Review Article

Euromediterranean Biomedical Journal
for young doctors
(formerly: Capsula Eburnea)

THE IMPORTANCE OF THE NURSING FOLDER INTRODUCTION AND ITS FORENSIC VALUE.

Nunziata Barbera, Francesca Indorato, Angelo Montana, Salvatore D'Agati, Concetta Neri, Guido Romano

SUMMARY

In this paper, the authors seek to outline the medico-legal aspects of the nursing folder and the requirement for precision in its compilation in terms of content, requirements, management and filing.

This article also discusses the importance of the introduction of the nursing folder and emphasizes its status as a public document. The passing of Law n. 42/1999 was fundamental in empowering the nursing profession and marking the passage from "*auxiliary health care profession*" to "*health care profession*".

Introduction

The passing of Law n. 42 of 26 February 1999 was instrumental in delineating the professional figure of the nurse giving it full recognition - both legally and formally - through the replacement of the definition of "*auxiliary health care profession*" to "*health care profession*" (1, 2).

At present the nursing profession has connotations that are the result of its history: in fact it plays an important role in personal care and nurses are required to update their skills in order to adapt to the new social-health and multicultural context. There have been important changes inside and outside the profession which have led to a substantial revision of the content of the profession itself, which has also experienced normative changes (3).

The claim that the nursing profession has value not so much as an aid to another health profession, but as the holder of a specific role for the health of the person and the community has radically changed the professional job description and legal profile of the nurse; hence, the ethical and professional obligation to document the needs of the patient and the quantity and quality of care through the adoption of the nursing folder (art. 69 of D.P.R. 384/90) (4). In the last decade, it has become an essential tool and at the same time a complex issue.

Nursing Folder's features

It is widely known that the nursing folder plays a role in rendering the process of nursing care transparent in accordance with the nurse's professional job description (5). This is formally stipulated in art. 69 of D.P.R. 384/90 (4), which establishes the need to improve quality of care through the adoption of the nursing folder.

The structure of the nursing folder allows the identification of different phases of the decision-making and operative processes and it should be used frequently in order to

Address of the authors

Department "G.F. Ingrassia – Area of Legal Medicine – University of Catania - Italy

***Send correspondence to**: Prof. Nunziata Barbera, toxicologyct@hotmail.com*

***Received**: August 08th, 2012 — **Revised**: September 24th, 2012 — **Accepted**: October 23th, 2012*

ensure care continuity, standardization of the care pathway and uniformity regarding assessments and evaluations, thus building a shared professional language (5). Consistently, the nursing folder is an important professional and organizational tool.

In fact, prior to the introduction of the nursing folder the decision making process was not documented and most of the documentation made exclusive reference to prescriptions and not to nursing, since a nurse's diagnostic and decision-making skills were not recognized.

Indeed, the nursing folder offers an additional and independent source of information to that of the physicians and is completed in collaboration with them.

The filling of the nursing folder is equivalent to performing a notarial deed, since it is done in the capacity of a health care professional and for this reason it assumes a privileged probative value compared to other means of ascertaining the truth. According to the most recent orientation of criminal law (6), the nursing folder is a private, though not secret document. Therefore, the health care worker who issues a copy to a third party, who has the right to request it, does not commit any violation of professional secrecy according to art. 326 c.p; it is also a public document and therefore it constitutes full proof of the truth until it is shown to contain false statements (7, 8, 9). It clearly emerges that the content of the folder is a bond of truth of all that the public officials or health care workers in charge of public service have certified (10). Moreover, being an integral part of the medical record (drafted by the physician), for greater completeness of health records, it should be stored within it.

Crimes relating to the failure or incorrect nursing folder compilation

In the event of intentional incorrect compilation of the nursing folder the nurse may commit crimes which are described in most cases as "*material falsification of a public document*" (art. 476 c.p.) (11) and "*ideological falsification of a public document*" (art. 479 c.p.) (12).

The crime of material falsification of certification (art. 476 c.p.) (11), may occur, for example, in those cases where a relevant clinical fact is not contextually linked to its observation or effectuation; or when a record is corrected or changed even if the amendment is made to establish the truth; or to correct false information; and, finally, if the information has not been acquired directly by the nurse making the entry or the action was not performed personally by the aforementioned nurse. This is not legal as it may result in a mystification between the apparent author and the true author of the document.

The offence of ideological falsification of a public document committed by public officials (art. 479 c.p.) (12) occurs when an untrue fact is intentionally attested in a public document which should be proof of the truth; or when the public official falsely affirms that a fact was done by himself or happened in his presence; or when, lastly, he omits or alters a declaration received personally.

