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DOCUMENTATION ERROR FOR FORGOTTEN DJ STENT IN PYELOLITHOTOMY

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Abstract:

A 40 year old patient admitted in neurology unit for Pyelolithotomy, after surgery the dr. forgets to document the presence of stent in kidney and its removal. After discharge the patient came with complaint of high grade fever and severe pain. After investigating it was diagnosed that stent was present in the kidney. When inquire about this the patient refuse to accept its presence and on discharge card it also missed.

Results

The outcomes of this documentation error highly effect to the patient, to health care team and health institute. Decision making theory applied to solve this issue.

Discussion

According to literature review the researcher said that documentation is a most important part of nursing duties. Proper documentation minimizes problems and save record. Online system should be used for documentation record.

Key words: *documentation error, documentation and advance technology, forgotten DJ stent, Pyelolithotomy,*

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INTRODUCTION:

Documentation Error

Proper documentation is an integral part of nursing profession. Failure to document patient record accurately means death or life of patient. Missing the record of patient, patient condition and any surgical procedure related to patient care can result in poor outcomes for patients, and issues for the facility, the physician in charge, and the nurse (Lippincott, 2018).

Case Scenario:

A 40 year old patient admitted in nephrology unit of public hospital for Pyelolithotomy because he had a history of renal stone from last five years. Patient verbalize that he used herbal medicine for its treatment but could not cure so now he was complaint of severe pain and urinary incontinence. Lab investigations were as follows CBC with elevated ESR, BUN was 69 mg/dl (high) and serum creatinin level was normal, sodium level was 126 mEqL (low), potassium level was 5.8 mEqL (high). Calcium level was 8.2 (low). On urine examination red blood cells and pus cells were present.Decision was taken for the surgery to remove the stones from kidney. During surgery, the surgeon used DJ STENT for removal of stones but he missed to document for this stent and also its removal process “date and time”. It was also missing from nursing Notes and after discharge not mentioned on discharge card or any other documentary record. But the Nurse verbalizes about the stent and she asked for its removal after one month. Family member of patient did notnotice about what nurse verbal advice and forget the removal of Stent. After two month patient came in emergency unit with high grade fever, chills and severe lower abdomen pain. After complete history, X-Rays report and ultrasound report find the presence of DJ Stent in left kidney. Case was reported to the Medical Superintendent of the Hospital. M.S higher an Inquiry committee to investigate the real problem how it was happens. Through this inquiry it was investigated that surgical team forget to document about the surgical stent and committee punish them as deduction of 15 days salary, and make a plan record on paper and in computer system.

RESULTS:

The errors are common in health care system like medicine error, surgical error, timing error and documentation error. The documentation error is a mistake that can be done by health care provider or health care system. The documentation error in case of Pyelolithotomy it creates multiple problems for the patient health care provider and health care system.

The patient suffered his health instead of cure. Due to presence of stent the patient became infected, infection leads to high grade fever and severe pain. It was high risk to the health of patient and much fatal

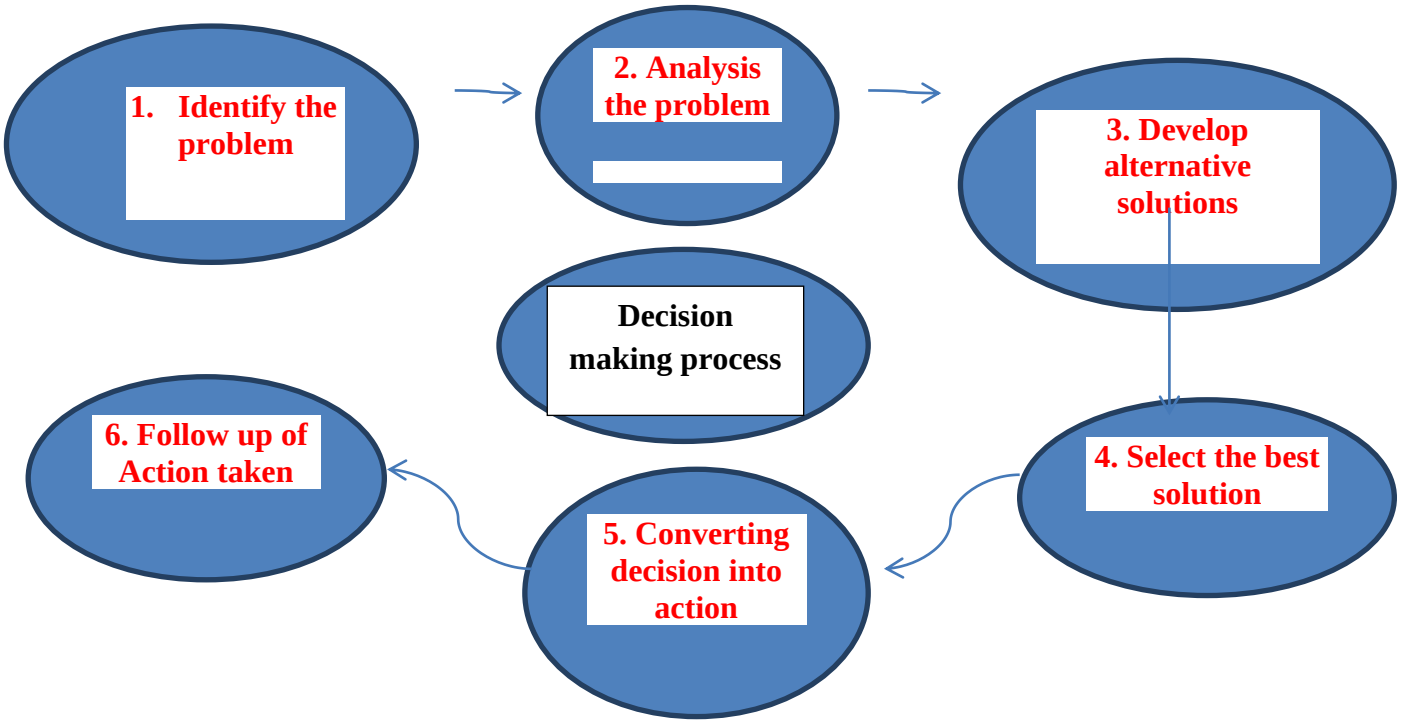
The effects of documentation error on health care providerswere the threat of job due to careless attitude toward patient care. They received show cause notice against irresponsible behavior for the patient and they paid fine against this mistake.

