Mrs. H was a 71-year-old long-term resident of a skilled nursing facility. Her medical history was significant for severe malnutrition, pneumonia, urinary tract infection, and brittle diabetes mellitus. She was unable to ambulate and required assistance with multiple activities of daily living. She had a history of variable cognitive deficits and of refusing treatment and medications, including her insulin. Most of her 6-year residency was uneventful, with a handful of hospitalizations for shortness of breath and diabetic ketoacidosis. She was full-code status as far as goals of care.

One evening at approximately 1:00 a.m. Mrs. H was noted as having a hard time breathing. Her oxygen saturation was 80% on room air, according to the nursing note; she was placed on oxygen at 2 liters per minute by the nurse. No other documented action was taken at that time. At 2:00 a.m., Mrs. H was documented as being “coherent,” with no further vital signs or oxygen saturation documented at that time. She was asked if she wanted to be hospitalized, and she declined. Nursing took no further action to either call the physician or notify the family of her change in condition.

At 3:00 a.m., Mrs. H’s oxygen saturation level had dropped to 70%. Her oxygen flow rate was raised to 3 liters per minute which increased her saturation to only 72%. Again, the nursing staff did not document that the physician or the family was notified of Mrs. H’s low oxygen.

At 4:00 a.m., Mrs. H’s oxygen saturation level had dropped between 61% and 62%. She was asked again if she wanted to be hospitalized. Instead of responding verbally, she was documented as shaking her head “no.” The nurse still believed Mrs. H was “coherent” and competent to make her own decisions despite her low oxygen levels. The chart again did not reflect any attempt to notify the physician or the family about her deteriorating oxygen saturation levels.

At 6:30 a.m., Mrs. H was scheduled for a blood sugar check; however, the medication administration record did not show that the check was performed. No reason was provided for failing to perform the blood sugar check at this time.

At 7:15 a.m., one of the daughters was notified of Mrs. H’s change of condition. By 7:30 a.m., she was noted to be unresponsive to verbal stimuli with decreased blood pressure and elevated heart rate. The nursing staff called the on-call physician. The call was not returned until 8:30 a.m., when a nurse called from the physician’s office. There was no documentation in the nursing home chart as to what information was exchanged during this telephone call, but no immediate orders were received.

At 9:15 a.m., Dr. M was in the facility doing rounds. He gave a verbal order to transport Mrs. H to the local emergency department. Mrs. H was finally transported an hour later at 10:15 a.m. Mrs. H died 7 days later in hospice care. The cause of death on the death certificate was hyperosmolar/diabetic ketoacidosis for days, protein calorie malnutrition for months, and diabetes mellitus for years.

Family Recourse
Mrs. H’s three daughters sued the facility for 1) medical malpractice, 2) elder abuse, and 3) wrongful death. The complaint contained allegations of inaccurate recordkeeping, failing to document and report changes in condition, and obtaining reimbursement from Medicare for services not actually rendered.

Relevant to this case is 42 C.F.R. §483.75(l), which pertains to clinical records: “(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are — (i) complete; (ii) accurately documented; (iii) readily accessible; and (iv) systematically organized.” The clinical record “must contain enough information to show that the facility knows the status of the individual, has adequate plans of care, and provides sufficient evidence of the effects of the care provided. Documentation should provide a picture of the resident’s progress, including response to treatment, change in condition, and changes in treatment.”

Accurate documentation reflects the nursing process. Nurses should use critical thinking at all times in their practice. Thus, their documentation should describe the nurses’ critical thinking process: 1) assessment of a resident’s conditions, causative factors, and/or risk factors; 2) analysis of potential outcomes or consequences; 3) a plan of action; and 4) evaluation of the resident’s response to the plan. Not only does this documentation process serve as a best practices guide and assist with interdisciplinary communication, but it also serves as a risk management tool whose value should not be underestimated.

