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Avoiding Bias and Misinterpretation in Nursing Documentation

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Abstract: Nursing documentation is essential to safe, effective, and accountable nursing practice, yet the language nurses use in clinical records can unintentionally create misunderstanding, introduce bias, or increase legal vulnerability. When documentation does not clearly reflect the nurse's observations, intentions, or actions, the documentation can be misinterpreted by colleagues, administrators, or courts. This discussion highlights the importance of precision, neutrality, and trauma-informed approaches in nursing documentation. It will examine how ambiguous or biased working can compromise professional credibility and erode patient trust. By analyzing commonly used phrases, considering both their intended meaning and how the documentation could be misconstrued, this article illustrates the hazards of poorly worded records. It further offers clarity and guidance on replacing ambiguous statement with objective, patient-centered documentation that supports continuity of care, and strengthens the legal defensibility of the record.

INTRODUCTION

Nursing documentation serves as a written record of patient care, providing both a clinical and legal account of events that can inform ongoing treatment and serve as a history of the care provided. Accurate and objective documentation is vital for delivering quality care, directly affects patient outcomes, and serves as an important record in legal proceedings (Ghaith et al., 2022). Certain commonly used phrases in nursing documentation can be misleading, lack clinical precision, or introduce unintended bias. The purpose of this paper is to examine problematic phrases commonly found in nursing documentation, analyze the rationales for avoiding these phrases, and discuss more evidence-based alternatives that promote clarity and accuracy.

Phrase 1: "Bruises in different stages of healing"

The intended meaning is that the nurse suspects potential abuse when observing multiple bruises that vary in color and anatomical location. Historically, nursing and medical training often emphasized that bruises in different "stages of healing" can indicate abuse (Clarysse et al., 2018). The problem is that evidence does not support dating bruises based on visual inspection, as the color of the bruise reflects complex physiological processes and is influenced by multiple individual and situational factors. The color variation in bruises results from hemoglobin breakdown, not necessarily from injuries sustained at separate times. A bruise occurs when capillaries rupture, allowing hemoglobin to leak into the surrounding interstitial tissue, resulting in a pink or red discoloration. The immune system degrades the hemoglobin into iron (heme) and protein (globin). Proteins are metabolized into amino

acids and removed, while iron aggregates as hemosiderin, which appears golden-brown to blue-black over time. Concurrently, heme is broken down into biliverdin, producing a green discoloration, and later into bilirubin, imparting a yellow hue before being reabsorbed (Nash & Sheridan, 2009), leaving the coloration of hemosiderin alone. The body slowly absorbs the hemosiderin as the bruise disappears completely. The progression of bruising is influenced by individual factors, such as medication use, chronic disease, acute health conditions, and nutritional status, as well as situational factors, including the mechanism of injury, object involved, and location of impact (Maguire et al., 2005, 2013). It is common for bruises resulting from a single incident to present in multiple colors simultaneously and bruise appearance cannot reliably show age, whether assessed clinically or through photographs (Maguire et al., 2005; Johnson et al., 2021).

The best practice is to document the bruise's location, size, color, and pattern, as well as record the verbatim report as to the mechanism of injury. Bruising that is patterned, found on the posterior body, crosses the midline, or is inconsistent with the reported mechanism of injury should prompt further evaluation for possible abuse (Pierce et al., 2021; van Houten et al., 2022). The use of validated screening tools, such as TEN-4-FACEp, enhances the clarity and objectivity of assessment for potential physical abuse in pediatric populations (Pierce et al., 2021). Whenever possible, bruising or other injuries should be documented through medical photography using forensic standards. This includes obtaining an identifying photograph (face with chart or date), a wide view to show the injury's location on the body, a close-up of the injury itself, and an image with a measurement scale to provide size reference (Yesodharan et al., 2021). Use of validated and objective tools for pediatric patients (Pierce et al., 2021),

Phrase 2: "Patient reports alleged assault/rape/altercation."

