Clinician.com
Healthcare Risk Management

Documentation Do's and Don'ts: Know What Really Matters

January 1, 2026
By Gregory Freeman

Executive Summary

Documentation can prove crucial for defending claims or addressing safety issues. Clinicians should understand best practices and mistakes to avoid.

- Poor documentation can work against the defense.
- Document thoroughly but avoid opinions.
- Be wary of overusing convenience functions in electronic health records.

"Document, document, document!" is the mantra of healthcare risk management. If it was not documented, did it really happen? If it was documented, was it documented properly? Knowing the right and wrong ways to document can make the difference when defending a malpractice claim or conducting a root cause investigation.

Clinical documentation is both an art and a science, says Anne Hirsch, MD, an internal medicine physician in West Linn, OR. It is how clinicians think on paper and, increasingly, how their actions are judged, she says. In an era of electronic health records (EHRs), interoperability, and heightened patient access to notes, she says documentation serves multiple masters: patient care, billing, compliance, communication, and legal protection.

"For risk managers and defense attorneys, the medical record is the single most important artifact in any malpractice claim. It is both the clinician's best defense and, if poorly done, their greatest vulnerability," Hirsch says. "A well-documented record tells a coherent, contemporaneous story of sound reasoning and compassionate care. A disorganized, judgmental, or inconsistent record tells a very different story."

Hirsch offers this list of the essential do's and don'ts of documentation, common misconceptions, and the elements that make both risk managers and defense attorneys either groan or breathe a sigh of relief.

The Best Practices

Document contemporaneously.

Timeliness is critical. Document as close to the time of the encounter as possible. Notes created hours or days later — especially after an adverse event — raise questions about accuracy and

credibility. If delayed, make that explicit ("Late entry: documented on 10/20/2025 to reflect visit on 10/18/2025 due to weekend call volume").

Timestamp metadata can be examined in litigation. A clearly labeled late entry is defensible; a backdated one is not, she says.

Record objective facts, not opinions.

Describe what you observe, hear, and do — not what you think of the patient, colleague, or situation. Use precise, clinical language rather than subjective or emotional terms. Replace "patient was uncooperative" with "patient declined to complete physical exam after explanation of its purpose."

Objective documentation preserves your credibility, Hirsch says. Jurors and peer reviewers equate tone with professionalism.

Document clinical reasoning.

A note that simply lists findings and actions without explaining why decisions were made leaves your judgment open to interpretation. Briefly state your rationale — especially when you deviate from standard pathways or choose to defer a test or treatment.

Example: "CT deferred due to stable neuro exam, low suspicion for intracranial pathology, and patient preference after discussion."

In legal review, a clinician's reasoning often becomes the central question, Hirsch says. Documenting it contemporaneously shows thoughtful care, not hindsight justification.

Capture informed consent and patient communication.

Record key aspects of discussions about risks, benefits, and alternatives. When patients refuse care, document the discussion in detail.

Example: "Discussed recommendation for colonoscopy given age and family history. Patient declined at this time, acknowledging potential risk of delayed diagnosis."

Informed refusal documentation is one of the strongest defenses against "failure to diagnose" claims, she says.

Include coordination and follow-up details.

Document calls, messages, handoffs, and orders placed. When responsibility transfers, note to whom and when. Include time-sensitive follow-up plans ("Patient to follow up with cardiology within two weeks; office staff to confirm appointment.")

Many malpractice claims stem not from a single clinical decision, but from breakdowns in follow-up or communication, Hirsch says.

Review, verify, and reconcile.

Ensure that medication lists, allergies, problem lists, and test results are up to date. Discrepancies across notes — especially in EHRs where data is auto-populated — can create dangerous confusion and legal exposure.

Use late entries and addenda appropriately.

If you must add information later, clearly label it as an addendum, include the date/time, and do not modify or delete the original entry.

Keep it professional and patient-centered.

Assume your patient, their attorney, and a jury will one day read your note. Maintain a neutral, respectful tone even when documenting challenging interactions.

