Legal Aspect of Nursing Documentation: Perspectives from the Alabama Board of Nursing

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Disclaimer

- The views and opinions expressed here do not necessarily reflect those of the Alabama Board of Nursing and/or the State of Alabama.
- Nothing in this presentation is intended to be, nor should it be relied upon as, legal advice. Participants should seek the advice of their own attorneys.

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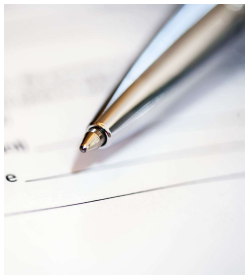
Objectives

- Describe the ABN standards for nursing documentation.
- Discuss the grounds for discipline of a nursing license based on documentation issues.
- Apply the ABN standards for nursing documentation to factual scenarios.
- Demonstrate understanding of the ABN's nursing documentation standards as applied to emerging technologies.



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ABN Standards for Documentation

ABN Administrative Code § 610-X-6-.06:

(1) The standards for documentation of nursing care provided to patients by licensed nurses are based on principles of documentation, regardless of the documentation format.

(2) Documentation of nursing care shall be:

(a) Legible.

(b) Accurate.

(c) Complete. . . .

(d) Timely. . . .

(e) A mistaken entry in the record by a licensed nurse shall be corrected by a method that does not obliterate, white-out, or destroy the entry.

(f) Corrections to a record by a licensed nurse shall include the name or initials of the individual making the correction.

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Legible.

"What one person finds difficult to read, another might decipher with context. However, in a medical or legal context, illegibility generally refers to handwriting that cannot be reliably and accurately interpreted by other healthcare professionals or reviewers involved in the patient's care or subsequent legal analysis. This includes:

- Indecipherable letters or words
- Ambiguous numbers (e.g., confusing a '1' for a '7', or 'mg' for 'mcg')
- Unclear abbreviations or jargon
- Overlapping script or notes crammed into small spaces."

How does illegible handwriting in medical records cause problems in legal cases?

https://medicalrecordsreview.com/illegible-medical-records-legal-cases/
(last accessed May 5, 2026).

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Why is legibility important?

PT rpts kwgt SH PN lt ROM. RT PT.

PT	PN	SH	ROM	RT
• Patient • Physical Therapy	• Peripheral Neuropathy • Pain • Postnatal	• Social history • Self harm • Shoulder	• Range of Motion • Rupture of Membranes	• Refer to treatment • Right • Respiratory Therapy

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Possible Interpretations

PT rpts kwgt SH PN lt ROM. RT PT.

- Patient reports ???? Surgical history for peripheral neuropathy with limited range of motion. Refer to treatment with physical therapy.
- Patient reports ???? Surgical history postnatal linked to rupture of membranes. Respiratory therapy for patient.
- Patient reports right shoulder pain with limited range of motion. Right with physical therapy.
- Patient report left shoulder pain with limited range of motion. Refer to treatment with physical therapy.

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Accurate.

"Often, malpractice lawyers decide whether to pursue litigation cases based solely on the quality of documentation. . . . . [I]naccurate documentation makes up the second most common category of documentation-related malpractice cases. Common issues in this category include using inaccurate templates, copying and pasting from other notes, and providing information that conflicts with other clinicians for the same encounter. Each of these issues has become more problematic with the shift to electronic health records (EHR)."

Ghaith, Summer, Gregory P. Moore, Kristina M. Colbenson, Rachel A. Lindor, Charting Practices to Protect Against Malpractice: Case Reviews and Learning Points, West J. Emerg. Med., 2022 Apr 28:23(3):412-417, https://pmc.ncbi.nlm.nih.gov/articles/PMC9183775/ (last accessed May 6, 2026).

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Why is accuracy important?

"After categorization of patient-reported very serious mistakes, those specifically mentioning the word diagnosis or describing a specific error in current or past diagnoses were most common (98 of 356 [27.5%]), followed by inaccurate medical history (85 of 356 [23.9%]), medications or allergies (50 of 356 [14.0%]), and tests, procedures, or results (30 of 356 [8.4%]). A total of 23 (6.5%) reflected notes reportedly written on the wrong patient. Of 433 very serious errors, 255 (58.9%) included at least 1 perceived error potentially associated with the diagnostic process (eg, history, physical examination, tests, referrals, and communication)."

