MEDICAL RECORDS LEGIBILITY AND CLARITY POLICY  MS 103

PURPOSE:
1. To define standards for the legibility and clarity of clinical documentation,
2. To provide a mechanism for evaluating the legibility and clarity of physicians’ clinical documentation,
3. To implement corrective actions whenever necessary, and
4. To eliminate illegible and unclear clinical documentation in the Medical Record.

DEFINITIONS:
1. Illegible: Any chart entry for which two professionals with relevant credentials cannot agree on the entry’s content.
2. Unclear: Any chart entry for which two professionals with relevant credentials cannot agree on the entry’s meaning or intent.

Examples of unclear clinical documents include:
- Documents containing unapproved abbreviations
- Documents containing trailing zeros after a decimal point (e.g. “5.0 mg”).
- Documents omitting leading zeros for decimal fractions (e.g. “.5 mg”)
- Completed orders with subsequent additions, deletions or alterations
- Orders for imaging studies which omit the indication for the study
- Medication orders lacking an accepted drug name, dose, dosing interval or route of administration
- Pro re nata ("prn") orders omitting indications and parameters (e.g. “Tylenol 650 mg Q4H prn” or “in and out cath prn”)
- Orders specifying ranges of doses (e.g., 4-6 mg) or dosing intervals (e.g. Q4-6H)

POLICY:
1. All medical record entries must be legible and clear.
2. All medical record entries are to be dated, the time entered, and signed.
3. All physician signatures must be accompanied by the physician’s identification number. Illegible signatures must also include the physician’s legibly printed name.
4. Orders that are illegible will not be accepted by Nursing, Ancillary or Pharmacy staff.
5. Orders that are unclear, ambiguous or difficult to interpret will not be accepted by Nursing, Ancillary or Pharmacy staff.
6. Illegible and unclear orders must be corrected promptly.
7. The legibility and clarity of clinical documents will be monitored via Peer Review and quality audits.
8. Legibility and clarity assessment of chart entries and orders will be used to evaluate physician performance.
9. Inadequate legibility or clarity of physician documentation will result in corrective actions as necessary to assure patient safety.

PROCEDURE:
1. Nurses, pharmacists and allied health practitioners will clarify illegible or unclear orders with the ordering providers or their on-call representatives.
2. Orders that are illegible or unclear will not be executed until clarified in writing or by telephone order with a “read back” confirmation.
3. Legibility and clarity rankings for orders will be as follows:
   0: Pre-printed order forms completed appropriately
   1: Legible handwritten orders without unapproved or unclear abbreviations, alterations, omission of required elements or other high-risk features
   2: Orders containing significant illegible entries or other high-risk features
   3: Orders containing multiple illegible entries or other high-risk features
4. Legibility and clarity rankings for medical record entries other than orders will be as follows:
   0: Typed or dictated clinical notes
   1: Legible and clear handwritten notes
   2: Chart entries with significant illegibility, omission of required elements, use of “do not use” abbreviations or inappropriate alterations
   3: Frequently illegible, incomplete, ambiguous, contradictory or unclear chart entries
5. Legibility and clarity peer review results will be reported to the Medical Staff for each physician’s Professional Practice Evaluations (PPEs), at reappointment and whenever there is a reasonable concern that illegible or unclear documentation may constitute a threat to patient safety.
6. Any illegible or unclear entry that results in an adverse event will be referred to the appropriate Departmental Committee and the Risk Management Committee.
7. Chart reviews performed in non-Medical Staff processes, such as Quality Assurance or Pharmacy reviews, will classify legibility using the same criteria as used in Peer Review. Charts with adverse rankings (2 or 3) will be promptly forwarded to the Medical Staff for review.
8. Legibility and clarity data will be presented to the appropriate physician’s Department.
CORRECTIVE ACTIONS:
1. Consistently legible and clear documentation:
   • No corrective action
   • Routine monitoring via the PPE process and at biennial re-credentialing
2. Infrequent notes ranked 2 for legibility or clarity:
   • Letter to the physician describing his or her opportunities for improvement
   • Re-evaluation in one (1) year
3. Any order or multiple notes ranked 2 for legibility or clarity:
   • Letter to the physician describing his or her opportunities for improvement
   • Consideration of mandatory printing of orders and use of pre-printed order forms
   • Focused documentation quality reviews at three (3) to six (6) month intervals
4. Any record ranked 3 for legibility or clarity:
   • Letter to the physician describing his or her opportunities for improvement
   • Mandatory printing of orders and use of pre-printed order forms
   • Completion of a prescribed penmanship course
   • Focused documentation quality reviews at three (3) month intervals
5. If any documents is ranked 3 or multiple documents are ranked 2 during focused documentation quality reviews, the physician will be referred to his or her Medical Staff Department and the EMB for further actions which may include but are not limited to:
   • Letter to the physician describing his or her opportunities for improvement
   • Mandatory dictation of all notes
   • Completion of a prescribed penmanship course at the physician’s own expense
   • Focused documentation quality reviews at three (3) month intervals
6. For persistent non-compliance with legibility or clarity standards, the physician will be referred to his or her Medical Staff Department and the EMB for further action, which may include but is not limited to:
   • Letter to the physician describing his or her opportunities for improvement
   • Mandatory dictation of all chart entries at the physician’s own expense
   • Focused documentation quality reviews at three (3) month intervals
   • A fine not to exceed $1000
   • Mandatory attendance a medical documentation course at the physician’s own expense, e.g. the UC San Diego PACE Medical Record Keeping course
   • Voluntary resignation from the Medical Staff
   • Involuntary separation from the Medical Staff
FORMS
Peer Review Form

REFERENCES
None

REVISION HISTORY
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APPROVAL
Roger Lee, MD
Chief of Staff

Philip Levin, MD
Chief Medical Officer