Documentation: Accurate and Legal

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Purpose

The purpose of this course is to outline accuracy and legal requirements for nursing documentation, including a review of different formats for documentation.

Goals

Explain the purposes for documentation.
Explain the differences among the NANDA nursing diagnoses, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC).
Discuss the Health Insurance Portability and Accountability Act, Privacy Rule.
List and explain at least 8 different factors to consider in documentation.
Explain how to document errors, continuations, and late entries.
List and explain the primary characteristics of different formats for documentation.
Explain how critical pathways are used.
Discuss 3 common components of computerized documentation systems.

Introduction

Documentation is a form of communication that provides information about the healthcare client and confirms that care was provided. Accurate, objective, and complete documentation of client care is required by both accreditation and reimbursement agencies, including federal and state governments. Purposes of documentation include:

- Carrying out professional responsibility.
- Establishing accountability.
- Communicating among health professionals.
- Educating staff.
- Providing information for research.
- Satisfying legal and practice standards.
- Ensuring reimbursement.

While documentation focuses on progress notes, there are many other aspects to charting. Doctor's orders must be noted, medication administration must be documented on medication sheets, and vital signs must be graphed. Flow sheets must be checked off, filled out, or initialed. Admission assessments may involve primarily checklists or may require extensive documentation. There is very little consistency from one healthcare institution to another. This poses a real challenge for nurses, especially since it is increasingly common for nurses to

work part-time in more than one healthcare facility as hospitals use temporary nursing agencies to fill positions. Understanding the basic formats for documentation and effective documentation techniques is critical. With the movement toward quality healthcare and process improvement, nurses may be involved in evaluating documentation and making decisions about the type of documentation that will be utilized. Accurate documentation requires an understanding of nursing diagnoses and the nursing process.

Nursing diagnoses, interventions, and outcomes

NANDA International (formerly the North American Nursing Diagnosis Association) sets the standards for nursing diagnoses with a taxonomy that incudes domains, classes, and diagnoses, based on functional health patterns. Nursing diagnoses are organized into different categories with over 400 possible nursing diagnoses:

Moving (functional pattern):

- Impaired physical mobility
- Impaired wheelchair mobility
- Toileting self-care deficit.
- Ineffective breast feeding

Choosing (functional pattern):

- Ineffective coping
- Non-compliance
- Health-seeking behavior.

These NANDA nursing diagnoses are then coupled with the Nursing Interventions Classification (NIC), which is essentially a standardized list of hundreds of different possible interventions and activities needed to carry out the interventions.

The client outcomes related to the NIC are outlined in the Nursing Outcomes Classification (NOC), which contains about 200 outcomes, each with labels, definitions, and sets of indicators and measures to determine if the outcomes are achieved. These criteria, for example, can be used to help determine a plan of care for a client with pain and diarrhea.

NANDA **Nursing diagnosis**	**NIC** **Intervention**	**NOC** **Expected outcomes**
Chronic pain	Pain management Medication management Relaxation therapy Guided imagery	Improved pain level Improved comfort Enhanced pain control
Diarrhea	Management and alleviation of diarrhea	Improvement in symptom control Improvement in comfort.
Risk for deficient fluid volume	Fluid and electrolyte monitoring	Fluid and electrolyte balance

Each NIC intervention would have a number of possible activities that could be utilized, depending on physician's orders and nursing interventions, to achieve positive outcomes.

While not every healthcare institution uses the same databases or lists of diagnoses, interventions, and outcomes, the basic structure is usually similar, and these lists are used extensively to provide a basis for documentation. Computerized documentation systems usually incorporate this or a similar taxonomy, so that the nursing diagnoses are entered into the system, which then generates lists of interventions and expected outcomes. In non-electronic documentation systems, books or kardexes with these listings may be available for reference.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 outlines the rights of the individual in relation to privacy regarding health information. The final Privacy Rule was issued in 2000 and modified in 2002. HIPAA provides the individual with the right to decide who has access to private health information and requires healthcare providers to provide confidentiality. Personal information about the client is considered protected health information (PHI), which comprises any identifying or personal information about the client and health history, condition, or treatments in any form, including electronic, verbal, or written—so this includes documentation. If left at the bedside, documentation must be secured in such a way that it cannot be seen by those unauthorized.

