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IM 8
QI assignment: Documentation Errors

During my orientation for preceptorship, my nurse made a documentation error. I observed my nurse doing daily assessments on our patient and noticed that she did not chart the findings. The nurse was unable to chart the assessments because, during the assessment, she received a call from a nurse aide saying that one of our patients had come back from dialysis. Instead of documenting the findings in the patient's room, the nurse finished the daily assessments of the patient and left the room. Then, we went to the dialysis patient room and had the patient settle in. We did post-procedure assessments on the patient and documented the assessments. Once we were done with patient care for the rest of the patients, my nurse tried to chart the daily assessments of the patient that she failed to document. The nurse mistakenly documented the assessments on the wrong patient profile. However, before the nurse filed her documentation, she caught herself and was able to fix the documentation error. The nurse recharted the document on the right patient profile, but it took a while to finish the charting.

Describe the scenario. In what way did the patient care or environment lack? Is this a common occurrence?
In the scenario above, the nurse was interrupted while performing daily assessments. The nurse finished the daily assessment but could not document it in the patient room. Once she was done with the tasks of all her patients, the nurse tried to catch up with the documentation she missed. The nurse charted the documentation, and before she filed the document, she double-checked her documentation and noticed that she was charting on the wrong patient profile. Fortunately, the nurse caught herself before she filed it and prevented from making a documentation error. Due to the nature of the nursing environment, nurses are often interrupted while doing patient care, assessments, charting, etc. Thus, documentation errors are one of the common mistakes nurses make.

What circumstances led to the occurrence?
The nurse made a documentation error because she could not chart the assessments in the patient room right away. The nurse was interrupted by a call from a nurse aide, and she could not chart the assessment as soon as possible because she was doing post-procedure assessment and patient cares for other patients. The nurse barely had time to document, and when she tried to chart the documents, she didn't notice that she was charting on the wrong patient profile.

In what way could you measure the frequency of the occurrence? (Interview nurses, examining charts, patient surveys, observation, etc.)
Documentation errors are common, and the frequency of documentation errors can be measured in many ways. Interviewing nurses, examining charts, and observing are some ways you could use to measure documentation errors. Nurses often don’t realize they make documentation errors, and some don’t report them due to fear of getting in trouble.

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

Wrong documentation can negatively impact patient care, lawsuits, unclear communication between healthcare teams, etc. To prevent documentation errors, nurses should examine their charts or check their documentation before filing the documentation and ask if they need clarification on what to chart. Also, all unit staff members and nursing students should get proper training on charting patient electronic medical records. Adequate training and examining or double-checking to ensure it is under the correct patient profile could prevent documentation errors.

How will you measure the efficacy of the interventions?

The efficacy could be measured by checking every nurse's charting, keeping track of the nurse's performance on documentation, and the number of documentation errors. By doing these, all the staff members could reflect on their performance and work together to achieve zero documentation errors.