Healthcare

VANTAGE POINT®

A Healthcare Risk Management Resource | 2026 Issue 1

Documentation Deficiencies: Crafting a Reliable Record of Care

Comprehensive documentation is central to effective healthcare risk management. First and foremost, a detailed and accurate healthcare information record enhances care by strengthening communication among providers and team members regarding patient/client/resident needs, diagnostic workup, the plan of care, staff observations and interventions, and responses to treatment. In addition, careful documentation has a positive impact on many other organizational processes, including but not limited to the following:

- **Quality assurance and performance improvement,** by gathering the information needed to evaluate the level, quality and effectiveness of care.
- **Regulatory compliance,** by serving as the primary tool by which surveyors, leadership, payors and others can assess adherence to legal requirements, accreditation standards and organizational protocols.
- **Peer review,** by facilitating data collection in such areas as adverse events, provider outcomes, hospital readmissions, drug usage rates, and patient/client/resident complications and mortality.
- **Payor reimbursement,** by capturing and confirming the care and services provided.
- **Legal defensibility,** by providing a real-time, comprehensive, objective and precise record of assessment findings, clinical actions taken and unexpected occurrences in the wake of a claim.

In this issue…

Multiple risk factors can affect documentation quality, including insufficient staffing, inadequate training and flawed digital record-keeping systems. This edition of *Vantage Point*® reviews common documentation errors and presents several case scenarios from across the spectrum of healthcare delivery, focusing on those aspects of care most vulnerable to documentation deficiencies. In each case, practical strategies are offered to maximize the healthcare information record's accuracy, clarity, thoroughness and functionality. Also included is a review of the vital role that sound documentation plays in defending against professional liability claims and regulatory actions brought by state licensing boards.

Coming soon …

***AlertBulletin*® 2026-Issue 1** will address documentation deficiencies specific to the electronic healthcare record. Watch for this publication to post online at https://www.cna.com/industries/healthcare in March 2026.

Common Documentation Errors and Causal Factors

Records that are illegible, inaccurate, delayed, lacking in detail or otherwise deficient can potentially place healthcare organizations, providers and staff members at a serious disadvantage in the event of a lawsuit or regulatory action. The following table reviews the most common documentation pitfalls, along with some of their root causes:

Errors	Root Causes
Failure to track test results (See Case Scenario 1.)	• **Failure to confirm completion of diagnostic tests** and to document reminders to patients/clients/residents of pending tests. • **Failure to identify and document critical, unexpected or abnormal test results** in a concise and unambiguous manner. • **Failure to flag abnormal, life-threatening or critical results** in the electronic healthcare record (EHR) and to verbally notify the provider. • **Failure to notify the patient/client/resident of abnormal results,** leading to lack of essential follow-up.
Lack of response to changes in condition (See Case Scenario 2.)	**Missing, inaccurate or untimely documentation regarding reportable changes,** including the following: • **Detailed observations** of the patient's/client's/resident's condition. • **Test results, specialist evaluations, vital signs** and other relevant diagnostic data. • **Calls made to providers,** as well as orders received and actions taken. • **Notification of family members,** parents/guardians and/or significant others, as authorized.
Failure to pursue a treatment plan (See Case Scenario 3.)	• **Incomplete/missing assessment findings,** care and safety measures, and instructions for patients/clients/residents. • **No clinical rationale given for decisions made,** including failure to escalate observation measures. • **Failure to document notification of family members and other providers of treatment decisions** in the healthcare information record. • **Failure to document proactive safety measures taken** and related considerations.
Incomplete documentation or gaps in care timelines (See Case Scenario 4.)	• **Incomplete documentation,** including such information as treatments given, medications administered and responses to care. • **Poor communication among team members during transitions of care,** resulting in critical information missing from the healthcare information record. • **Technical glitches in EHR systems,** resulting in inaccurate or incomplete data entry.
Failure to follow up (See Case Scenario 5.)	• **No documentation of missed appointments/procedures** in the progress notation of the healthcare information record. • **Failure to fully document informed refusal of care,** including efforts made to convey the potential consequences of non-adherence with care directives. • **Neglecting to document efforts to communicate with non-adherent patients/clients/residents,** whether in person, by telephone or by letter.
Untimely notes	• **Late entries,** leading to inaccuracies when details are forgotten or facts, dates or times are poorly recalled. • **Falsification of the record of care** in the form of unethical and indefensible alterations. • **"Pre-charting" of clinical events,** resulting in falsely dated or incorrect information in the healthcare information record.