Personal information may be shared with parents, spouse, legal guardians, or those involved in care of the client without a specific release, but the individual should always be consulted if personal information is to be discussed in a room with others present to ensure there is no objection.

Some types of care are provided extra confidentiality: These include treatment for HIV, substance abuse, rape, pregnancy, and psychiatric disorders. In these cases, no confirmation that the person is a client may be given. In other cases, an individual may elect opt out of the directory, that is to have no information released to anyone, and this must be respected by all staff.

Charting guidelines

A common understanding regarding documentation is that if it’s not written, it didn’t happen. This is not actually true: even if a nurse forgets to chart a medication, the medication was still given. However, if there is a legal action and the chart is examined, there is no evidence that the medication was given as ordered, and a nurse that admits to carelessness in documenting has little credibility. Further, if a medication that is not ordered is given in error, failing to chart it doesn’t mean it didn’t happen. It means that the nurse has compounded a medical error with false documentation by omission, for which there may be serious legal consequences.

Regardless of format, charting should always include any change in client’s condition, any treatments, medications, or other interventions, client responses, and any complaints of family or client. The primary issue in malpractice cases is inaccurate or incomplete documentation. It’s better to over-document than under, but effective documentation does neither.

State nursing practice acts may vary somewhat, but all establish guidelines for documentation and accountability. Additionally accreditation agencies, such as the Joint Commission, require individualized plans of care for clients and have standards for documentation.

Nursing process

There are many different approaches to charting, but nurses should remember to always follow the nursing process because that's the basis for documentation, regardless of the format in which documentation is done:

- Assessment: Review of history, physical assessment, and interview.
- Diagnosis: Nursing diagnosis based on NANDA categories.
- Planning: Assigning of priorities, establishing goals and expected outcomes.
- Implementation: Carrying out interventions and noting response.
- Evaluation: Collecting data, determining outcomes, and modifying plan as needed.

Vocabulary

A standardized vocabulary should be used, including lists of approved abbreviations and symbols. Abbreviations and symbols, especially, can pose serious problems in interpretation. While most institutions develop lists of approved abbreviations, the lists may be very long and difficult to commit to memory and often contain abbreviations that are obscure and rarely used. It is better to limit abbreviations to a few non-ambiguous terms. Nurses should make a list of the abbreviations that they frequently use, and then they should check their lists against approved abbreviation lists to ensure that they are using the abbreviations properly. The use of the term "patient" or "client" should be used consistently through all documentation at an institution. "Patient" is the older term, but as part of the quality healthcare movement, the term "client" is becoming more commonly used.

Description

Nurses should avoid subjective descriptive terms (especially negative terms, which might be used to establish bias in court), such as tired, angry, confused, bored, rude, happy, and euphoric. Instead, more objective descriptions, such as "Yawning every few seconds," should be used. Clients can be quoted directly, "I'm really angry that I can't get more pain medication when I need it."

Advance charting

Charting in advance is never acceptable, never legal, and can lead to unforeseen errors. Guessing that a client will have no problems and care will be routine can result in having to make corrections.

Timely charting

Charting should be done every 1-2 hours for routine care, but medications and other interventions or changes in condition should be charted immediately. Failure to chart medications, such as pain medications, in a timely manner may result in the client receiving the medication twice. Additionally, if one nurse is caring for a number of clients and is very busy, it may be easy to forget and omit information that should be charted.

Writing

If hand entries are used, then writing should be done with a blue or black permanent ink pen, and writing should be neat and legible, in block printing if handwriting is illegible. Some facilities require black ink only, so if unsure, nurses should use black ink. No pen or pencil that can be erased can be used to document.

Making corrections

If errors are made in charting, for example, charting another client's information in the record, the error cannot be erased, whited-out, or otherwise made illegible. The error should be indicated by drawing a line through the text and writing "error."

Date:	Time:	Progress Notes:
02-01-08	1320	~~Client complained of slight nausea~~
		~~after light lunch of turkey sandwich and~~
		Error----------M. Brown, RN

Correct forms

Client records are often very complicated with numerous sections, but it is important that documentation be done on the correct form so that the information can be retrieved and used by others.

