Avoiding Incomplete Documentation

Problem

Paperwork is usually the nurse’s least favorite task on her daily agenda. Spending time with the patient and providing bedside care are preferred activities. However, it cannot be emphasized enough that the documentation of the health care provided is the legal evidence that it actually occurred.

The omission of even simple tasks or events from the patient’s chart that occur during a hospital stay can be impede effective care and be detrimental to any case should it be taken to court.

Consequence

In nursing, assessment documentation is the legal statement that what is written was performed. Failure of the nurse to complete appropriate documentation represents carelessness and can be used as evidence of negligence or malpractice. Incomplete documentation can also interfere with the continuity of care and can pose safety risks to the patient.

Solution

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

- Make time to document patient care and interventions completely and efficiently.

- On admission, thoroughly document the patient’s history; a common error is failure to document important medical history.

- Medical institutions open themselves and their employees to possible litigation if the admission database is incomplete and proper information is missing.

- Documentation can be considered incomplete if the handwriting is unclear.

- The medical record provides clinical communication and care planning among clinicians serving the patient as well as the basis for evaluation of the adequacy and appropriateness of care.
• Nurses often have time constraints, whether due to poor staffing, complicated care issues or simply wanting to leave work on time.

• Avoid the temptation to write hastily, use poor grammar or use incorrect spelling / terms when documenting.

• Incomplete documentation is considered unfinished documentation and conveys the message that the assessment has not been completed appropriately by the nurse.

• Illegible medical records are open to scrutiny and can be used as evidence in a malpractice suit against the nurse.

• Clear, legible handwriting and thorough documentation may not keep the nurse out of the court room, but may provide protection for her license and career.

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.