Errors	Root Causes
Electronic record lapses	• **Copying and pasting previous entries** into the EHR. • **Conversion errors** stemming from use of a hybrid paper/electronic record. • **Over-reliance on standardized templates,** potentially leading to lack of clinical details. • **Failure to respond to all prompts** on assessment forms, care checklists or flowsheets. • **Overriding of valid EHR alerts,** leading staff to ignore potentially urgent situations.
Poor handoffs	• **Lack of a structured handoff policy** mandating the use of checklists, documented read-backs and computerized sign-offs. • **Failure to utilize electronic scripts designed to facilitate handoffs,** such as the SBAR technique (i.e., **S**ituation, **B**ackground information, **A**ssessment findings and **R**ecommendations).
Failure to note chaperone use	**Lack of chaperone-related documentation,** including … • **Presence of a chaperone during sensitive exams or procedures,** along with the supporting rationale. • **Chaperone's name,** job title and extent of involvement. • **Patient/client/resident consent or refusal,** signed by the individual or authorized proxy. • **Postponement of care** caused by unavailability of a chaperone or refusal to consent. (See *AlertBulletin*® 2025-Republished, "Medical Chaperones: Drafting Effective Policies and Procedures.")
Interpersonal conflicts	• **Inappropriate finger-pointing on record** between providers and team members regarding provision of care. • **Misunderstandings among treatment team members,** resulting in conflicting notations in the record of care.
Privacy breaches	• **Inappropriate disclosure** of protected health information. • **Less-than-secure EHR systems** with inadequate encryption and access controls. • **Failure to train staff on securing data** contained within the record of care.
Insufficient adverse event notation	• **Failure to document unexpected occurrences** in an objective manner. • **Failure to note interventions made** and patient/client/resident response.
Over-reliance on artificial intelligence (AI)	• **Insufficient documented explanation by providers** about how AI decisions can influence clinical decision-making. • **Failure to note AI outputs** and their supporting rationale in the EHR system. • **Failure to use unbiased judgment and critical thinking skills** when accepting AI-generated decisions.

Case Scenarios and Key Takeaways

1. Faulty tracking of test results leading to delayed diagnosis and death.

A 22-year-old morbidly obese female presented to a clinic with a complaint of left calf pain. Based upon assessment findings, a nurse practitioner (NP) ordered a Doppler ultrasound of the left lower extremity to rule out a deep vein thrombosis (DVT). The ultrasound order was intended for the same day, but it was inadvertently entered into the EHR as a routine order. There was no communication between the NP and the medical assistant (MA) regarding the order. As a result, the MA interpreted the order as non-urgent and scheduled it for the following week. The NP's documentation did not reflect her "same-day" intention. The ultrasound revealed a DVT, and the patient was advised to go to the nearest hospital. While awaiting treatment in the emergency department, the patient died of bilateral pulmonary emboli, secondary to the DVT.

A lawsuit was filed, asserting failure to diagnose the DVT. Subsequent discovery focused on the lack of documentation by the NP to support her testimony that she had ordered a same-day ultrasound and informed the patient about the risks associated with a DVT. Defense experts also criticized the NP for adding a late entry to the EHR, noting the need to perform the ultrasound order that day. The case settled in excess of $950,000.

Documentation Takeaways

- **Incorporate built-in "forcing functions" into the EHR** to alert staff to urgent or stat orders.
- **Implement a formal protocol for tracking pending diagnostic tests** and flagging time-sensitive procedures.
- **Document patient/client/resident communications regarding the importance of adherence** to treatment plans and diagnostic testing.
- **Adhere to written protocol when making late entries** and/or addenda to the healthcare information record.

2. Missing documentation regarding a change of condition.

A 75-year-old male resident was admitted to a skilled nursing facility with a history of stroke and limited mobility. Although the resident was identified as being at high risk for pressure injuries (PIs) upon admission, the facility failed to implement evidence-based prevention methods. Specifically, the resident's care plan did not include regular repositioning, the use of specialized support surfaces or adequate skin assessments.

The resident developed a stage 4 PI on his coccyx, extending into adjacent muscle and bone, with associated infection. Despite the wound being visible and malodorous, there was no documented evidence that the nursing staff identified the injury in a timely manner or notified the physician. The resident experienced significant pain and discomfort, negatively affecting his overall health and quality of life.

The facility's failure to implement evidence-based prevention methods, along with lack of documentation regarding detection and treatment of the PI, made legal defense difficult. The total incurred for this case was more than $2 million.

Documentation Takeaways

- **Utilize evidence-based screening tools** and recommendations for prevention and treatment of PIs promulgated by the National Pressure Injury Advisory Panel (NPIAP).
- **Perform and document skin assessments upon admission** and at regular intervals thereafter.
- **Identify relevant PI risk factors** and underlying clinical conditions.
- **Thoroughly document the defining characteristics of wounds,** i.e., location, size, surrounding skin condition, injury margins, wound bed and signs of possible infection.
- **Include evidence-based preventive measures in PI care plans,** including but not limited to proper support surfaces, nutrition and repositioning. (See "Pressure Injuries: Prevention and Intervention Strategies for Aging Services Organizations," CNA Special Resource, May 2024.)
- **Revise the PI care/service plan as needed** in response to clinical changes. (See *AlertBulletin*® 2025-Issue 2, "Change of Condition in Residents: Enhancing Detection and Response.")

