

Elder Law: A Practice Focus

Nursing Home Documentation is Key to Exposing Abuse and Neglect

By Kenneth L. Connor
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The biggest challenge facing a lawyer with an elderly client allegedly victimized through abuse or neglect by a nursing home is to show that the client's deterioration resulted from the facility, rather than from the inevitable consequences of old age and ill health.

Many jurors likely will presume that a nursing home resident's diminished condition was inevitable given the person's age and pre-existing medical condition, and defense counsel will certainly argue this notion.

To get the jurors past such misgivings, the nursing home's medical chart – its chronicle of your client's care – should figure prominently in your case. Facilities that receive Medicare or Medicaid reimbursements are required by federal regulations (42 C.F.R. 483) to maintain records that are complete and accurate. Thus, the chart should be assumed to include documentation of the care your client received. Usually you will find that the chart, better than any witness, explains to the jury the inadequate care provided to your client.

To use the chart effectively for this purpose, examine it primarily for four deficiencies: false charting, inconsistent charting, gaps in charting, and absence of charting.

LIES IN THE CHART

Proving false charting requires you to compare the facility's chart with external documents and facts. For example, check for charting on nonexistent days, such as Feb. 30 or June 31, or on days when your client was out of the facility, including pre-admission, post-death, and during hospital stays.

In addition, use discovery to obtain timecards showing the actual hours worked by the employees charting your client's care. A comparison of the chart with the employees' timecards will allow you to confront nurses or certified nurse assistants with the unreliability of the information they entered into the chart to the effect that, say, your client ate 40 percent of the noon meal on a day when the staffer was not even working. Evidence of multiple instances of false charting inevitably triggers outrage among jurors.

You can also uncover false charting by examining out-of-sequence entries in the record. Consider this scenario: Your client developed a Stage IV pressure ulcer that ultimately caused

his death. When you examine the chart, you see skin-assessment entries as follows: March 1: No skin breakdown. March 8: Stage III pressure ulcer. March 3: New skin breakdown noted. March 15: Stage IV pressure ulcer. No skin interventions are noted on the treatment sheets until March 8, the same day that the first doctor's order for treatment was generated.

The question becomes: How did your client go from no skin breakdown to a Stage III pressure ulcer in the span of a week without intervention? And why was the March 3 entry, which first documents the facility's awareness of the pressure ulcer, made out of sequence and only after the pressure ulcer developed to Stage III status?

Out-of-sequence entries are often evidence of a poorly contrived attempt to cover up the facility's failure to detect and begin treatment of a condition that eventually caused your client's injury or death.

INCONSISTENCIES

The second area of charting irregularities you should look for is inconsistent charting. To prove this, compare two sets of data relating to the same issue and determine whether the two records are mutually exclusive. If so, the question is, which data entry is correct? They can't both be right; hence, the reliability of the charting is called into question.

For example, compare your client's activities of daily living sheets and meal-consumption logs with the nurses' notes. It is not uncommon to see dramatic discrepancies between the two relating to meal consumption. This becomes particularly significant if your client is suffering problems associated with malnutrition.

Additionally, compare the physician's orders with the medication administration record or the treatment administration record. Are there incongruities? Are the doctor's orders being followed? A comparison of these documents will often uncover problems such as over-usage of medication (turning an otherwise appropriate drug into a chemical restraint) or underusage (possibly leaving your client in severe pain for hours, days, or weeks).

INTO THE GAPS

The third area of charting deficiencies that you should pursue relates to gaps in charting. Typically, you will see gaps ranging from a few hours to several days or even weeks during a significant time in your client's residency.

These gaps will actually sum up your case for the jury: The facility was not charting during a critical period in your client's residency because it was not delivering the care that otherwise should have been documented; hence, the resulting condition of your client. The classic example is the failure to document turning and repositioning during a time when your client develops pressure ulcers.

A long-accepted nursing axiom is Not documented, not done. Most nurses and certified nursing assistants will acknowledge that they were taught the truth of the axiom in their training and that they were taught the importance of documenting the care given to a resident.

Nevertheless, at trial the nursing homes' lawyers and expert witnesses will fight that assumption every time, arguing that the fast-paced environment of a facility makes dotting every i and crossing every t nearly impossible.

But Not documented, not done will make eminent sense to the jury if you simply compare the paper with the person. When jury members see a period of no documentation that correlated with your client's significant deterioration in condition, they quickly begin to understand the truth behind the axiom.

MISSING DOCUMENTS

The last area of charting discrepancies that you should be on the lookout for is absence of charting – i.e., whole sections of the charting record that are missing and never produced during discovery.

This goes beyond Not documented, not done to the extent that you may be able to achieve a spoliation instruction from the judge, in which he or she instructs the jury that they should infer that certain portions of the chart that were not produced would have been adverse to the nursing home's case if they had been produced. These instructions are not easily won, but when delivered by the court, their value cannot be overstated.

To be sure, the nursing home will vigorously fight you on each of these four areas. Generally, its most vigorous defense will be on the issues of gaps in charting and absence of charting. The defense will likely produce an expert who will attempt to debunk Not documented, not done, claiming that the facility puts the patient ahead of the paper.

This type of witness should be exposed to the jury for what he or she is: a can't lose witness for the defense. If the care was documented, the expert assumes it was delivered. If the care was not documented, the expert still assumes it was delivered. With such a witness, the facility can't lose. But with an adequate cross-examination, the jury will distinguish between a true expert and a nursing home apologist.

A good strategy when cross-examining a defense expert is to elicit an admission from the witness that his or her opinion is only as reliable as the information on which it is based. Thereafter, establish that the expert's opinion that adequate care was provided is based largely on the information contained in the chart. Then confront the expert with all of the errors, inconsistencies, and gaps in the chart. Conclude the examination with an inquiry as to whether the jury should attach the same degree of reliability to the expert's opinion that they attach to the chart.

Litigation against nursing homes is an arduous and laborious process. But by getting all the mileage possible out of the facility's own chart, you will be well on your way to proving that the harm your client suffered was preventable, not inevitable.

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