Physician orders

Policy must be followed in noting orders on the physician order forms. If a physician telephones and order the it should be designated as "T.O." to indicate a telephone order with the date, time, and physician's name as well as a note indicating that the order has been repeated to the physician. Verbal orders, designated as "V.O., " should be written exactly as dictated and then verified.

Time

Nurses must always chart the time of all interventions and notations. Time may be a critical element, for example, in deciding if a patient should receive pain medication or be catheterized for failure to urinate. Many healthcare institutions now use military time to lesson error, but if standard time is used, the nurse should always include "AM" or "PM" with any notations of time.

Client identification

The client's name and other identifying information, such as client identification number, should be on every page of every document in the client's record or any other documents, such as laboratory reports.

Signature

The nurse must always sign for every notation in the client's record and for action, such as recording or receiving physician's orders.

Allergies and sensitivities

Allergies and sensitivities should be entered on each page of the clinical client's record, according to the policy of the institution. In some cases, this may involve applying color-coded stickers, and in others, the lists may be printed or handwritten. Nurses should always ensure this information is accurate and

should check allergies and sensitivities before administering any medications or treatments.

Spelling/grammar/spelling

Client records are legal documents, so any documentation should be written in clear standard English with good grammar and spelling to prevent misinterpretation. Slang or non-standards terms not be used.

Omissions

Any medication or treatment that is omitted or delayed must be noted in the records with the reason. For example, a treatment may be delayed because the client is in physical therapy. In general, it's better to make plans to avoid omissions and delays if possible.

Continued notes

When notes are continued from one page to another, a notation that the entry is continued on the next page must be made to indicate that the note is incomplete as well as a notation on the next page to indicate it is a continuation. Both pages must be signed.

Date:	Time:	Progress Notes:
02-01-08	1320	Client complained of slight nausea
		after light lunch of turkey sandwich and
		(Continued on next page-------)M. Brown, RN

Date:	Time:	Progress Notes:
02-01-08	1320	(Continued from prior page----------)
		8 oz. milk. Sipped ginger ale with relief of
		nausea in 15 minutes.---------M. Brown, RN

Spaces

No blank spaces should be left in charting because this could allow others to make later additions or alterations to the nursing notes. A straight line must be drawn through any empty space on a line.

Late entries

Late entries must carry the date and time they were actually entered into the document, and they should carry the notation "Late entry" followed by the date and time of the event/item. The late entry should never be written between or above lines in an attempt to keep the notes chronological. Timely charting may eliminate late entries.

Date:	Time:	Progress Notes:
02-01-08	1320	Late entry (02-01-08—1140) Client refused
		Lunch: "I'm not hungry because I ate 3

		candy bars this morning."------M. Brown, RN

Medication/treatment errors

Each healthcare facility has procedures in place for dealing with medication or treatment errors, and this includes filling out an incident report. Generally, no notation is made in the client's chart concerning the incident report, but this may vary from one institution to another. However, the nursing notes must indicate all treatments and medications given, even if they are incorrect. Thus, the treatment given, for example the wrong dose of a medication, must be recorded on the record of medications and notations in the nursing note should include:

- Name and dose of medication.
- Name of physician and time notified.
- Nursing interventions or medical orders to prevent or treat adverse effects.
- Client's response to treatment.

Date:	Time:	Progress Notes:
02-01-08	1320	Meperidine 100mg IM. Client lethargic in 20
		minutes, but alert and responsive. Bp 1110/76-
		P. 80 R. 16._____M. Brown, RN
02-01-08	1345	Dr. B. Jones notified. VS to be checked every
		15 minutes x 2 hours.--------M. Brown, RN
02-01-08	1500	Client alert, responsive. VS stable: 118/78
		P. 82. R. 20----------M. Brown, RN

Generally, clients and families are not advised of errors by the nurse involved, and in many cases they are never advised at all. This is an ethical issue that has many implications, both legal and moral. Clients, by law, have access to their records, but most people wouldn't recognize an error unless it's identified as such. Some healthcare facilities are now utilizing an open policy in which clients and families are informed of medical error, but more often this is not the case. A nurse should have a clear understanding of the policy in effect at the healthcare facility at which he/she works because notifying clients of errors could result in considerable legal ramifications.

