

**The Miriam Hospital  
Administrative Manual**

**Subject:**  
Legibility of Medical Record

**File Under: MS 19 and HIS 28**

**Issuing Department:**  
Health Information Services

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10/24/2005

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**Approved By:**

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(Director)

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(Executive)

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**PURPOSE:**

This policy establishes standards for legibility of documentation in the medical record consistent with accreditation standards to protect patients' safety. It includes documentation standards for **all** documentation in the patient's medical record, handwritten and computer generated.

**POLICY:**

- A. It is the responsibility of the medical staff to set legibility standards for medical record documentation and to monitor compliance with these standards as part of the hospital's performance improvement and medical error reduction activities.
- B. This policy is applicable to **all** documentation within the medical records. Handwritten documentation in the medical record will be legible.
- C. A standardized process to review and monitor the legibility of documentation handwriting and the use of unsafe abbreviations will be the responsibility of the Medical Records Committee and will be reported quarterly to both the Medical Executive Committee and Patient Safety Committee.

**PROCEDURE:**

Whenever possible, all consults, histories and physicals, interpretations of diagnostic testing and postoperative/procedure results shall be dictated.

No abbreviations from the "Do Not Use Abbreviation List ("Unsafe Abbreviations") shall be used in the medical record.

All documented notes shall include date, signature of the author, contact number, and the name of the author. The author should identify his/her role at the head of the note and their level of training (i.e. Attending, Consultant, Fellow, Resident PGY 1, 2, 3). The use of a pre-printed stamp (with printed name and beeper number) stamped below a signature is available for all house staff. The entire staff is encouraged to use pre-printed stamps, or if not using the stamp, **must clearly print their name and contact number on all notes below their signature.**

## **The Miriam Hospital Administrative Manual**

Legibility of Medical Record

Revised 07/01/2008

If a healthcare professional writes an entry in the medical record that is not legible, the entry must be clarified with the healthcare professional prior to implementation. Clarification of written entries will be documented on the record as a “clarification” dated and signed by the healthcare professional receiving the clarification. Reference Policy: PS-18 Patient Care Orders and Verification.

### **Chart Review Process:**

#### **Legibility:**

Legibility and the use of “unsafe abbreviations” will be monitored via concurrent and retrospective chart reviews. A random sample of charts will be reviewed monthly. Aggregate data will be presented to the Medical Records Committee on a quarterly basis. Documentation will be evaluated as either legible or illegible.

#### **Definitions:**

**Legible:** Can be read with confidence without consultation with others

**Illegible:** Cannot be read with confidence despite consultation by two professionals. Entry is poorly written or printed.

**Confidence:** Provider would be willing to act on an order/recommendation on the basis of the provider’s understanding of what the documentation reads.

**Provider Review Process:** A formal notification/feedback process will be established by the Medical Records Committee with reporting to the appropriate Chiefs, Department Managers, and Credentialing Committee in accordance with established guidelines.

#### 1) Do Not Use Abbreviations (Unsafe Abbreviations):

- When concurrent instances are identified – the provider should be asked to correct in the medical record, date, and initial.
- Retrospective review – the medical records department will monitor and contact the provider to correct in the medical record. Repeated occurrences will be reported to Chiefs or department manager through a letter from the Chair of Medical Records Committee.

#### 2) Legibility:

- When concurrent instances are identified, the provider should be asked to correct in the medical record, date, and initial.
- Retrospective Review - Instances of illegible handwritten documentation in the medical record will be reported back to the individual by the Medical Records Department for correction/clarification in the chart. Consult the attending for assistance when needed.