

EHR

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Do's and don'ts of defensive documentation

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DOCUMENTING CARE is a basic nursing responsibility, but it's one that nurses often struggle with because of time constraints and challenges associated with electronic health records (EHRs), such as poor user interfaces that leave nurses unclear as to where to document findings. However, taking time to document correctly and completely provides the first line of defense should you be named in a lawsuit.

CONSEQUENCES OF POOR DOCUMENTATION

Documentation issues can have serious legal consequences. [The NSO/CNA Nurse Liability Claim Report \(4th Ed.\)](#) found that failure to document or falsifying

documentation increased in frequency and severity in 2020, compared to 2015 and 2021. The average total incurred professional liability claims by documentation allegations rose from \$139,920 in 2015 to \$210,513 in 2020.

Documentation issues also can impact your license; the board of nursing may take disciplinary action or even rescind a license in the case of documentation maleficence. The NSO/CNA report noted that about half (49.6 percent) of all license protection matters related to documentation involved fraudulent or falsified patient care or billing records. Most nurses would not knowingly engage in these practices, but keep in mind that this category includes situations such as failing

to document care as required by a regulatory agency. Thus, simply omitting information can lead to punitive action.

Finally, deliberately falsifying documentation (such as submitting false claim to Medicare) can subject nurses to sanctions under the federal False Claims Act.

Here are some strategies to follow to ensure your documentation is effective:

Do's

- **Follow organizational policies and local, state, and federal regulations related to documentation.** Failure to do so is a red flag to an attorney.
- **Ensure you are in the correct patient record.**
- **Be accurate.** This may seem

obvious, but a 2020 study by Bell and colleagues found that 21 percent of patients who reviewed EHR ambulatory care notes about them reported an error, with 42 percent labeling the error as serious.

- **Use accepted abbreviations** and medical terminology. One resource is The Joint Commission's list of "do not use" abbreviations, published in 2018. For example, it states to write out "unit" instead of using "U" or "u." Another resource is the Institute for Safe Medication Practices' "List of Error-Prone Abbreviations, Symbols, and Dose Designations."
- **Document positive and negative findings.** Negative findings may be overlooked. For example, nurses know to document signs and symptoms of infection, but they may forget to note the absence of them.
- **Record all care, even if it's "routine."** For instance, regular checks for signs of skin injury around an endotracheal tube should be documented.
- **Document in real time** to help ensure accuracy. In some organizations, you can access the EHR from a secure mobile device you carry with you.
- **Note when you notified other healthcare providers of a change in a patient's condition.** You'll also want to note the response. If the response is inadequate or not appropriate, document that you followed up with another person, such as your supervisor.
- **Document communications with patients and their families/caregivers.** This includes providing education (both verbal and written): If a patient suffers harm as a direct result of not following instructions, this information can

protect you.

- **Use checklists appropriately.** Checklists can save time, but it's easy to move too quickly, accidentally selecting "yes" because several of the previous answers were "yes," when "no" is correct. In addition, remember that checklists are not all-inclusive, so avoid relying too much on them. For instance, an assessment checklist doesn't necessarily cover everything you need to check on a patient.
- **Be cautious of templates.** Templates can help reduce missed care and save time, particularly for routine assessments; however, they are simply a starting point. You still need to ensure you completely assess patients and document care provided.
- **Pay attention to alerts.** Over-riding a valid EHR alert can lead to practice errors.
- **Review entries before submitting** and sign and date each entry. In EHRs, signatures are generally automatic, but you should verify the information is correct.
- **Make documentation changes and corrections per organizational policy.** It's helpful to provide a reason for the change, if possible. Make changes and corrections as soon as possible.
- **Speak up about what's not working.** This is particularly important for the EHR. A well-designed EHR can save time, but one that is not well designed can rob you of time. Even the best EHRs can benefit from tweaking. In some cases, forms can be created or refined to make it easier to document care, or the number of false alerts can be reduced. The IT staff can sometimes make a simple adjustment such as including a new option for recording sputum

findings. Although these simple changes may only save a few seconds, those seconds add up over the course of a day, week, month, and year.

Don'ts

- **Don't share your password** for EHR records.
- **Don't leave blanks in forms.** Use N/A (not applicable) if something does not apply.
- **Don't be subjective.** State only the facts. For example, "patient slurring words, eyes bloodshot" rather than "drunk". In addition to creating potential legal issues, keep in mind that many patients are now requesting their medical records and will see what you have written.
- **Don't be judgmental.** Avoid negative descriptors such as "noncompliant." Be particularly sensitive to possible racial biases. For example, a 2022 study by Sun and colleagues found that Black patients had 2.54 times the odds of having at least one negative descriptor in the history and physical.
- **Don't prechart** (for example, entering information into the EHR before the start of a routine procedure). Situations can change and you may forget to amend the record. For example, during a procedure, a medical device different from what was originally planned may be used. In addition, the EHR keeps track of entries, so anyone reviewing the entry would know the timing was not correct.
- **Don't copy and paste text from one patient record to another.** If you do decide to do this, be sure to carefully review the text and make changes as necessary. Otherwise, you may introduce errors.
- **Don't make late entries.** If you

VALUE OF DOCUMENTATION

It can be easy to focus on documenting in the healthcare record as an onerous task, but in addition to being a legal document, the record provides a tool to:

- Document services provided to patients, their responses to treatments, and caregiver decisions.
- Communicate information about the plan of care and outcomes to other members of the healthcare team.
- Demonstrate nurses' contribution to patient care outcomes. It also helps nurses meet standards of professional practice. For example, to meet standards related to evaluating a patient's progress towards goals, the nurse and others on the healthcare team need to review past documentation.
- Identify areas that need improvement; nurses can work with a team to address quality issues to enhance patient care.
- Provide evidence that an organization is meeting standards set by accrediting bodies that are protecting patients.
- Provide information to ensure proper billing coding so that organizations receive the reimbursement they are entitled to. Proper reimbursement promotes an organization's financial health, enabling it to deliver quality care to patients.

must, be sure to make the late entry per your organization's policy. Remember that the EHR will have a record of each entry, including date and time.

- **Don't assume you have to be the one to document something.** When a new piece of information must be obtained on a regular basis, organizations often automatically

turn to nurses. However, someone else in the organization may be able to collect the data, which helps avoid additional time demands on you, reducing the potential for documentation errors.

PROTECTION THROUGH DOCUMENTATION

Your documentation should include clinical information (such as assessments and responses to medications); patient education; and diagnostic tests, referrals, and consultations. Following the tips in this article will help ensure you cover these areas, thus protecting yourself from legal action and promoting optimal patient care (sidebar). As you document, you may want to keep in mind some of the characteristics of high-quality documentation from the American Nurses Association: accurate, relevant, consistent, clear, concise, complete, thoughtful, timely, and reflective of the nursing process. 🌈

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