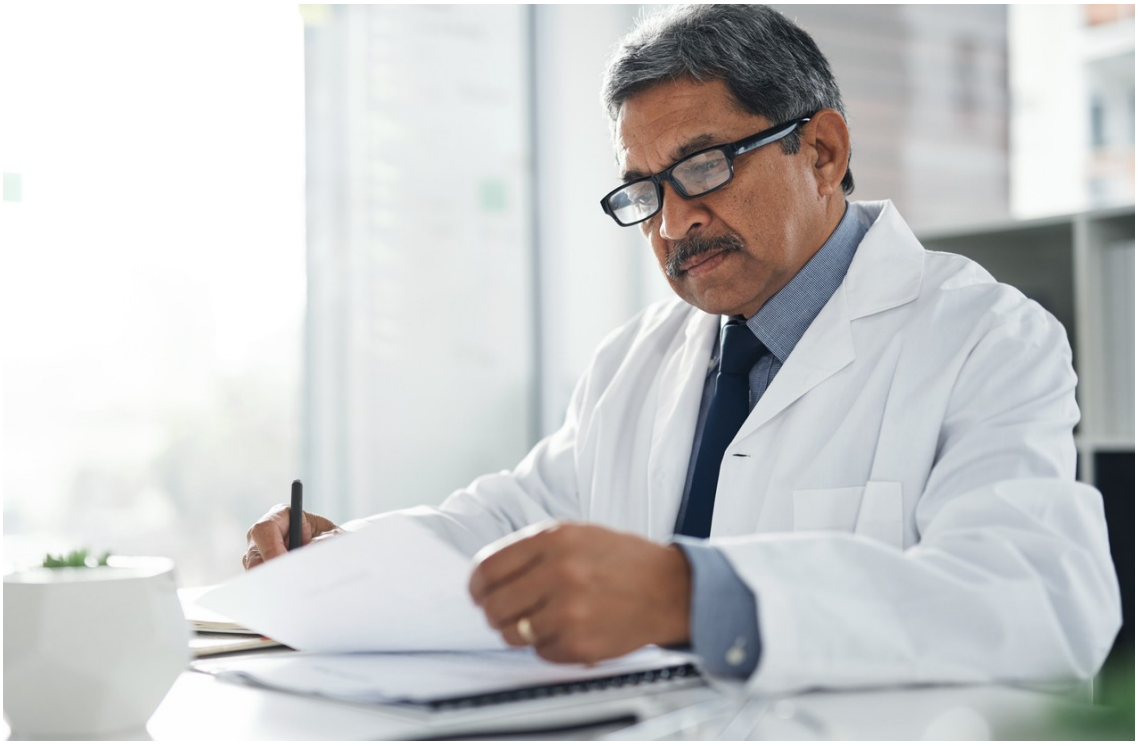
Physicians Reviewing Nursing Notes



By Jeffrey A. Woods, JD

In a hospital setting, nurses are typically the eyes and ears of the physicians when it comes to patient care. They round on the patient twenty-four hours a day and usually have more time to interact with the patient and family than physicians do. Their notes documenting these interactions, as well as medication dosage and vitals, provide valuable information about a patient's condition including response to treatment, pain levels, and change in status. These notes can help physicians to have a more complete picture allowing for more informed decisions about diagnosis, treatment plans, and medication adjustments.

However, the extent to which physicians read nursing notes can vary depending on the setting, the physician's workflow, the usability of the hospital's EHR, and most importantly, the physician's customary habit. Physicians who don't read nursing notes typically rely on

other methods in an attempt to save time such as summaries, verbal reports, or specific sections of the medical record that they feel provide them with more concise information These “short-cuts,” though, could result in miscommunication and missed information.

A study done on the habits of physicians found that fewer than 20% of nursing notes are read by physicians.[1] Another study conducted several years later used eye-tracking technology to evaluate physicians’ visual attention patterns as they read three progress notes, using verbal handoffs as a context to determine what information in the notes the test subjects thought was most . Despite variation in the volume of data in different zones of the notes, subjects overwhelmingly skimmed over zones containing imported patient data, while fixating largely on the “Impression and Plan” zone of the notes. Sections such as “Medication Profile,” “Vital Signs,” and “Laboratory Results,” received less attention and were read very quickly even if they contained more content than the impression and plan. [2]

Physicians who fail to read nursing notes face potential liability risks as this can lead to missed critical patient information, potentially resulting in misdiagnoses, inappropriate treatment plans, and complications that could harm the patient The failure to read available nursing notes could be a violation of the standard of care and if the result of this failure is patient harm, it could serve as a basis for a malpractice judgment against the physician. It is important to remember the audit trail of the EHR records, which documents exactly what was available to the physician at the time and whether or not it was reviewed. From a juror’s perspective, they often have a difficult time understanding why a physician would not review available information recorded by someone who was directly attending to the patient around the clock. The question jurors wrestle with is, “why would nurses be required to document the patient’s important information if the physician is not going to read it?”

To mitigate the risk, physicians should always carefully read and consider nursing notes, especially for patients who are in serious or critical condition. If the notes are unclear or raise concerns, speak directly with the nursing staff. Physicians should document in the patient’s medical record the information in the nursing notes that they reviewed and relied upon in making their care decisions.

[1] Hripcsak G, Vawdrey DK, Fred MR, et al. Use of Electronic Clinical Documentation: Time Spent and Team Interactions. J Am Med Inform Assoc 2011, 18: 112-117

[2] Brown PJ, Marquard JL, Amster B, Romoser M, Friderici J, Goff S, Fisher D. What Do Physicians Read (and Ignore) in Electronic Progress Notes? Appl Clin Inform. 2014 April 23;5(2) ; 430-44