



Healthcare

# Defensive Documentation

## Using the Assessment Process to Establish a Stable Framework

### Executive Summary

Defensive healthcare documentation is essential for patient care and legal protection. Insufficient documentation can lead to misunderstandings, disputes, and higher liability risks. By using assessment processes as a documentation framework, healthcare providers create thorough health records supporting legal defense, continuity of care, and improving patient outcomes.

### Highlights of Defensive Documentation

Defensive documentation starts at or before admission when team members gather information about incoming patients. It's important to pay close attention to patient details such as allergies, potential medication interactions, indications of sepsis, and changes in mental status — areas that are sometimes overlooked during the admission process.

### Assessment and Care Plans

Assessing a patient and documenting findings requires using objective measurements and data to support observations. Assessments start upon admission and should be regularly updated throughout the patient's stay<sup>1</sup>. This helps ensure the patient's needs and goals are addressed. Accurately documenting and updating vital signs, medical history, and the patient's current health status is crucial for responding promptly and appropriately to changes in condition.

Assessments play a key role in understanding and treatment of the patient's diagnoses. Medical judgment should be clearly documented and linked to the assessment<sup>2</sup>. Using standardized medical terminology can clarify the treatment rationale and offers legal protection by connecting specific interventions to assessments based on professional standards.

Comprehensive care plans should address identified diagnoses and patient needs. Care plans should be objective, with clearly defined measurable goals and expected outcomes, and should align with evidence-based practices. Clear and concise documentation facilitates better tracking of patient progress and provides support in defending the quality of care provided.

Care plans should frame the patient centered interventions provided and patient responses in real-time<sup>3</sup>. It's important to include specific details about the interventions provided, timeframes, and patient reactions. Many healthcare professionals are familiar with the saying, "If it wasn't documented, it didn't occur." While this may not always be true, it is easier to track the care provided when documentation is done routinely, rather than "by exception". Documentation by exception can leave gaps in the clinical record, which may give the false impression care or treatment was not provided, even though it was.

### Refusals of Care

Documenting a patient's refusal of care is critical. Despite best efforts, patients and/or responsible family members may choose to forego recommended medication, treatment, and care. When this occurs, the documentation should be precise, including date(s), time(s), details and rationale of the refusal(s).

It is essential to document the informed consent process, including the risks, benefits, and potential consequences of the care and treatment, and the patient's or family's understanding. The patient's capacity should be regularly evaluated and documented, along with details on how the information was communicated (e.g., verbally, in writing, via audio, etc.). A follow-up plan should also be included, which may involve notifying the physician and responsible party, as needed.

## Evaluation

Continually assessing the effectiveness of interventions and making updates to the care plan is essential. Clearly explain the rationale for any modifications to the original plan based on the patient's progress and treatment goals. Throughout the patient's stay, document all communications with the physician, other healthcare professionals, the patient or the responsible party, as applicable.

## Conclusion:

Clear, comprehensive, and accurate documentation improves patient safety and helps protect healthcare providers from liability. Adhering to a standardized assessment process (assessment, diagnosis, planning, implementation, and evaluation) ensures a detailed and precise medical record, which can be valuable in defending against potential liability. Ongoing training in documentation practices and understanding legal implications can further enhance healthcare providers' ability to manage risks effectively.

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## References:

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<sup>2</sup> Smith, J. A., & Brown, L. (2020). Importance of thorough patient assessment in healthcare documentation. *Journal of Nursing Law*, 25(2), 45-57.

<sup>3</sup> Garcia, T. H., & Lee, N. (2020). Effective care planning as a defensive strategy in nursing. *American Journal of Nursing*, 120(5), 34-40.

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