

Late Entries

A late entry only applies to documentation within the EHR that is entered after the point of care.

Case Scenario: A nurse on the general medical/surgical floor completes an intake assessment for a new patient to the unit. She is called away to care for an emergency with another patient and forgets to document the assessment within the electronic record at the end of her shift. The next day, she reports for her shift and enters the information at that time.

Concerns: Visit documentation was not completed in a timely manner, requiring the clinical provider to document information about the visit as a late entry or after the visit is locked. In order to place the documentation in the proper place in the EHR the visit may have to be “unlocked.” In addition, the late entry may not be readily identifiable. It may or may not appear in the correct chronological order.

Practice Guidelines: Any clinical provider documenting within the health record may need to enter a late entry. The organization should clearly define how this process occurs within their system. Tracking and trending within the electronic record will be dependent on the system; the organization should clearly understand this process. In addition, specific policies and procedures should guide clinical care providers on how to correctly make a late entry within the health record. The author should document within the entry that it is a late entry.

Typically late entries apply to direct documentation only; for example, physician orders, progress notes or nursing assessments. Dictated report such as history and physicals, although dictated outside of organizational time frames, would not be considered a late entry.

Note: *Some systems may not have late entry functionality. The late entry is shown as an addendum.*