Bell SK, Delbanco T, Elmore JG, Fitzgerald PS, Fossa A, Harcourt K, Leveille SG, Payne TH, Stametz RA, Walker J, DesRoches CM. Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes. JAMA Netw Open. 2020 Jun 1;3(6):e205867. doi: 10.1001/jamanetworkopen.2020.5867. PMID: 32515797; PMCID: PMC7284300.

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Example of Inaccuracy Noted by Study Participant

"Another commented, 'Pathology report summary stated I had 2 positive lymph nodes but [the] detailed report stated 3 positive lymph nodes. That changes the staging and the treatment options. My physician had only read the summary and didn't realize I had 3 positive lymph nodes.' In this case, the patient reportedly notified the physician of the additional positive node, thereby changing the treatment plan because of the wider spread of the cancer."

Bell SK, Delbanco T, Elmore JG, Fitzgerald PS, Fossa A, Harcourt K, Leveille SG, Payne TH, Stametz RA, Walker J, DesRoches CM. Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes. JAMA Netw Open. 2020 Jun 1;3(6):e205867. doi: 10.1001/jamanetworkopen.2020.5867. PMID: 32515797; PMCID: PMC7284300.

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Complete.

"Complete documentation includes reporting and documenting on appropriate records a patient's status, including signs and symptoms, responses, treatments, medications, other nursing care rendered, communication of pertinent information to other health team members, and unusual occurrences involving the patient. A signature of the writer, whether electronic or written, is required in order for the documentation to be considered complete."

ABN Administrative Code
§ 610-X-6-.06(2)(c).

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Complete.

"Cases that involve missing documentation comprise a broad range of clinical circumstances. Common scenarios identified included lack of documentation about informed consent discussions, patients acting against medical advice (AMA), specialist consultations, and communication with patients regarding return precautions or post-discharge care."

Ghaith, et al., Charting Practices to Protect Against Malpractice: Case Reviews and Learning Points, West J. Emerg. Med., 2022 Apr 28:23(3):412-417, https://pmc.ncbi.nlm.nih.gov/articles/PMC9183775/ (last accessed May 6, 2026). (internal citations omitted).

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Why is completeness important?

"Empirical studies reveal that many EHR datasets have substantial missingness: in some settings, 30–40% of variables may be missing more than half their expected values, especially for laboratory or social determinants data, and overall missingness rates for key clinical variables often fall in the 15–30% range, depending on context . . .. Missing or fragmented EHR records have been linked to an increased risk of medication errors, redundant testing, misdiagnoses, and worse health outcomes, especially among marginalized populations."

Gurupur, V., Hooshmand, S., Prabhu, D. F., Trader, E., & Salvi, S. (2025). Incompleteness of Electronic Health Records: An Impending Process Problem Within Healthcare. *Healthcare*, *13*(22), 2900. https://doi.org/10.3390/healthcare13222900 (internal citations omitted).

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Timely.

"1. Charted at the time or after the care, to include medications. Charting prior to care being provided, including medications, violates principles of documentation.

2. Documentation of patient care that is not in the sequence of the time the care was provided shall be recorded as a "late entry," including a date and time the late entry was made, as well as the date and time the care was provided."

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Why is timeliness important?

"Incomplete/Delinquent medical records are nowadays imposing a critical challenge upon financial, administrative and legal affairs in practicing Medicine. Our review shows that CMS recovery audit with hospital denials went high from 7-10% in recent years because of open/incomplete medical records."

Chowdhury M, Peteru S, Askandaryan A, Banik D, Hiana J. Incomplete Medical Charts: Impacts And Possible Solutions. Eur Psychiatry. 2022 Sep 1;65(Suppl 1):S747. doi: 10.1192/j.eurpsy.2022.1930. PMCID: PMC9567488.