If a nurse is appropriately charting assessments of a resident’s condition, there will be times when that resident undergoes a change of condition or an unusual occurrence. If there is a change of condition, that change should be documented with a detailed description of what happened. The nurse also must document which physician and responsible party were notified and when they were notified. In this way, the clinical record contains proof of the care provided. As the plaintiffs’ attorneys pointed out and over in this matter, “if it’s not in the chart, it didn’t happen.”

In Mrs. H’s case, the nursing progress note for the 10 hours before her discharge to the ED looked like this:

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that Mrs. H was “coherent,” almost as an attempt to justify the failure to notify the physician. It is not clear at all whether Mrs. H would have had the capacity to make any type of rational health care decision when her oxygen saturation level was heading toward 60%.

A related part of documenting the nursing process is ensuring that a nurse is performing and documenting within the confines of his or her license. The plaintiff here had a credible argument that the author of the nursing notes, even if he or she were a registered nurse (RN), had no authority to declare Mrs. H “coherent” when her oxygen saturation was deteriorating rapidly. As a licensed vocational nurse (LVN) or licensed practical nurse, the note’s author would have been acting well outside the authority of his or her license by essentially making a diagnosis of Mrs. H’s mental state, especially during a change of condition.

LVNs can collect data, but they do not have the authority to synthesize the data and make complex nursing assessments. In terms of potential liability in an elder neglect claim, allowing LVNs to act outside the scope of their licensure can provide a jury with ammunition to find corporate ratification.

In the case of Mrs. H, her chart was replete with notes, assessments, and care plans authored by LVNs instead of RNs. We are seeing this practice called into question more and more in the litigation arena. Even though it may be a long-standing practice to allow LVNs to perform assessments and author care plans, they are technically acting outside the scope of their license — at least under California law — because the very nature of the assessment or care plan is to synthesize health care data, perform an assessment, then formulate a plan of care based upon that assessment. Only RNs are qualified to make these types of decisions.

In Mrs. H’s case, even if the nurse making the chart entries had been a RN, he or she at a minimum acted below the standard of care by failing to notify the physician and family members immediately of Mrs. H’s change of condition, in accordance with federal regulations. ¹

This case includes some valuable lessons on multiple levels, with plenty of room for improvement. A drop in oxygen saturation, even if the oximeter may be malfunctioning, would be considered a significant change by anybody’s standards. The federal regulations under 42 CFR §483.10(g)(14) require a facility to “immediately inform the resident; consult with the resident’s physician, and notify, consistent with his or her authority, the resident’s representative(s)” of any significant change of condition. In fact, any change requiring a change in orders is considered a significant change of condition. Nurses should not shy away from calling the attending physician for assistance, even in the middle of the night, when a patient becomes acutely ill.

Other concerns beyond those pointed out in the vignette include the delay in getting hold of the physician or designee once the nurse belatedly decided the change of condition had become significant enough to call the doctor. When someone is critically ill and unresponsive, it’s inappropriate to wait over an hour for a response — the nurse must either contact another provider or use nursing judgment to call for emergency transport. If that means calling the director of nursing services or the medical director, then that is appropriate. It’s not acceptable to let a patient’s condition continue to deteriorate. Even after the physician evaluation, there was a delay in securing the transport.

Multiple documentation issues are very concerning, and the poorly legible nurse’s note with the times listed in the margin corresponding roughly to the narrative certainly suggest that the documentation was done after the fact. It’s commonplace for nurses to document at the end of a shift, but if they do that, the time the note is written should be made clear, and the narrative can mention that at some earlier time the vitals were at a certain level, a physical assessment demonstrated a finding, a new intervention was initiated, or another particular change was noted. The failure to check the pre-breakfast blood sugar was also not explained, a fact that seems more egregious in retrospect given her ultimate diagnosis (and death due to) hyperglycemic complications.

Obviously, the old “if it wasn’t charted, it wasn’t done” mantra is not accurate. Many things occur every day in a nursing home that are not charted, and they are done. Ultimately, most of us would agree that providing the actual care is more important than documenting it. But it is important to document, for the reasons well laid out here.

—Karl Steinberg, MD, CMD, HMDC
Editor in Chief

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