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Poor Nursing
Documentation
Examples

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The patient sued, and the hospital had to pay her \$1.5 million in damages. 9 Types of

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medical errors. Here are some of the top 9 types of medical documentation errors: Sloppy or illegible handwriting. Failure to date, time, and sign a medical entry. Lack of documentation for omitted medications and/or treatments.

Nursing Documentation: How to Avoid the Most Common ...

EXAMPLE 1: POOR

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Revised 3/3/2016

Please complete electronically. Referral Information Date Sent to Permedion: 1/10/16
Hospital/Facility Name: Hollywood Memorial Hospital
Contact Person: Diane Smith, RN
Email address: diane.smith@hmh.com
Phone: 614 333 9823
City, State Hamilton, OH
Date of Admission: 1/8/16

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Example 1 - Poor

**Documentation -
HMS Permedion**

Nursing

Documentation: Good
vs. Bad Admission -
GOOD 80-year-old
female admitted to SNF
following
hospitalization for right
hip fracture r/t fall, and
secondary HTN and
CHF. Prior to fall,
resident lived at home
with spouse. Arrived
via W/C Express.

Daughter and husband

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at center waiting for resident. Resident alert, recognizes family.

Nursing Documentation: Good vs. Bad

Let's look at an example. A Case of Missing Documentation : In Susan Meek. V. Southern Baptist Hospital of Florida, Inc. d/b/a Baptist Medical Center , the patient (plaintiff) was admitted

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to the hospital for a
hysterectomy.

MEDICAL ERRORS IN NURSING: PREVENTING DOCUMENTATION ERRORS ...

More "Examples Of
Poor Nursing
Documentation" links
Example 1 - Poor
Documentation - HMS
Permedion OH Mental
Health and Addiction
Services Inpatient
Psychiatric

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Precertification Page 1
of 6 EXAMPLE 1: POOR
Documentation
Revised 3/3/2016
Please complete
electronically.

Examples Of Poor Nursing Documentation

Paying a price for poor
documentation.

Childers, Karen P. RN,
MSN. Nursing2005: ...

For example, charting
by exception lets you
write narrative

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information only when patient information is outside the norm, but omitting information could have legal implications for you and your facility. ...

Nursing documentation that isn't up to snuff takes a ...

Paying a price for poor documentation : Nursing2020

The patient's vital signs were not taken every 10 minutes (as

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Examples
specified by hospital protocol for patients on nitroglycerine drips).

The serial documentation by the nurse attending the patient in the ED was not consistent and included a gap in documentation of vital signs from 4:36–5:05 p.m.; further, nothing was documented from 6:50–7:49 p.m.

CASE STUDY: Failure to Follow Protocols,

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Examples
An example of documenting a patient's rude behavior might look like this:
Upon entering the patient's room, patient stared at me with what appeared to be an angry expression. Upon asking the patient how he was feeling this morning, he responded in a very loud voice, "Get out of my room and don't come back."

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**Stay out of court
with proper
documentation :
Nursing2020**

1. " Both breasts are equal and reactive to light and accommodation." 2. "Patient's chin cannot touch the table." 3. "Remnants of a soldier can be seen in the vagina." 4. "It should be noted that there is no noticeable difference in temperature between

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the legs". 5.

60+ Funny Charting Errors Found on Actual Medical Records ...

ANA's Principles for
Nursing Documentation
| Overview of Nursing
Documentation • 3

Overview of Nursing
Documentation n
Clear, accurate, and
accessible

documentation is an
essential element of
safe, quality, evidence-

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based nursing practice. Nurses practice across settings at position levels from the bedside to the administrative office; the

ANA's Principles for Nursing Documentation

In essence, poor documentation is anything that inhibits a clear presentation of a patient's story, Combs says. "For instance, if a

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provider is documenting congestive heart failure, he or she will need to include the acuity and type of congestive heart failure to ensure the highest level of specificity," she says.

Poor Documentation: Why It Happens and How to Fix It

Nursing
documentation: How

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Examples
does it affect care? and published in the Journal of Research in Nursing – looked at nurse documentation for older patients on acute wards in England. It involved in-depth interviews at the start of 2015, with eight nurses employed by Nottingham University Hospitals NHS Trust.

'Inaccurate and incomplete' nurse record ... - Nursing

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nursing documentation facilitates continuity of care (Jefferies et al, 2010b), and enhances collaborative working. Keeping our colleagues informed of patients' care helps to preserve their safety and improve risk management. For example, one of the documents shared across professional boundaries is the discharge summary.

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Viewpoints 'If it's not written down; it didn't happen'

For example, a medical assistant may complete a history and physical on a patient in totality. The supervising physician may subsequently log in to the record, evaluate only proof of positives and negatives, and electronically sign the documentation in such

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a way that it overwrites
the presence of the
medical assistant. ...
because some poor ...

Documentation Bad Habits: Shortcuts in Electronic Records

...

Misplaced or incorrect
documentation in a
patient's record can
also cause severe
physical harm and
even death. An
example of a copy and
paste error that

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Burgess came across recently involved a newborn that had a slight hematoma of the head right after delivery.

Preventing Healthcare's Top Four Documentation Disasters

asked to comment on whether the care provided by the nursing staff met the requisite standard of care. Legal claims

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continue to demonstrate that even the most competent, caring and dedicated nurse may be defensive in the absence of good documentation. Poor documentation can have a negative impact on

Documentation - the Court's Perspective

examples *please keep in mind these excerpts are actual

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documentation from
medical records “rsd
was found sitting in
floor with w/ behind her
by nsg staff. tab alarm
sounding no injury
noted. rsd denied pain.
rsd self release belt
had been sent to
laundry and was not in
plae”. disussion
please.....
. 32

Did I Write That? - FADONA

Incomplete
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documentation in patient clinical records can cause your organization legal and settlement fees, cause you to lose your license, contribute to inaccurate statistical databases, cause lost revenue/reimbursement, and result in poor patient care by other healthcare team members. That's why every organization should ensure accurate and complete clinical

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documentation (at any cost).

Poor documentation: The consequences - www.hcpro.com

Nursing documentation is the record of nursing care that is planned and delivered to individual patients by qualified nurses or other caregivers under the direction of a qualified nurse
[]. Nursing documentation is the

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principal clinical information source to meet legal and professional requirements [].It is a vital component of safe, ethical and effective nursing practice whether done manually ...

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ecf8427e.

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