Correcting Documentation Errors

Problem

Practice-related issues such as errors in documentation are more common in nursing today than ever before. The incidence of malpractice lawsuits no longer involve just the institution but may involve the nurse personally as well.

The failure of the nurse to correct errors in documentation is problematic and can be used against her in law. Proper documentation can provide strong support for the nurse and demonstrates competent practice patterns if ever required during testimony in a disciplinary hearing or a lawsuit.

Consequence

Failure by nurses to correct errors in documentation can lead to potential disciplinary action and legal liability. More importantly, incorrect documentation interferes with effective communication, care and evaluation by the health team of the patient.

Solution

Here are some suggested steps to take to address this problem.

- Be familiar with the policies and procedures in your agency to address charting mistakes.
- The term “mistaken entry” should be used instead of “error” when correcting documentation.
- Always use a single line though the mistaken entry and place the date, time, and initials above the line for clarification of the error.
- Follow hospital policy and adhere to their guidelines for documenting errors to avoid legal pitfalls.
- Simple mathematics often account for documentation errors.
- The intake and output measurements should always be double checked for addition or subtraction mistakes; if unsure, have another nurse check the calculations.
• Inaccurate fluid calculations may mean delayed treatment or a possible fluid overload if additional fluid is given to correct an erroneous low output.

• The use of a calculator eliminates some addition or subtraction errors; however, a documentation mistake in the placing of the numerical values would still cause a miscalculation.

• Other numerical mistakes happen by misplacing values into the wrong column or proper area; if the mean arterial pressure value was placed into the central venous pressure column, erroneous treatment by the physician may occur as he interprets the mistaken value as correct.

• Never use correction fluid to cover a mistaken entry or other methods to hide an error; this could be interpreted in court that a nurse was trying to “cover up” something.

• Altering words or entries after being documented in the chart is considered fraud and makes the nurse open to disciplinary action or litigation.

• Documentation errors must be corrected following accepted hospital policy and procedures.

References

Avoiding Common Nursing Errors, Lisa Marcucci, MD, Editor, Lippincott Williams and Wilkins, 2010.

Note: A narrated e-Learning module of this Nugget is available at LearningNurse.com.