Avoiding Plagiarism in Documentation

Problem

Nurses often find completing detailed shift documentation is a tedious task. As a result, they are always on the lookout for shortcuts. One of the quickest means of documentation is copying the previous shift’s nurses assessment notes. This copying is considered nursing documentation plagiarism and is a form of assessment dishonesty.

Consequence

Incorrect documentation interferes with effective communication, care and evaluation by the health team of the patient. The nurse could face disciplinary action or termination from a job if some form of her erroneous charting ends up in a malpractice suit.

Solution

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

- All forms of nursing documentation that assess the patient’s progress become part of the patient’s medical record.

- The nurse’s notes become a legal document of the patient’s care and emphasize the skills used in implementing such care; nursing documentation is the critical component that will be considered in any nursing malpractice action.

- Erroneous charting could be repeated if a charting shortcut is made by copying documented assessment notes from any previous shifts.

- Documentation of the nursing process is the responsibility of the nurse and must be done independently with honesty, integrity and accuracy.

- Independent assessment and charting provides a measure of quality assurance and a verification in patient care.

References

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