually decrease their chances of ever being named in a malpractice lawsuit. Malpractice cases often are decided based on documentation. The only viable way to defend against allegations of professional negligence is accurate and complete patient charting or defensive documentation.
Conclusions: By examining case law involving inadequate or inaccurate documentation, nurses will be able to effectively adopt documentation practices or policies to decrease potential litigation.
Implications for Nursing Practice: Educating nurses about the principles of documentation and the importance of implementing risk-reduction practices will help guard against liability and ultimately improve patient care.

With an increase in lawsuits naming nurses as defendants, being educated about the law can be a nurse’s most valuable asset. Professionals from all fields are being held liable for damages resulting from their actions and decisions; today, nurses are facing the same level of security (Howard, Steiert, Deason, & Godkin, 1997). In 747 cases filed from 1988 through 1993, nursing negligence in hospitals caused or contributed to 219 deaths (Miller-Slade, 1997).

This article is a follow-up to Part I of “Nurse Documentation: Not Done or Worse, Done the Wrong Way” (Frank-Stromborg, Christensen, & Do, 2001) that discussed the various methods and forms of documentation used by nurses and the use of emerging technology and its impact on patient charting. This article discusses the elements of a malpractice lawsuit and describes how inadequate nursing documentation can result in a malpractice action. Examples of real lawsuits involving nurses and their documentation practices are provided for nurses to effectively adopt documentation practices or policies to decrease potential litigation.

Nursing Liability for Inadequate Documentation

The liability that a nurse may encounter revolves around documentation like the patient record. The patient record serves not only as a confidential record that identifies the patient and healthcare services provided, but it is also a business and legal record that serves multiple purposes (Aiken & Catalano, 1994). Malpractice cases often are decided based on documentation (Trott, 1998). Therefore, in documentation, every word counts. Legally speaking, a nurse’s document is just as important as the care provided. A nurse’s document must have a written record of assessments and the interventions performed in response to those assessments. Nurses must guard against liability by keeping up-to-date on every aspect of their practice, identifying risk factors associated with documentation, implementing risk-reduction practices, and following these practices until they become second nature.

Key Points . . .

- Nurses are increasingly liable for improper documentation of patient care because the law presumes that if the work was not documented, it was not done.
- The nurse’s document must have a written record of assessments noted and the interventions performed in response to those assessments.
- Nurses must guard against liability by keeping up-to-date on every aspect of their practice, identifying risk factors associated with documentation, implementing risk-reduction practices, and following these practices until they become second nature.