Document everything that you considered and offered the patient, even if they declined. This is helpful to ensure that your documentation matches the code that you selected for that encounter, and frequently allows you to use a higher level of service for that encounter as well, Hirsch says.

The Don'ts: Pitfalls that Undermine Credibility and Increase Risk

Never alter or backdate a record.

Any appearance of record tampering can be catastrophic. EHR metadata logs are easily retrieved in litigation, and discrepancies destroy credibility even in an otherwise defensible case.

Don't use judgmental or inflammatory language.

Avoid labeling patients as "noncompliant," "difficult," or "drug-seeking." Instead, describe the observable behavior: "Patient declined to take prescribed medication, expressing concern about side effects."

Derogatory or emotionally charged notes not only sound unprofessional but can bias future care and harm your defense, Hirsch says.

Don't copy and paste blindly.

Cloning text from previous encounters without verifying accuracy is one of the most common and most dangerous documentation habits, she says. Copying old vitals, exam findings, or problem lists can perpetuate errors.

Don't document speculation or blame.

Avoid guessing about another clinician's decision or attributing motives. Instead, focus on your own assessment and plan.

Don't chart for others.

Each entry should reflect who provided care and who documented it. Signing for another clinician, even with consent, creates serious legal and ethical risks, Hirsch says.

Don't use vague, filler, or contradictory phrases.

Entries like "patient stable" or "monitoring" are meaningless without context. Be specific: "Hemodynamically stable, HR 80, BP 122/74, no dyspnea."

Don't assume EHR templates protect you.

Templates save time but often include unchecked boxes or auto-populated statements that can conflict with free text. Review every entry before signing, Hirsch advises.

Dispel the Documentation Myths

There also are a number of misconceptions about documenting, Hirsch says. She cites these most common misconceptions about documentation:

Myth #1: "If it's not documented, it wasn't done."

Although this phrase is widely repeated, it is an oversimplification, Hirsch says. The truth: Undocumented care is difficult, but not impossible, to defend. However, the absence of documentation shifts the burden of proof to you. The safest course is to ensure that key steps and decisions are documented.

Myth #2: "More documentation equals better protection."

Excessive, redundant, or copied text can obscure the essentials, she says. Quality, not quantity, matters most. A concise, coherent note demonstrating clear reasoning is far more persuasive than a multi-page printout full of boilerplate text.

Myth #3: "Electronic records are self-explanatory."

EHRs contain vast data, but they do not capture the nuances of clinical judgment, communication, or context, Hirsch says. A well-crafted narrative note remains irreplaceable.

Myth #4: "Charting after an adverse event is risky."

In fact, failing to document your response to an adverse event is riskier, she says. The key is to chart accurately, clearly label any delayed entries, and avoid speculation about cause or fault.

Myth #5: "Documentation is only for protection."

While legal protection is one purpose, the primary goal is continuity of care and communication. Good documentation improves safety and teamwork, which in turn reduces the likelihood of litigation.

Avoid the Biggest Mistakes

Risk managers can alert clinicians to the biggest mistakes made with documentation and how to avoid them. Hirsch says these are some of the biggest pitfalls:

Inconsistency across notes. Contradictions between clinicians' documentation, such as "normal exam" vs. "abnormal finding," can create confusion and credibility issues.

Failure to update plans. Notes that repeat "continue current regimen" for months without evidence of review suggest inattentiveness.

Neglecting follow-up. Missed test results, untracked referrals, or absent callback documentation are among the top sources of malpractice claims.

Omitting discussions about uncertainty. Jurors expect clinicians to acknowledge uncertainty and risk — not perfection.

Incomplete handoffs. Documentation that fails to specify who will follow up, when, and how invites system failures.

Poorly worded patient portal notes. Since patients now have access to their notes, language that feels judgmental or dismissive can lead to complaints and mistrust.