Types of documentation

Flow sheets

Flow sheets are a component of all other types of documentation. They may vary considerably in format, but usually involve some type of vertical columns or horizontal rows as well as graphs in order to record date, time, assessments, interventions, and outcomes. Flow sheets may require check marks or initials to indicate that actions were done. Leaving something blank indicates it was not completed, so it's important to fill the flow sheets out completely. Often abbreviations are used because of the small space for writing, and these may be

indicated by a legend at the top or bottom of the sheet. The purpose of flow sheets is to reduce the time needed for charting and to eliminate redundancy; however, flow sheets do not replace nursing notes completely. Sometimes nurses repeat in the progress notes information that is already in the flow sheets, creating unnecessary duplication, and creating lengthy progress notes that lack purpose.

Narrative

Narrative documentation is the most traditional style of charting and one with which many nurses feel comfortable. Narrative documentation provides a running chronological report of the client's condition, interventions, and responses over the course of a shift. It's a fairly easy method of charting because there is no numbering of problems or crosschecking between a flow sheet and the narrative to match information.

Date:	Time:	Progress Notes:
02-01-08	0830	Client awakened only 1 time during the night
		to urinate. No complaints of pain. Dressings
		intact. Ate 100% of breakfast. Ambulated in
		hallway for 5 minutes without assistance.
	0930	Transported per w/c to PT----M.Brown, RN

One of the weaknesses inherent in narrative documentation is that it is often disorganized and repetitive, and different nurses may address different issues, so a complete picture of the client may be difficult to ascertain from reading the notes. It may also be difficult to trace problems, interventions, and outcomes without reading through the entire chart. Nurses using narrative charting need to use the plan of care and physician's orders to help to plan and organize the information they document, and they need to review the notes for at least 2 previous days to ensure that important issues are not overlooked.

Source-oriented

Source-oriented documentation is a form of narrative documentation in which each member of the health team keeps separate narrative notes, usually in separate records so that there is little or no interdisciplinary sharing of information. This is a traditional method of record keeping, but it can result in fragmented care, and/or time-consuming meetings to share information. Many institutions have moved away from this type of documentation.

Problem-oriented (SOAP)

Problem-oriented documentation has a number of components:

- Assessment data.
- List of client problems, numbered sequentially from when first noted.
- Initial plan of care that outlines goals, outcomes, and needs.
- Progress notes

This type of charting focuses on the client's problems and utilizes a structured approach to charting progress notes: SOAP

- Subjective data Client's statement of problem.
- Objective data: Observations of nurse.
- Assessment:
- Plan:

Problems are numbered and the SOAP format used to review each problem.

Date:	Time:	Progress Notes:
02-01-08	1320	Problem#I: Temperature elevation.
		S: Client states, "I feel very hot." Complains
		of headache (2 on pain scale of 0-10)._____
		O. T. 102 orally. Face flushed. Client
		covered with sheet only. Abdominal incision
		clean and no erythema or tenderness. BP
		118/72, P. 90, R. 20. Sl. Basilar rales.
		A. *Deficient fluid volume (500ml/24 hours).*
		Ineffective breathing pattern. (shallow)----
		P: Acetaminophen 500mg for fever. Provide
		fluids to increase intake to 1500-2000/24
		hrs. Instruct in DB and C exercises and
		assist client every 2 hours. B. Moore, RN

In some cases, an extended format is used (SOAPIER) that includes:

- Intervention
- Evaluation
- Revision

There are some problems with this type of documentation. Because this format is followed for every problem, charting can be extremely time-consuming and repetitive. Also, sometimes problems overlap and the same information is entered repeatedly. Often, standard plans of care or pathways are used as guidelines, and nurses sometimes simply copy from the guidelines to save time rather than really considering the individual needs.

Problem oriented: PIE (problem, intervention, evaluation)

This is a simplified approach to focusing on the client's problems, interventions, and evaluations. This documentation format omits the care plan but utilizes flow sheets and progress notes. The progress notes utilize nursing diagnoses as the problem. A number of different problems (with interventions and response) may be recorded, numbered sequentially, and each problem is evaluated at least one time during each shift.