3. Failure to properly address suicide risk. A 35-year-old female with a longstanding history of depression was referred for outpatient counseling. At the sixth counseling session, she reported having suicidal thoughts but denied having a plan. The counselor documented that he believed the client was a "danger to self/others" but failed to prepare a safety plan with the client. Two days after the suicidal ideation was noted, the client died by suicide.

Expert testimony was pivotal to the outcome of subsequent litigation. The plaintiff's expert testified that the notation "danger to self/others" implied a serious concern for the client's safety. Defense experts opined that the counselor's observation warranted an updated suicide risk assessment and completion of a written collaborative safety plan. The documentation, which noted the implied risk of suicide but did not mention a treatment plan to address this risk, prompted a settlement in excess of $500,000.

Documentation Takeaways

- **Perform and document suicide risk assessments at the start of treatment and at key points in therapy,** such as inpatient admission, changes in condition, and transitions between inpatient and outpatient care. Thoroughly record all assessment findings and safety measures taken.
- **At the outset of counseling, inform the client about situations in which confidentiality protections may not apply,** such as when foreseeable harm to self/others is noted. (See the 2014 American Counseling Association [ACA] Code of Ethics, as well as state and federal statutes.) Document these discussions and obtain a signed statement confirming that the client understands these exceptions.
- **Ask questions regarding suicidal ideation openly,** and ensure that the counseling plan aligns with the risk assessment findings.
- **Use an evidence-based suicide risk assessment tool** and consider co-occurring issues that may increase the client's level of suicide risk, such as depression, substance use disorders and access to lethal means. (See Appendix A in the linked resource.)
- **When working with clients, utilize a safety planning template to identify possible warning signs of a developing crisis,** as well as protective factors and coping strategies. (See Appendix B in the linked resource.)
- **Create and document the safety plan during the same session** in which suicidal ideation is identified.
- **Discuss the potential for impaired judgment and altered cognition in a crisis,** as part of the safety planning process.
- **Adhere to state-specific legislation regarding the duty to protect/warn,** and practice in compliance with the standard of care and state licensing/certifying board requirements. If more than one standard of care, law or regulation applies, adhere to the most stringent applicable standard.
- **Perform comprehensive client assessments** and document both current complaints and a client history in order to determine the proper diagnosis, as noted in E.5.a. of the ACA Code of Ethics.
- **Document all discussions of suicide risk** among providers, staff, patient/client/resident and family.

Quick Links to CNA Resources

- *AlertBulletin*® 2025-Issue 3, "Treatment Teams: A Keystone of Healthcare Safety Culture."
- *CareFully Speaking*® 2022-Issue 2, "Resident Documentation: Creating a More Useful Record of Care."
- *inBrief*® 2025-Issue 2, "Delegation: A Brief Guide to Safely Transferring Healthcare Tasks."
- *inBrief*® 2022-Issue 2, "Diagnostic Errors: Common Causes, Effective Countermeasures."
- *Vantage Point*® 2024-Issue 1, "Medical Error Prevention: Reinvigorating Patient Safety Measures."

4. Incomplete documentation and falsification of the record, leading to permanent injury.

A 40-year-old patient presented to a clinic and requested Phentermine for treatment of longstanding obesity. A nurse practitioner (NP) informed the patient that the drug could not be prescribed due to elevated blood pressure. The patient returned to the clinic the next day and again requested the drug. Clinic coverage on that day was delegated to an unlicensed medical assistant, who reviewed the NP's previous progress note and decided to dispense the drug because the patient's blood pressure had decreased slightly. Ten days after initiating the drug, the patient suffered a stroke due to an intracranial bleed and was left with a permanent neurological deficit. The attending neurosurgeon documented that the stroke was due to hypertension in relation to Phentermine use.

A lawsuit was filed, asserting that the NP failed to conduct and document a complete assessment and obtain the patient's informed consent (IC) before prescribing the drug. In deposition, the NP testified that she advised the patient to follow up with her primary care physician regarding treatment of hypertension. However, the progress note did not support this contention. Instead, it indicated that the patient had been told to return the following day for a blood pressure check, and that the drug would be dispensed if the results were in the normal range. Despite the NP's testimony that existing documentation did not accurately reflect her discussion with the patient, the discrepancy diminished her credibility, as did a self-serving late entry by the NP in the EHR, in which she attempted to amend her original notation. A settlement was negotiated for over $975,000.