When defense attorneys review records, they look for coherence, professionalism, and integrity, Hirsch says. She says these issues reliably elicit groans:

- **EHR "note bloat."** Ten pages of irrelevant or copied text make it nearly impossible to find the real story.
- **Contradictions between entries**. Two notes on the same patient with opposite assessments, often from copy/paste, can be devastating.
- **Lack of follow-up.** A lab result flagged as "abnormal" with no documented acknowledgment is a red flag.
- **Blame-shifting language.** "The nurse failed to notify me" or "radiology didn't call" can turn a defensible event into a finger-pointing exercise.
- **Angry or sarcastic tone.** Notes that read like venting ("patient refused again as usual") make juries question the clinician's professionalism and empathy.
- **Metadata manipulation.** When time stamps do not match the narrative, it raises the specter of post-hoc editing — a credibility killer.

On the other hand, Hirsch says there are elements that can reassure the risk manager that the documentation will be helpful. She says these are things that will reassure the risk manager:

- **Clear, logical chronology.** A record that tells a consistent, chronological story is powerful evidence of organized, competent care.

- **Rationale for key decisions.** When your thought process is visible, reviewers see professionalism rather than negligence.
- **Timely communication documentation.** Noting calls, messages, and consultations demonstrates diligence and teamwork.
- **Evidence of informed consent and refusal.** Records that show patients were informed participants in decision-making strongly support the defense.
- **Consistent tone and professionalism.** A calm, factual, compassionate note signals integrity and earns the trust of jurors and experts alike.

EHRs have standardized care but also introduced new documentation risks, Hirsch says. Clinicians should be encouraged to avoid auto-fill errors because default phrases can contradict custom text. EHRs provide audit trail discoverability because every edit is logged and retrievable.

Copy-forward issues can happen with EHRs, as small inaccuracies compound over time, she says. Alert fatigue is another risk with EHRs, Hirsch says, because ignoring repeated prompts without documentation can appear negligent.

“Clinicians should use EHRs as a support tool, not a substitute for clinical judgment,” Hirsch says. “Regular audits and training on documentation best practices are essential.”

Hirsch advises remembering a simple rule of thumb: Write every note as if it will one day be read aloud and displayed on a 12- x 10-foot screen in a courtroom. That mindset naturally leads to professionalism, objectivity, and clarity, she says.

“The medical record is both a communication tool and a legal instrument. Its audience includes colleagues, auditors, patients, and — sometimes — a jury. The best documentation shows that you cared, thought critically, acted promptly, and communicated clearly. The worst documentation obscures those facts,” Hirsch says. “In risk management, the record doesn’t just defend the clinician — it defends the quality and integrity of care itself.”

Paint an Accurate Picture

The key goal for documentation is to paint an accurate and complete picture of the patient’s care, says Jennifer Flynn, CPHRM, risk manager with Nurses Service Organization in Fort Washington, PA.

“When we look in the records, when we’re trying to build a defense, we say the goal here is that the documentation should reflect accurate, timely, complete records. It goes through your patient assessment, your interventions, the patient’s response, the technique or the modality that you used in treating that patient,” she says. “Nurses and other providers alike need to realize that when they sign that progress note or close out that record, the accuracy, the timeliness, the completeness, and their objectivity is what’s going to remind them when they’re being asked questions about their treatment and care decisions.”

Those questions may include why they made that decision, how the patient responded, and whether it was in line with widely accepted practices at the time of the incident, she says. The documentation helps answer those questions better than pure memory, Flynn says, because it can take months or years for a claim to be filed.

"If you look up the statute of limitations for medical malpractice in any state across the country, it usually is around two or three years or more for an adult patient, and could be quite longer for a pediatric patient or a minor patient. So when you tack on the time that it might take for a person to file a liability lawsuit against the time to litigate that claim, it could be four years down the road or more where you're having to be answer questions," Flynn says. "What's going to help with that recall is the record. What's going to create that timeline of care? It's going to be the record. What's going to remind you of the observations that you had at the time that you were giving care, and the decisions that you made, and why you created that record in the first place? It's going to be found in the record."

Clinicians can get in the habit of poor documentation over their careers, Flynn says. They hear others passing on misconceptions about how it is necessary only to document certain things or that documenting by exception is acceptable.