Related to the preparation of the folder is also the "*crime of refusal or omission of official acts*" (art. 328 c.p.) (13). This occurs when a public official or health care worker in charge of a public service in cases regarding justice, public safety, public order or hygiene and health refuses or omits to expedite a public document which must be completed without delay, or within thirty days of receipt of the written request from the interested parties without giving reasons for the delay (*ex* art. 328 c.p.) (13).

A nurse may fall foul of these crimes because, legally, the function of the nursing folder is to attest to the truth of acts carried out directly and known to the health care worker who records them; it is also a special public document, since its formation is not limited to a single place and time. Nevertheless, it is important to note that each record has a definitive character and independent value, so the writer, once the annotation has been recorded, may no longer dispose of it.

The health records - and, therefore, also the nursing folder - acquire a character of definitive assessment when the nurse affixes their own notes regarding the provided assistance (14).

The ordinary justice system provides many examples of the importance of the nursing folder and its probative value during the process of professional liability cases. Indeed, the sentence n. 9739/2005 of the Supreme Court (15), the judgment of the

Supreme Court section V n. 22694 of the 16/06/2005 (16), the sentence n. 75/2005 of the appeal n.13/2005 of the Regional Court of Administrative Justice in Trentino-South Tyrol in Trento (17), the judgment 893/1994 of the District Court in Florence (18), the sentence n. 8875/1998 of the Supreme Court (19) and the sentence n.11316 of the *Civil Cassation* of the 21th July 2003 (20) are just some of the many judgments that highlight the crucial role that the nursing folder has during an investigation and in the establishment of professional negligence.

Conclusion

The primary aim of the nursing folder is to maintain a high standard of care even as various health care professionals alternate and allow these health care professionals to proceed with continuity of decisions during shift changes. In fact, as the art. 27 of the Ethical Code of Nurses declares, "*The nurse ensures continuity of care also making a contribution to the creation of a network of inter-professional relationships and effective management of information tools"* (21).

Respect for the essential requirements (truthfulness, accuracy, completeness, relevance, clarity, pertinence, traceability) that characterize the nursing folder also allows for the collection of data in a complete and detailed way, permitting, in fact, the evaluation of the performance of the professional (22).

In cases where professional responsibility is disputed, the poor compilation of the folder or related certificates can lead to a "*presumption of guilt*" (Supreme Court 11316/2003) (23). Indeed, if it is not possible to draw any useful elements for the evaluation of the health care worker's conduct from the folder, the Court may make recourse to logical assumptions as evidence. A lack of compilation of the folder may also result in the "*crime of refusal or omission of official acts"* (*ex* art. 328 c.p.) (13).

For all the reasons stated so far, the nursing folder clearly has a great forensic significance. It should be noted that as yet insufficient attention is focused on the value of the nursing folder from the administrative and legal points of view. It is not uncommon, in fact, to find omissions, corrections, inadequate compilations, posthumous insertions, illegible entries, etc. This indicates that there are many heath care professionals who do not understand the value of the nursing folder which represents a legal document since it is written by a figure identified as public official in the full exercise of their functions and is therefore regulated by the legislation relating to public documents (24).

References

1. Legge 26 febbraio 1999, n. 42, "Disposizioni in materia di professioni sanitarie". Available from: http://www.parlamento.it/parlam/leggi/99042l.htm
2. Barbera N, Neri C, Tumino M, Tornello C, D'Agati S, Romano G: La Cartella Infermieristica. Considerazioni medico-legali. Jura Medica 2011; 2: 239-245.
3. Cipolla C, Artioli G: La professionalità del care infermieristico: risultati della prima indagine nazionale. Franco Angeli 2003.
4. D.P.R. 28 novembre 1990, n. 384 "Regolamento per il recepimento delle norme risultanti dalla disciplina prevista dall'accordo del 6 aprile 1990 concernente il personale del comparto del Servizio sanitario nazionale, di cui all'art. 6, D.P.R. 5 marzo 1986, n. 68 (2)". Available from: www.normattiva.it/uri-res/N2Ls?urn:nir:stato:decreto.presidente.repubblica:1990-00-00;384~art49
5. Chiari P: Linee guida alla documentazione infermieristica. Azienda Ospedaliera di Bologna, 1999. Available from: www.thinktag.it/system/files/1033/lg_cartella.pdf?1292012188
6.Cass. pen., 2.09.2002, n. 3050, Available from:www.foroeuropeo.it/sen/cas/02/3050/htm
7. Belvedere A, Riondato S: Trattato di biodiritto. Le responsabilità in medicina. Edited by Giuffrè Editore, Milano, 2011.
8. Art. 2699 c.c. (Atto pubblico): "L'atto pubblico (2714) è il documento redatto, con le richieste formalità, da un notaio o da altro pubblico ufficiale autorizzato ad attribuirgli pubblica fede nel luogo dove l'atto è formato". Available from: www.altalex.com/index.php?idnot=36509
9. Efficacia dell'atto pubblico: "L'atto pubblico fa piena prova, fino a querela di falso (Cod. Proc. Civ. 221 e seguenti; Cod. Pen. 476).

