



# TEXAS HEALTHCARE **SAFETY** **CONFERENCE**

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**“Prevent Becoming A  
2nd Victim When  
Patient Injury Occurs”**

## STEPS

All documentation will be analyzed – so always chart as required.



# DOCUMENTATION

- Accuracy
- Timelines
- Make sure your entries are complete
- Date and sign entries
- The chart is not a scratch pad
- Do not let mistakes follow mistakes
- If your handwriting is unreadable – print
- Late entries

# DOCUMENTATION

- Record cancellations and changes in appointments
- Document consents
- Inform patient of adverse events and document it
- If contentious or non-compliant patient – document details of behavior (be objective – not subjective)
- Be consistent in your method of documentation
- Document any issues where chain of command is involved

# DOCUMENTATION

- Avoid opinions about the patient or any type of subjective documentation that is not related to the diagnosis
- If there are errors, make sure your correction of the error is clearly written and initialed
- Time your correction if necessary
- Spoliation
- Assume all chart entries are going to be trial exhibits

# THE NURSES DUTY TO INTERVENE INITIATING THE CHAIN OF COMMAND

- When it comes to medical care and decision-making, do nurses still believe that the physician is in charge – that the physician’s word is law?
- It’s crucial that nurses and physicians have a clear understanding of the philosophy and procedure and policy that is to be followed in a chain of command process.



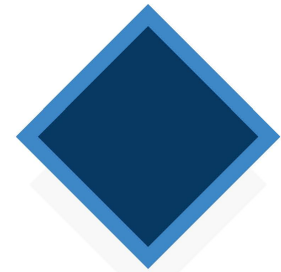
# THE NURSES DUTY TO INTERVENE INITIATING THE CHAIN OF COMMAND

- Even without any formal policy, the nurse's responsibility is still there to recognize problems with patient care and to take appropriate action.
- Why is the chain of command important? Is it a tool or a weapon?
- Courts have held that nurses have a duty to question a physician's order if it is not consistent with standard medical practice.





# RECOMMENDATIONS



Exercise a collaborative mentality to providing healthcare



Before calling a physician, gather all the information you need



Provide that your assessment of the patient is thorough

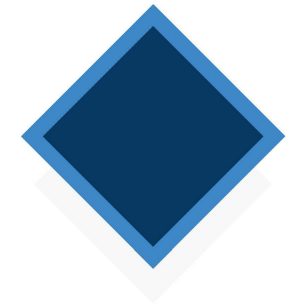


Organize your thoughts

# RECOMMENDATIONS

- ◆ Know what you want when you call the physician
- ◆ Ask the physician if he or she needs more information

# RECOMMENDATIONS



State directly if you think it is an emergency situation



State directly if you want the physician to see and examine the patient

# STEPS

Most common threat for harm to healthcare providers is if a patient falls while under your care



# Who is the target in patient fall lawsuits?

Nurses

# CHARTING IS CRITICAL WHEN YOU HAVE A PATIENT FALL

- In fall-related lawsuits, usually you will find that the patient was reviewed for fall precautions and was given a fall risk assessment.
- However, many times you will never see that an actual prevention was documented. It would be incredibly helpful in defending a lawsuit if the nurse charted when a prevention was used. For example, chart that the bed alarm was on, that the patient was rounded on, placement of the patient closer to a nurse's station, or the use of a sitter.



# CHARTING IS CRITICAL WHEN YOU HAVE A PATIENT FALL

- Additionally, there is usually inadequate post-fall assessments.
- Nursing assessments tend to say “no complaints voiced,” “awake, alert, and orientated.”
- That is not a sufficient assessment. That is an observation, not an assessment.
- If you want to prevent litigation, nurses need to document the actual strategies in place to prevent a fall and a post-fall assessment.



# STEPS

- Do not ignore your intuition.
- If you know a patient or their family is unhappy, address it. Talk to them and listen!
- If you do not – it will potentially harm you and your license.
- Find out now what the issues are – not later!





**THANK YOU!**