"I think sometimes, and even in the electronic record these days, they might not have the ability to write a narrative that is explaining that treatment and care. For documentation, the nurse needs to know that that's their protection from these allegations, and to provide a rebuttal to these allegations that you as a nurse did what you said you did relative to that treatment and care," Flynn says. "I know these days that with electronic records, there are a lot of time-saving measures that providers employ, like copying and pasting, but maybe what providers don't realize is that once that note is copy and pasted forward and is put into the record, it still needs to be reviewed for accuracy, for completeness, for any edits that need to happen since that last note was created."

When the clinician signs off on that record, they are attesting to its accuracy and completeness, she says.

"Where we see pitfalls in the defense of some of these cases is that these notes are pulled forward and nothing has changed in them," Flynn says. "Though the patient or client might be declining in health, its not reflected in the record, and that record needs to tell the story of the patient's changing condition."

Documentation can make all the difference in showing that a clinician acted appropriately, says Nick Bach, PsyD, a psychologist in Louisville, KY. He has worked with clinicians navigating malpractice cases and has seen firsthand how poor documentation can complicate defense efforts and damage patient trust.

His first word of advice is to avoid assumptions. The second is to write for the jury.

“I always inform clinicians that notes aren’t merely for other providers; they are legal records that may be read out in court,” Bach says. “Documentation needs to be factual, objective, and timely while steering clear of vague words like ‘patient appears fine’ or judgmental ones such as ‘non-compliant.’”

One of the greatest mistakes Bach has witnessed is copy-pasting from preceding notes, which may include outdated or irrelevant information prejudicial to credibility.

“Another almost certain way to increase your legal exposure is backdating or altering entries after the fact,” he says. “Sarcasm or emotional commentary in the record is anything that makes a good defense attorney break out in cold sweats. I’ve seen comments like ‘patient is being dramatic’ turned against the clinician.”

The other famous misconception is that less documentation equals less liability, Bach says. On the contrary, incomplete records appear to suggest negligence or concealment, he says.

“Should teams do periodic chart audits on their own?” Bach asks. “Not necessarily as a punishment, but so as to inculcate good habits, ideally well before a claim can ever come up.”

It is a best practice for clinicians to document their clinical findings, assessment, reasoning, and treatment recommendations objectively and promptly at the time of patient care, ideally within 24 to 48 hours, says Elizabeth L.B. Greene, JD, partner with Mirick O’Connell in Worcester, MA. Centers for Medicare and Medicaid Services (CMS) guidelines include that documentation should be sufficient to justify the services rendered or the level of care billed. Accurate records are essential for continuity of care, as other clinicians may rely on that documentation soon thereafter, particularly in acute or complex cases. Clinicians also should remember that federal and state laws give patients the right to access much of their own medical information.

The quality and completeness of a provider’s documentation can affect patient care, billing compliance, and risks for legal exposure, she says. Deficient documentation may impair care coordination and also may influence whether a patient or their counsel perceives substandard care and pursues litigation.

Common pitfalls include overuse of the electronic medical record (EMR) “copy/paste” feature and “cloned notes,” which can perpetuate overdocumentation and outdated/inaccurate information, which may obscure the actual course of care, Greene says.

“This erodes confidence in the reliability of the record for the treating physician themselves, subsequent physicians, patients, and their counsel, as they may be unable to determine what care was provided when, and the source of information in the record,” she says. “In litigation, credentialing or licensure investigations, or audits, ‘cloned’ and untimely documentation adds to the risk of exposure as it undermines the reliability of the record and the credibility of the provider.”

Greene says other common documentation issues include not documenting the rationale or clinical basis for patient care and treatment decisions, particularly when they may be inconsistent with a specialist's recommendation; unexplained inconsistencies between providers' notes, including those from the same encounter; inaccuracies or omission of significant discussions with patients or consultants; not documenting the risks, benefits, and alternative treatment options when obtaining a patient's informed consent or a patient's refusal of care; not documenting follow-up instructions given to patients, particularly when there is a risk of serious harm to the patient; not documenting tests ordered and results, medication changes, allergies, missed appointments, the provider's efforts to address non-compliance; and co-signing or countersigning a note that has not been personally reviewed.