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ABN Grounds for Disciplinary Action Related to Documentation

"Failure to practice nursing in accordance with the standards adopted by the Board in Alabama Board of Nursing Administrative Code Chapters 610-X-5, 610-X-6, 610-X-7, or 610-X-9."

ABN Administrative Code § 610-X-8-.03(7)(a).

"Failure to . . . Document nursing care."

ABN Administrative Code § 610-X-8-.03(7)(e)(4).

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ABN Grounds for Disciplinary Action Related to Documentation

"Falsifying, altering, destroying, or attempting to destroy patient, employer, or employee records."

ABN Administrative Code § 610-X-8-.03(7)(f).

"Intentionally or negligently misrepresenting or falsifying facts in billing a patient or any public or private third-party payor."

ABN Administrative Code § 610-X-8-.03(7)(n).

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Disciplinary Example 1

On or about May 15, 2023, until resignation on or about January 19, 2024, Respondent was employed as a Licensed Practical Nurse with a home health company in [city]. [X], RN, Director of Operations, documented a patient's caregiver reported the patient had not been seen since their Start of Care visit on January 5, 2024, and a review of records showed two documented visits by Respondent dated January 12, 2024, and January 15, 2024. [X] detailed that the "agency investigated these reports and found 2 visits were documented on the patient but in fact a visit was not made." [X] documented that a visit discrepancy report was obtained, and the records showed Respondent had documented other visits that were not made.

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Grounds for Discipline

Standards of practice require nurses to have knowledge and understanding of the laws and rules regulating nursing; accept individual responsibility and accountability for judgments, actions and nursing competency, remaining current with technology and practicing consistent with facility policies and procedures; and accept individual responsibility and accountability for accurate, complete and legible documentation related to patient care records. The practice of practical nursing includes the performance, for compensation, of acts designed to promote and maintain health, prevent illness and injury, and provide care utilizing standardized procedures and the nursing process, including administering medications and treatments, under the direction of a licensed professional nurse or a licensed or otherwise legally authorized physician or dentist. Such practice requires basic knowledge of the biological, physical, and behavioral sciences and of nursing skills but does not require the substantial specialized skill, independent judgment, and knowledge required in the practice of professional nursing. Additional acts requiring appropriate education and training may be performed under emergency or other conditions which are recognized by the nursing and medical professions as proper to be performed by a licensed practical nurse. Alabama Board of Nursing Administrative Code §§ 610-X-6-.03(1)(7) and (15)(a); 610-X-6-.05(1). Respondent's conduct as described in Paragraphs II and III of the Findings of Fact demonstrates that Respondent failed to practice nursing in accordance with the standards adopted by the Board, in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and Alabama Board of Nursing Administrative Code § 610-X8-.03(7)(a). Said conduct is unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health.

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Grounds for Discipline

Respondent's conduct as described in Paragraphs II and III of the Findings of Fact demonstrates that Respondent falsified patient, employer, or employee records, in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and Alabama Board of Nursing Administrative Code § 610-X8-.03(7)(f). Said conduct is unprofessional conduct of a character likely to deceive, defraud, or injure the public in matters pertaining to health.

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Discipline Received

12 MONTHS OF PRACTICE PROBATION

PAYMENT OF FINE

COMPLETION OF COURSES

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Disciplinary Example 2

On or about [date], while employed as a Certified Registered Nurse Practitioner at [facility], Respondent saw Patient A in the clinic and signed off on the visit note. It was later determined that some elements of the exam were auto-populated into the visit record for the day and did not reflect data from the day of the visit.

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Grounds for Discipline

Standards of practice require nurses to have knowledge and understanding of the laws and rules regulating nursing and accept individual responsibility and accountability for accurate, complete, and legible documentation related to patient care records. Alabama Board of Nursing Administrative Code § 610-X-6-.03(1) and (15)(a). Respondent's conduct as described in Paragraph(s) II demonstrates that Respondent failed to practice nursing in accordance with the standards adopted by the Board, in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and Alabama Board of Nursing Administrative Code § 610-X-8-.03(7)(a).