Documentation Takeaways

- **Incorporate structured documentation formats into the EHR** to maximize accuracy and clarity of records.
- **Digitize the handoff reporting process** to help staff convey and recall vital information about the plan of care.
- **When delegating care to unlicensed personnel, ensure that the healthcare information record reflects, at a minimum:** the nature of the assigned task, objective assessment findings, pertinent observations and supervisory progress notes.
- **Memorialize IC discussions using a standard form that discloses the nature of the proposed care,** as well as potential complications and other risks, probable consequences of refusing treatment and available alternatives.
- **Supplement the IC discussion with a progress note in the healthcare information record,** noting the content of the discussion, questions asked and answers given, names of staff and/or family members present, educational materials provided, and whether the patient/client/resident agreed to or declined the recommended treatment.

5. Failure to follow up with a patient resulting in delayed cancer diagnosis.

A 58-year-old woman was evaluated by a physician assistant (PA) for postmenopausal bleeding. A pelvic exam revealed a retained intrauterine device (IUD). Diagnostic tests included an ultrasound, which showed a thickened, sponge-like endometrial lining with a possible blood clot, as well as a Pap smear, which was negative for intraepithelial lesions or malignancy. An endometrial biopsy could not be performed at the visit due to the presence of the IUD, prompting the PA to schedule a dilation and curettage (D&C) procedure for its removal, as well as a biopsy to rule out endometrial cancer. The patient was given preoperative instructions by staff, as well as the address of the surgery center. The PA also advised the patient to return two weeks after the procedure to review the results and discuss the next steps. The patient failed to return to the office and did not respond to numerous follow-up efforts, including three phone calls and two letters, all of which were documented in the healthcare information record.

Approximately 10 months later, the patient was diagnosed with endometrial carcinoma and underwent a total hysterectomy. A subsequent lawsuit alleged that the diagnostic delay resulted in progression of the cancer and required a more aggressive form of treatment. Expert testimony corroborated that the PA had documented his discussion with the patient regarding the risks, benefits and alternatives of the D&C, as well as the need for the patient to comply with follow-up directives. However, the expert opined that the PA failed to advise and document the explicit risk of cancer, contrary to his deposition testimony, wherein he explained that his notation about "follow-up care" indicated a suspicion of malignancy in the context of postmenopausal bleeding. The case was settled in mediation for under $100,000. Of note, the relatively low settlement amount reflected the thoroughness of the PA's documentation of follow-up communication with the patient.

Documentation Takeaways

- **Utilize online resources and educational tools during the IC process** to clarify and reinforce key messages and major risks, and document their use in a progress note.
- **Document communications with patients/residents/clients in detail,** including treatment-related instructions and the risks associated with non-adherence.
- **Have staff members witness important discussions,** whenever possible, and document their names and titles in the healthcare information record.
- **Attach a copy of preoperative instructions to the care record,** making sure that they clearly convey the severity of the condition and the risk of not pursuing treatment.
- **Document any correspondence with patients/clients/residents regarding non-adherence,** placing a copy in the healthcare information record.

Effects of Documentation Practices on Litigation and Regulatory Actions

Sound documentation can significantly influence the outcome of professional liability claims and regulatory investigations, as described below:

Jurors' perceptions. A well-documented and organized healthcare information record may positively influence a jury by strengthening provider credibility, thus enhancing the effect of subsequent testimony. Comprehensive records create an impression of conscientiousness and conformity with accepted standards and protocols, while records with noticeable gaps tend to create doubts among jurors about attention to quality and patient/client/resident safety.

When examining the healthcare information record, jurors typically look for a clear timeline of events, valid rationales for medical interventions and evidence of close coordination within the care team. These core elements of documentation, among others, help jurors better understand the basic medico-legal issues at stake and the complexities of clinical decision-making.

Licensing challenges. Documentation also plays an important role in state licensing board actions. Sound records help establish the appropriateness of care delivered and the professionalism of the provider, while also demonstrating compliance with accepted documentation and billing standards.

While most complaints to state boards relate to quality-of-care concerns and/or unprofessional conduct, investigations can lead to secondary allegations based upon observed deficiencies in documentation. The following documentation-related guidelines, among others, can help minimize this risk:

- **Document compliance with evidence-based standards of care** when notating treatment in the healthcare information record.
- **Include communications with other healthcare providers** and members of the treatment team, in order to ensure that documentation reflects a commitment to teamwork and continuity of care.

Incomplete or inaccurate documentation can not only compromise safety, it can also create legal defensibility challenges, even when the patient/client/resident has received appropriate care. Healthcare providers can help improve continuity of care and reduce exposure to professional liability claims and regulatory actions by being aware of common documentation lapses and recommended risk management strategies, as described in this article.

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