The reputation of health care system was also on risk because of this negligence. The patient and relatives has no positive response regarding that health system.

There is no proper check and balance and proper way of documentation improve the health care system. No new technology (online) system is used to improve the patient record of patient in hospital.

Decision making strategy is used to handle the problem occur in an organization.

1. Identify the problem
2. Analysis the problem
3. Develop alternative solutions
4. Select the best solution
5. Converting decision into action
6. Follow up of Action taken



The excellent documentation should be

- Factual
- Accurate
- Complete
- Timely
- Organized

Unfreezing:

Lewins describe that unfreezing stage is a tendency to change the thoughts which are frozen in the mind and sense of safety and control. Unfreeze the mind and thinking of people and take next step of change. The significant power is needed to unfreeze and moving on.

Change:

It is the important stage in which leader make effort and brings change in whole organization by changing the mind of people.

Refreezing:

Changing thoughts and mind of organization it is important to refreeze the change and its roots and make it stable. It is important for people of organization to work efficiently.

DISCUSSION:

Nursing is practice professions which play multiple roles and provide quality care, education, and counseling. As per American Nursing Association, "Nursing is promotion, protection and optimization of health. The preventing from illness and injuries, and elevate the methods of identification of disease and its treatment". The documentation is a written proof of interaction between and among health care providers, patients, their families, and the institutes of health. From the time of Florence Nightingale, the documentation is an important part of nursing profession. Tasks of nursing profession is to provide care to the sick but also proper documentation the every procedure. Nursingdocumentation is most important part of the nursing duty. It includes all procedures and tasks like assessment of patient, nursing care plan, health needs, nursing interventions,its outcome and the of discharge advice (Krishna. R., 2018).

As the nursing documenting is important for nursing practice. The nursing documentation involves a complete patient status, patient'sdisorder and the care which patient need. Documentation is necessary for proper communication, promotion of health, and to maintain the legal standard of nursing profession.The proper documentationdeliversclarity ofproblemswhich are faced by nurses during nursing interventions and decision making (Eldin. D., 2012).

The nursing documentation is an integral part of nursing profession. Nursing documentation should be complete, accurate, up-to-date, and todeliverthe reliableevidences regarding assessment of patient, provision of care, and the assessment of responses against care. Inadequate nursing documentation never provides the essential information for providing

quality care, quality improvement and properdistribution of resources. It is critical that accurate and systematic communication should be done through effective documentation process application. It involves assessments, planning, implementation, and the evaluation of process (Obioma. C., 2017).

It is reported that many factors contribute to increase nurses' workload and it leads to incorrect information to be documented. Incorrect documentation of information can create problems to treat and manage the patient and if patient became affected due to this mistake , the patients relatives or next to kin has right to inquire the responsible nurse or other health care provider who make the documentation error because it is due to absence of document (Gilson, 2014).

It is defined by Healthcare Information Technology (HIT) that the use of latest technology like computer software and hardware for the purpose of storage and sharing the information based on health and health care system. It is also useful for decision making and communication. Healthcare Information Technology change the trend from simple charting to more advance level of technology. This system provide opportunities to improve the health care system by minimizing human errors, expanding health organization, and elevating nursing practice competencies (Yasser. K, 2017).

CONCLUSION:

In a nut shell the documentation error isa major error which creates harmful effects on patient health, problems for health care provider and health care system. It is very necessary to be careful about documentation of patient record to prevent from conflict and issues.

The quality of health organization increased when there is truthfulness, consistency and correctness in information related to health. Health information technology system is applied in health care system to minimize the occurrence of risk, reduce the cost and increase the benefits. Providing quality health care and improve the patient health it is also important to prevent from these hazards like documentation errors. Advanced technology is used to reduce these errors (Bowman. S, 2013).

The adverse events occur in hospital setting like documentation error which is harmful for patient health and its influences are bad. It is responsibility of health care provider to be done documentation. Errors that can cause adverse results for patient or health care system should be monitor properly (Smeby. S, 2015).

Recommendations:

In public hospitals there is need for improvement in whole health care system. The proper check and balance is necessary to minimize documentation error. By using different techniques documentation error can be control by double check and use advance technology like online record for proper documentation. The reminder phone call should done for follow up and decrease the level of error and improve the health.

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