"An additional pitfall for providers is documenting criticisms of another provider's prior treatment recommendations or diagnoses," she says. "Taking care to avoid these pitfalls in documentation strengthens both patient safety and the provider's defensibility in a claim or investigation."

Plaintiff's attorneys and investigators often request EMR audit logs, which create a detailed evidentiary path for assessment of care issues, and sometimes privacy breaches, Greene says. Significantly, the audit trail shows who accessed a record, what changes were made, by whom, and when. Alterations/additions to the patient's medical record, particularly after notice of a claim, are among the most concerning issues that may be found in a malpractice case, she says.

"Even if the information added is accurate, metadata in the EMR will reflect the timing of the change and is likely to be construed by plaintiff's counsel as an attempt by the defendant provider to alter evidence to make it more favorable to the provider," Greene says. "Record alterations can make a case more difficult and expensive to resolve. Providers facing this situation of wanting to alter or add to the record after notice of a suit should consult risk management or legal counsel before making any changes."

Accurate, timely patient documentation remains both a cornerstone of quality patient care and part of a clinician's strongest defense in any subsequent inquiry, Greene says.

Clinicians should always make sure they are documenting on the correct patient, says Megan J. Nelson, JD, an attorney with the law firm of Marshall Dennehey in Orlando, FL.

"This seems obvious, but clinicians have a difficult job of balancing their time between patient care and documentation. When the shift is busy, patient care takes priority, and charting may be delayed," she says. "The clinician may begin to rush through the documentation without focusing on what they are actually documenting. Before hitting save, clinicians should always review what was charted and ensure that there aren't any mistakes."

Clinicians should never document their opinions, Nelson says. Opinions can be misinterpreted and are difficult for the clinician to explain the reasoning for years after they have been

documented. A medical record should only contain facts regarding the patient's condition and the care being provided, she says.

A big mistake is rushing through the charting and not paying attention before saving the entry, Greene says.

"Some clinicians will copy and paste from the previous provider's notes and make edits. However, the previous provider may have made a mistake that wasn't caught during the edits," Nelson says. "I have seen clinicians document for four days that a patient had a fever, causing that patient's surgery to be pushed off. In reality, the patient had a fever four days prior, but the following three days, the patient had no fever."

Never underestimate the importance of good documentation, Nelson says. But also, it is true that not every single detail can be documented, she says.

"People say if it wasn't documented, it wasn't done. Just because something wasn't documented doesn't mean it wasn't done," she says. "The provider doesn't document that they washed their hands before entering the room, but they still washed their hands before entering. Each case is different, but clear and correct documentation is always helpful."

Greg Freeman has worked with Clinican.com and its predecessor companies since 1989, moving from assistant staff writer to executive editor before becoming a freelance writer. He has been the editor of Healthcare Risk Management since 1992 and provides research and content for other Clinician.com products. In addition to his work with Clinician.com, Greg provides other freelance writing services and is the author of seven narrative nonfiction books on wartime experiences and other historical events.

Sources

- Nick Bach, PsyD, Louisville, KY. Email: nickbachpsyd@gmail.com
- Jennifer Flynn, CPHRM, Risk Manager, Nurses Service Organization, Fort Washington, PA. Telephone: (215) 773-4513. Email: jennifer.flynn@aon.com
- Elizabeth L.B. Greene, JD, Partner, Mirick O'Connell, Worcester, MA. Telephone: (508) 860-1514. Email: egreene@mirickoconnell.com
- Anne Hirsch: Anne Hirsch, MD, Consultant, Health e Practices, West Linn, OR. Email: Anne@healtheps.com
- Megan J. Nelson, JD, Marshall Dennehey, Orlando, FL. Telephone: (407) 420-4380. Email: mjnelson@mdwcg.com