Date:	Time:	Progress Notes:
02-01-08	1320	P#1—Risk of aspiration secondary to decreased
		Level of consciousness.
		I#1—Head of bed elevated to 45 degrees while
		eating and for one hour after eating. Liquids
		thickened and fluids given with straw. Dr. B.
		Jones notified. Ativan DC'd.----B. Moore, RN
	1500	E#1—No aspiration. Client alert and responsive.
		----------B. Moore, RN

PIE charting focuses on the nursing process, but it omits the planning for care that is part of more comprehensive documentation formats, so this may pose a problem for less-experienced nurses, and it may result in different approaches to problem solving and inconsistencies of care.

Focus (DAR)

Focus charting includes specific health problems but also changes in condition, client concerns, or client events. The 3 items that must be documented are Data, Action, and Response. The nurse may enter focus problems as needed in response to client needs. This type of charting utilizes a 3-item (DAR) or 3-column (DAR) format to document data, action (including plans for follow-up), and response.

Date:	Time:	Focus	Progress Notes:
02-01-08	1320	Fever	D: T. 102 orally. Face flushed.
			Frontal headache (2 on 0-10
			scale)----------
			A: Acetaminophen 500 mg orally
			Cool compress to forehead.
			400 ml apple juice. Recheck

---			T. in 1 hour.------M. Brown, RN
02-01-09	1420	Fever	R: T. 99.8 orally. Face remains
			slightly flushed. No headache.
			_____M. Brown, RN

Charting by exception

Charting by exception (CBE) was developed in response to problem-oriented charting as a means to free nurses from having to do extensive time-consuming charting. Charting is done intermittently if there are unexpected findings or events. There are 3 main components:

- Comprehensive flow sheets with normal expected findings. Notes are required if the findings vary from those expected. Otherwise, no notation is needed.
- References to pre-established standards of nursing practice.
- Bedside charting with flow sheets left at the bedside so that any health professional can access the information.

Date:	Time:	Progress Notes:
02-01-08	1320	Client complained of frontal headache (2 on
		0-10 scale). Face flushed. T. 102 orally.
		Acetaminophen 500 mg orally and cool
		Compress to forehead, and 400 ml apple
		juice.----------M.Brown, RN
02-01-09	1420	T. 99.8 orally. Face remains flushed but no
		Headache.----------M. Brown, RN

There are some problems associated with CBE:

- Important information, such as changes in wound size, may not be communicated.
- Intermittent charting may not adequately represent subtle changes in condition.
- Since flow sheets are maintained at the client bedside, retrieving information may involve extra time.
- Charting tends to focus on interventions. Problems, such as discomfort while walking, may not be recorded if interventions are not needed.

Nurses using CBE must be aware of the importance of providing full and accurate information about clients.

Critical pathways

Critical pathways are specific multi-disciplinary care plans developed for diagnoses, procedures, or conditions, outlining interventions and outcomes. Not

only are outcome goals delineated but also the pathway lists the sequence and timeline of interventions to achieve the goals. Pathways are developed by interdisciplinary teams that analyze data, literature, and best practices in order to standardize care and achieve optimal outcomes. Nurses, doctors, and other healthcare providers may each have separate or combined critical pathways. Some critical pathways are used as guidelines and may be used to develop flow sheets. Others, those used for charting, are integrated directly with the care plan, and the form requires documentation, including dates and signatures, for each step in the pathway to ensure that interventions are done as scheduled and that outcomes are achieved. In some institutions, the integrated critical pathway/care plan has replaced both the care plan and the nursing notes because the format established allows room for comments and revisions.

There are many different formats for critical pathway/care plans, so nurses using critical pathways for documentation must familiarize themselves with the format used in their institutions. Typically, one critical pathway may have goals for different disciplines, so, for example, physical therapists, occupational therapists, and nurses may all be documenting on the same form. The important element in charting is that any variance must be noted and explained. Usually the intervention that is not performed is circled or otherwise indicated and an explanatory note outlining plans to resolve the problem/issue is made either on the flow sheet or on separate progress notes, depending on the way the critical pathway/care plan is organized.

Care is focused on length of stay; so critical pathways are used with case management for cost-reduction and quality improvement. One advantage of using critical pathways is that the entire course of treatment for a client can be outlined and coordinated at admission. While critical pathways may be established within an institution, standardized critical pathways are available from commercial sources.