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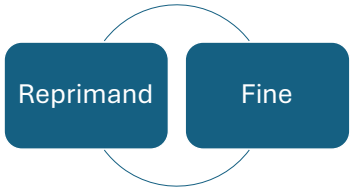
Discipline Received



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Disciplinary Example 3

<Excerpt> " . . . A Compliance Investigation Report confirmed the patient was [] and that when they reviewed the Visit Location Discrepancy Report, it showed that in August and September, Respondent started the visits for the patients anywhere from two to sixteen miles away from the patient's home. Respondent admitted to the facility that if she forgets to get her visits signed she will place an 'X' or a scribble in the caregiver signature field. . . . Respondent reported to the Alabama Board of Nursing's investigator that she was assigned forty visits in a five-day week, that it was not possible to complete all of them, and she assigned others to visit patients. She admitted that sometimes she would forget to close out a chart after leaving and would sign an X and reports she had done that several times over the previous few years. She also asserts that she would open the patient's records on the drive over to the patient's home so she could start the visit immediately upon arrival."

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Grounds for Discipline

<Excerpt> Respondent's conduct as described in Paragraph(s) II and III of the Findings of Fact demonstrates that Respondent intentionally or negligently misrepresented or falsified facts in billing a patient or any public or private third party payor, in violation of Code of Alabama 1975, § 34-21-25(b)(1)(g) and Alabama Board of Nursing Administrative Code § 610-X-8-.03(7)(n). Said conduct is unprofessional conduct of a character likely to deceive, defraud, or injure the public in a manner pertaining to health.

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Discipline Received

- Probation for 12 months
- Completion of courses
- Payment of fine

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Emerging Technologies: AI and Ambient Listening

"Ambient clinical documentation technologies can make three types of errors. First, it may omit information by failing to recognize, transcribe, and move information to a draft note. Second, it may incorrectly document information, such as the wrong name or dose of a medication. Third, it can hallucinate information, fabricating new and inaccurate information."

Gerke S, Simon DA, Roman BR. Liability Risks of Ambient Clinical Workflows With Artificial Intelligence for Clinicians, Hospitals, and Manufacturers. JCO Oncol Pract. 2026 Mar;22(3):357-361. doi: 10.1200/OP-24-01060. Epub 2025 Aug 1. PMID: 40749149; PMCID: PMC12626409.

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Touchstone for the Use of Technology

The registered nurse or licensed practical nurse shall:

. . . (3) Obtain instruction and supervision as necessary when implementing new or unfamiliar nursing techniques or practices

. . . (7) Accept individual responsibility and accountability for judgments, actions, and nursing competency, remaining current with technology and practicing consistent with facility policies and procedures.

ABN Administrative Code § 610-X-6-.03(3) and (7).

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Accountability

"The question of accountability is also pivotal. When AI assists or even directs certain aspects of nursing documentation, it must be clear who is responsible for the outcomes - whether the nurse, the healthcare institution, or the AI developers. Nurses should understand the capabilities and limitations of AI to ensure they do not over-rely on its guidance. Policy-makers are tasked with establishing and enforcing regulations that mitigate the over-reliance on AI, treating it as an aide rather than a substitute for clinical judgment."

Nashwan AJ, Abujaber A, Ahmed SK. Charting the Future: The Role of AI in Transforming Nursing Documentation. Cureus. 2024 Mar 31; 16(3):e57304. doi: 10.7759/cureus.57304. PMID: 38690502; PMCID: PMC11059141.

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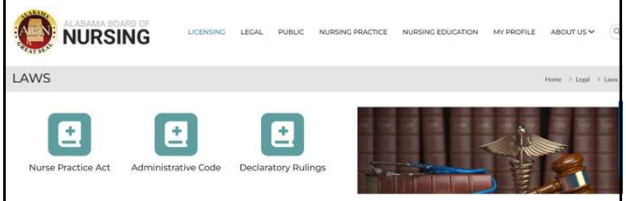
Summary:
Laws Regulating Nursing

- Nurse Practice Act
- ABN Administrative Code
- Declaratory Rulings
- Proposed Rule Changes
- Emergency Rules



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