10.Rodriguez D: Professione ostetrica/o - Aspetti di medicina legale e responsabilità. Edited by Eleda Edizioni, Milano, 2001.
11.Art. 476 c.p.: Falsità materiale commessa dal pubblico ufficiale in atti pubblici: "Il pubblico ufficiale, che, nell'esercizio delle sue funzioni, forma, in tutto o in parte, un atto falso o altera un atto vero, è punito con la reclusione da uno a sei anni. Se la falsità concerne un atto o parte di un atto, che faccia fede fino a querela di falso, la reclusione è da tre a dieci anni". Available from: www.altalex.com/index.php?idnot=36768
12.Art. 479 c.p. Falsità ideologica commessa dal pubblico ufficiale in atti pubblici: "Il pubblico ufficiale che, ricevendo o formando un atto nell'esercizio delle sue funzioni, attesta falsamente che un fatto è stato da lui compiuto o è avvenuto alla sua presenza, o attesta come da lui ricevute dichiarazioni a lui non rese, ovvero omette o altera dichiarazioni da lui ricevute, o comunque attesta falsamente fatti dei quali l'atto è destinato a provare la verità, soggiace alle pene stabilite nell'articolo 476". Available from: www.altalex.com/index.php?idnot=36768
13.Art. 328 c.p. (Rifiuto di atti d'ufficio. Omissione) "1. Il pubblico ufficiale o l'Incaricato di un Pubblico Servizio, che indebitamente rifiuta un atto del suo ufficio che, per ragioni di giustizia o di sicurezza pubblica, o di ordine pubblico o di igiene e sanità, deve essere compiuto senza ritardo, è punito con la reclusione da sei mesi a due anni. 2. Fuori dei casi previsti dal primo comma il pubblico ufficiale o l'incaricato di un pubblico servizio, che entro trenta giorni dalla richiesta di chi vi abbia interesse non compie l'atto del suo ufficio e non risponde per esporre le ragioni del ritardo, è punito con la reclusione fino ad un anno o con la multa fino a L. 2 milioni. Tale richiesta deve essere redatta in forma scritta ed il termine di trenta giorni decorre dalla ricezione della richiesta stessa ".Available from: www.altalex.com/index.php?idnot=36763
14.Le parole "avente efficacia probatoria" sono state introdotte dalla Legge 18 marzo 2008, n.48 (ratifica della "convenzione di Budapest"). Available from: www.altalex.com/index.php?idnot=40717
15.Corte di Cassazione, sez. IV Penale, 1 dicembre 2004-11 marzo 2005, n. 9739. Jura Medica, N. 3, 2005, Anno XVIII:649-656.
16.Available from: www.altalex.com/index.php?idnot=9934
17.Available from: www.regione.taa.it/tar.tn.it/pdf/sent200500075.pdf
18.Available from: www.jusabili.org/trib14121996.shtml
19.The sentence n. 8875/1998 of the Supreme Court.
20.Corte di Cassazione, Sez. III Civile, sentenza 21 luglio 2003, n. 11316. Jura Medica, N. 1, 2004, Anno XVII:188-190.
21.Art. 27, Capo IV, del Codice Deontologico dell'Infermiere, approvato dal Comitato centrale della Federazione con deliberazione n.1/09 del 10 gennaio 2009 e dal Consiglio nazionale dei Collegi Ipasvi riunito a Roma nella seduta del 17 gennaio 2009. Avaliable from: www.ipasvi.it/norme-e-codici/deontologia/il-codice-deontologico.htm
22.Rodriguez D, Aprile A: Medicina legale per infermieri. Edited by Carocci Faber, Roma, 2004.
23.Available from:www.scuolamedicina legale.unibo.it/bacheca CLAIMS/ 21.07.2003%20n.11316.pdf Cassazione Civile, sez. III, sentenza n. 11316 del 21 luglio 2003.
24. Gullace G, Damaschi V, Carbone C, Mancuso A, Fouladvand F, Buzzella E, Ferrari F: Cartella clinica integrata: documento unico per competenze diverse. Monaldi Arch Chest Dis. 2002; 58: 107-115.