In this statement the nursing is documenting the chief complaint, history or present illness, or review of systems which are subjective components of the chart and are as reported by the patient. These elements are the subjective components of the patient record and reflect the patient's own account of their condition. This section is inherently based on patient self-report, so the use of the term 'alleged' is unnecessary and potentially problematic. As a legal designation meaning "accused but not proven" (Merriam-Webster, 2025), alleged may imply doubt about the patient's statement, particularly in cases of sexual assault or interpersonal violence. Instead, documentation should objectively capture the patient's words without qualifiers, ensuring accuracy while avoiding language that may introduce bias or undermine credibility. The inconsistent use of the term "alleged" in specific complaints, but not others, can be exploited in legal proceedings to suggest that one did not believe the patient's report (Ghaith et al., 2022). Furthermore, language that conveys disbelief can retraumatize survivors and deter disclosure (Winters et al., 2020).

Best practice is to document subjective statements as direct quotations without adding qualifies, for example: *"Patient reports assault"* or "*Patient state they were raped earlier tonight."* If unable to document direct quote, summarize the report without adding qualifiers or interpretations. Consistently recording the patient's words in this way promotes neutrality and standardization in documentation. This approach aligns with trauma=informed care principles, which emphasize objective, nonjudgemental language to build trust and reduce the risk of traumatization (Brown et al., 2022; Wholeben et al., 2023).

Phrase 3: "Patient in no distress"

The intended meaning is that the patient appears clinically stable, with no observable signs of respiratory or cardiovascular compromise. The problem with this statement is that it does not clarify that the nurse is documenting only the absence of physical distress. Emotional distress can manifest in many ways and may not be outwardly visible and can go easily unrecognized. As written, the statement risks being interpreted as an indication the patient experienced no trauma (Alastalo et al., 2023).

There are two effective strategies to clarify this statement. The first is to use direct, precise language that makes clear the observation relates only to the patient's physical status. For example, *"Patient in no physical distress," "No overt signs of physical distress,"* or "*Respirations even and unlabored."* The second approach is to document both the physical and emotional state of the patient in objective terms. It is important to recognize that nurses are not trained to interpret or psychoanalyze psychological

states, instead, documentation should reflect observable findings. An example would be: *"Respirations even and unlabored, vital signs stable, patient sitting upright, maintain eye contact, responding appropriately to questions, and accompanied by a support person."* Regardless of approach, consistency in documentation is essential. Using clear, objective descriptors avoids assumptions, supports continuity of care and aligns with trauma-informed principles (Brown et al., 2022).

Phrase 4: "Incident report completed."

The nurse completed an internal risk management report in response to an adverse or unexpected event and is trying to document the completion of the internal reporting process for unanticipated event. The problem is the reference incident report is an internal risk management report that occurs following an adverse or unexpected event. Incident reports function as administrative instruments for institutional quality improvement and should not be included in the patient's medical record (Goekcimen et al., 2023; de la Torre-Pérez et al., 2023). Incident reports are designed to evaluate system processes and find potential risks to enhance overall patient safety, rather than to address the care of an individual patient. Referencing the completion of an incident report within the patient's medical record may make the report, and potentially the associated investigation, discoverable in litigation (Van Baarle et al., 2022). Although incident reports may include detailed accounts of the event, witnesses, and subsequent responses, they are not a substitute for thorough nursing documentation. Nursing documentation provides essential clinical details that directly influence patient outcomes and should be completed in real time or as soon as possible. This record not only supports the accuracy of incident reporting but also ensures that all members of the care team have access to a comprehensive description of the event and the intervention undertaken (Goekcimen et al., 2023; de la Torre-Pérez et al., 2023).

SUMMARY

Precision and neutrality in nursing documentation are crucial for ensuring patient care, maintaining professional credibility, and minimizing medicolegal risk. Ambiguous or judgmental language may compromise patient trust, bias clinical interpretation, or inadvertently create legal vulnerabilities. Nurses should use documentation that relies on objective descriptions and the interpretation of assessment and evidence-based, validated screening tools, such as TEN-4-FACESp for bruising assessment (Pierce et al., 2021), and trauma-informed communication strategies when documenting patient care (Brown et al., 2022; Wholeben et al., 2023). By adhering to these principles, nurses will enhance clarity, promote patient-centered care, and provide a correct representation of clinical findings in both care delivery and legal contexts.

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