

Deliberate Documentation: Strengthening Clinical Practice and Legal Defensibility



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Healthcare

KEY TAKEAWAYS

- **Importance of medical records:** Medical records ensure continuity of care, support treatment decisions and serve as a legal defense tool.
- **Principles of effective documentation:** Maintain accurate, timely and consistent records that reflect high-quality care and professional standards.
- **General documentation tips:** Record objective, relevant and timely information while avoiding references to incident reports or confidential analyses.
- **Documentation of unanticipated outcomes:** Document facts objectively, inform leadership promptly and support staff while following established procedures.
- **Documentation of disruptive patients/visitors:** Objectively describe behaviors, use quotations for accuracy and avoid subjective or stigmatizing language.
- **Documentation DON'Ts:** Avoid hypothesizing, assigning blame or referencing incident reports and personal notes.
- **Documentation DOs:** Record facts, conversations, patient reactions and follow-up plans clearly and objectively.
- **Remember:** Accurate documentation enhances patient care, reduces liability and fosters a culture of safety and accountability.

The medical record is a critical tool for ensuring continuity of care for a patient. It substantiates health conditions, illnesses and presenting concerns while tracking changes in vitals, documenting improvements or deteriorations and recording the timeliness and effectiveness of medications and interventions. A patient's record also serves as a central resource for treatment decisions, competency evaluations and legal considerations such as guardianship and consent.

In addition to its clinical role, the medical record is a legal document. It is the primary source used to assess a clinician's actions. For many matters, including potential allegations, questions regarding care and an actual lawsuit, many parties, including clinical staff, peer reviewers, third-party entities and attorneys, will scrutinize documentation for evidence of delayed, substandard or inappropriate treatment. Poor documentation will undermine credibility, reduce confidence in the medical record and raise concerns about the quality of care provided.

While many clinicians are trained to document defensively, the primary focus should be on maintaining accurate, detailed records that reflect high-quality care. Practicing deliberate documentation means working within your defined scope of practice, job role and professional standards. These guidelines vary based on regulations, laws and institutional policies. Deviating from them can result in claims of negligence if a breach of duty leads to patient harm.

Consistency is also key. Following standard procedures and documenting tasks the same way each time enhances reliability, strengthens the integrity of the medical record and provides protection in legal proceedings. Thoughtful, deliberate documentation is not just a safeguard, it is a fundamental part of responsible, high-quality patient care.

GENERAL DOCUMENTATION TIPS

- Documentation should be objective, factual, non-accusatory and within your scope of practice.
- Document information relevant to the patient's care and treatment, including any changes in acuity, patient assessment or transfer of care, as close to the time of occurrence as possible.
- If an addendum is required, clearly indicate why the documentation is being modified and ensure the new entry is dated, timed and signed.
- Document informed consent discussions, including the risks, benefits and alternatives that were explained to the patient, the patient's questions and responses and the patient's agreement to proceed with the proposed plan of care.
- Record interventions at the actual time they occurred.
- Document the results of interventions. Did the pain medication relieve the patient's pain? Did elevating the extremity after a PIV extravasation reduce swelling?
- If you escalate clinical concerns, document who you spoke with, when, each attempt made, information shared and the response or directives given.
- Ensure your documentation aligns with that of other medical team members and the overall timeline of events.
- Do **NOT** reference incident reports, serious safety events or root cause analyses in the medical record, as doing so may expose privileged and confidential information.



DOCUMENTATION OF UNANTICIPATED OUTCOMES

Unanticipated outcomes require prompt, objective documentation to ensure transparency and clarity in patient care. Proper documentation should focus on facts rather than speculation, ensuring that records accurately reflect events without assigning blame or making subjective statements.

Following an unanticipated outcome, it is essential to immediately attend to the needs of the patient and their family. Leadership, including nursing and division leadership, house supervisor, administrator on call and risk management, should be informed promptly. Support should also be extended to staff members involved in the event, such as through the employee assistance program, recognizing the emotional impact such events can have on healthcare providers and clinical staff. Any medical equipment or supplies contributing to the incident should be sequestered according to established procedures, and if possible, relevant supply information should be retained from packaging. A team huddle should then be conducted with members of the healthcare team to discuss the facts of the incident and assess any disclosure needs.

