

Ashley Craig

Quality Improvement Activity: Documentation Errors

A nurse was taking care of five patients on a med surg floor. There were only two hours left in their shift and they had not found the time to document anything due to how hectic the day got. When the nurse sat down to chart, they decided to copy and paste the assessments they did this morning from the previous assessment done. One patient had a stage one pressure ulcer that was documented the day before. The nurse did not end up assessing the pressure ulcer and decided to copy and paste this assessment as well. When the next shift took over, the oncoming nurse discovered the pressure ulcer to now be at a stage three. The break in skin and no interventions allowed bacteria to get in and cause an infection, and this patient ended up being at high risk for sepsis. The use of copy and paste and documenting on something that was not even assessed caused this patient's pressure ulcer to worsen without being caught.

What circumstances led to the occurrence?

The circumstance that led to this occurrence was the nurse falsely documenting on their patients. There was no proper assessment done to accurately record information. This nurse was not thorough and decided to take the easy route. Despite how busy the day got, they should have accurately assessed and documented on the patient in order to give them the best care.

In what way could you measure the frequency of the occurrence? (Interview nurses, examining charts, patient surveys, observation, etc.)

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In the case of documentation errors, examining charts would be the best way to measure the frequency of occurrences. This would show if the staff were accurately documenting everything that needs to be documented. It would also help to observe the nurses and see how they are documenting on their patients.

What evidence-based ideas do you have for implementing interventions to address the problem?

Stressing the importance of correct documentation could be brought up during every pre-shift huddle. Looking over documentation and finding out which areas need improvement so that it can be brought up before shift change would encourage nurses to focus on documentation. It can be easy to forget that documentation is one of the most important parts of our job as it helps direct the care of our patients.

How will you measure the efficacy of the interventions?

The efficacy of the interventions could be measured by reviewing charting done by nurses and examining how the nurse is charting on their patients after interventions had been done. Keeping track of the charting and seeing if there is improvement is important in continuing to make sure documentation is accurate and safe.