Simplified example of variance recording:

Day	1	2 (surgery)	3
Date	03-04-08	03-05-08	03-06-08
Mobility	Pre-surgical Limb exercises 1600	Bed rest	Sit on side of bed Stand with partial wt-bearing x 3 (VC #1)
Signature	O. Clay, PT	O. Clay, PT	O. Clay, PT
Cardiac status	EKG VS admission 126/70-82-20	VS q 2 hours 0800 (Surgery) 1400 142/80-88-16 1600 138/76-86-18	VS q 4 hours 0800 128/82-82-20 1200 130/84-86-18 1600 128/78-84-18
Signature	M. Brown, RN	M. Brown, RN	M. Brown, RN

Variance code			#1	
VARIANCE RECORD				
Date	**Day**	**V C**	**Event/Intervention**	**Sig.**
03-06-08	**3**	**#1**	**Client crying and refused**	**O. Clay, PT**
			to stand to bear weight.	
			States is frightened.	
			Passive exercises done X	
			3 and Dr. Smith notified.	

Critical pathway/care plans are often quite complex and may require considerable education and training before nurses and other staff utilize them correctly.

Link to examples of critical pathways at North Carolina Women's Hospital: <Clinical pathway examples>

An important aspect of critical pathways is continuous re-evaluation and modification if needed. Clients frequently have problems or issues that are not covered by the pathway, so the nurse must be on alert to look for variances and not just accept that the client will follow the pathway. Variances may be used to provide statistical data to determine the efficacy of the critical pathway as well as to evaluate nursing processes.

Computerized

More and more healthcare facilities are moving toward completely computerized systems for documentation. Unfortunately, there are a number of different systems, and sometimes facilities develop their own, so there is no consistency. In an ideal system, all parts of the system are integrated so that physician orders, laboratory reports, pharmacy requests, and nurses notes all use the same system and are cross-referenced. There are a number of different components that may be included in a computerized system:

- **Clinical decision support system (CDSS):** Interactive software systems with a base of evidence-based medical information. CDSS may be used for a variety of purposes, including providing diagnosis and treatment options when symptoms are entered into the system, or monitoring orders and treatments to prevent duplication or unnecessary testing.
- **Computerized physician/provider order entry (CPOE):** Interactive software applications that automates ordering for medications or treatments. Orders must be entered in a prompted format that eliminates many errors. These systems usually include CDSS to provide alerts if there is an incorrect dosage or duplication os order. CPOE eliminates handwritten orders and the information is transmitted automatically to the pharmacy, reducing time needed to order medications.

- **Electronic medical record (EMR):** The computerized client record, usually integrated with CPOE and CDSS, so that all notes are entered electronically. Computer terminals may be at point of care (client's room) or at a central nursing area, but safeguards must be in place to ensure that no unauthorized people can read the notes, so consideration must be given to placement of monitors to prevent inadvertent display of client information as well as to securing terminals in the client's room. In some cases, voice-activated systems may be used in which the nurse speaks into a special microphone and the text is displayed on the screen.

Security and maintenance are important for computerized documentation. Nurses must be trained to use the systems and must understand the need to log off the system to prevent unauthorized use and must know how to make error corrections. Staff should never allow others to use their passwords. This is especially important because most systems can track individual use of the system.

There are a number of clear advantages to computerized documentation:

- Records are clear and legible.
- Errors are reduced.
- Signatures are automatically entered in most systems.
- Record tampering is prevented, and deleting information from the record is difficult.

Summary

Documentation is a form of communication that provides information about the healthcare client and confirms that care was provided. Nurses must be familiar with the NANDA nursing diagnoses, the Nursing Interventions Classification, and the Nursing Outcomes Classification because they are used extensively as the basis for documentation. The Health Insurance Portability and Accountability Act and Privacy Rule provide the right of privacy to the client, and this extends to all forms of documentation related to the client. All charting should be accurate, complete, objective, and timely. There are a number charting guidelines related to vocabulary, descriptions, legibility, errors, and omissions to ensure that charting meets legal requirements and provides an accurate unbiased record of client care. There are many different types of documentation and very little consistency from one organization to another. Some basic formats for documentation include:

- Flow sheets
- Narrative.
- Source-oriented.
- Problem-oriented (SOAP and PIE).
- Focus (DAR).
- Charting by exception (CBE).
- Critical pathways.
- Computerized.

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