Documentation DON'Ts

- » Do not hypothesize or place blame.
- » Do not refer to incident reports.
- » Do not keep personal notes.

Documentation DOs

- » Document facts objectively.
- » List all individuals present for conversations.
- » Include what was said to the patient and family, along with their questions and reactions.
- » Record promised follow-up, timeframe and the names of contacts provided.

DOCUMENTATION OF DISRUPTIVE PATIENTS/VISITORS

When documenting interactions with disruptive patients or visitors, start by clearly identifying the individual involved and describing the specific behaviors or statements observed. Objective documentation in these situations is essential. It helps protect staff, supports accountability and creates a reliable record in case a claim or allegation arises later.

Clear, factual entries can establish patterns of behavior, justify necessary interventions and serve as a reference in legal or administrative proceedings. Be sure to note any verbal or physical threats, assaults or injuries.

Factly and objectively document any refusals and failure to adhere to treatment, if it is relevant to the patient's care. This demonstrates that care was delivered appropriately, professional standards were maintained and the clinician responded with composure and professionalism, even when patient or family decisions affected the course of treatment.

- Use quotations, when possible, to capture exact language. If obscenities or profanities are used, include them to accurately reflect the intensity of the situation.
- Record efforts to address disrespectful behavior, including when expectations were set, any interventions or behavior plans implemented and whether those expectations were followed.
- Use neutral language that avoids stigmatizing or labeling the patient.
- Chart specific actions, behaviors and appearances. Avoid subjective interpretations or assumptions.
- Ensure that correspondence (such as letters, administrative notes or external communications) is clearly labeled and distinguishable from clinical documentation within the medical record, whether in paper format or electronic systems.

By consistently applying these principles, clinicians help ensure that medical records remain clear, accurate and defensible. This ultimately improves patient care and reduces risk.

FINAL THOUGHTS

At Gallagher, we recognize that accurate documentation is foundational to patient care, regulatory compliance and risk management. Clear, objective and timely entries not only enhance clinical outcomes but also serve as a reliable defense during legal or regulatory review.

By adopting deliberate documentation principles, healthcare organizations can reduce liability exposure, improve operational efficiency and promote a culture of safety and accountability. Proactive, high-quality documentation protects your practice, supports your patients and strengthens your organization's commitment to excellence.

We welcome the opportunity to collaborate with you. If your team is seeking support with documentation practices and risk mitigation strategies, Gallagher National Risk Control team is here to help strengthen your approach and advance safer care.





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About the Author

Lizzie is a dedicated professional who provides comprehensive clinical risk management support and consultation to clients. Her main goal is to help them develop and implement effective strategies that reduce their overall cost of risk in all aspects of their operations. With her extensive knowledge and expertise in healthcare, Lizzie offers valuable guidance on clinical risk and safety program development. She ensures that clients have robust systems in place to mitigate potential risks and enhance their risk management capabilities.

Lizzie's proactive approach is evident in her dedication to promoting risk management initiatives. She actively engages clients in creating successful solutions that not only serve their bottom line but also foster a culture of patient and staff safety and risk awareness within their organization or entity.

Lizzie began her career as a pediatric nurse in 2008 and joined Gallagher in 2024. She brings extensive experience in the healthcare industry and risk management. With a strong foundation as a registered nurse, Lizzie has a wealth of knowledge in clinical, management and administrative hospital roles, including inpatient, ambulatory clinics and dialysis. Prior to joining Gallagher, she found her passion as a risk manager at Children's Hospital Colorado. In this role, she channeled her expertise into navigating complex clinical and nonclinical risk scenarios and claims management.

Lizzie's educational background includes an M.S. in Nursing Leadership and Management from Regis University, a B.S.N. in Nursing from Regis University and a B.A. in Biology from the University of Colorado, Boulder. She is a registered nurse (RN) and holds certifications as a Certified Professional Healthcare Risk Manager (CPHRM), Certified Pediatric Nurse (CPN) and Nurse Executive Board Certified (NE-BC).

In addition to her professional achievements, Lizzie is an active member of the American Society for Health Care Risk Management. She also served as a board member and secretary for the Colorado Healthcare Associated Risk Managers.

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