Ensuring Legibility of Patient Records

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Today's medical record serves a multitude of purposes. It provides:

- a method of clinical communication and care planning among healthcare practitioners serving the patient
- a basis for evaluating the adequacy and appropriateness of care
- supporting documentation for the reimbursement of services provided
- protection of the legal interests of the patient, healthcare practitioners, and the facility
- clinical data for research and education

Documentation in the patient record must be clearly readable to support all uses. The illegibility of entries found in patient records, however, has long been a challenging issue for HIM professionals. Illegibility poses serious risks to patient care, drains valuable healthcare resources, jeopardizes optimal reimbursement, and carries potentially disastrous legal ramifications for healthcare organizations.

Legibility Issues

The illegibility of medical record documentation has several implications.

Risks to Patient Care

Illegible medical record entries can lead to misunderstanding and serious patient injury. An Institute of Medicine report, "To Err is Human: Building a Safer Health System," published in 2000, estimates that as many as 98,000 people die in any given year from medical errors that occur in hospitals. Various studies on medical errors and preventable adverse events list "failure of communication" as a factor that contributes to errors.

An example of failure to communicate stated in the report: illegible writing in medical records resulted in administration of a drug for which the patient had a known allergy. The report specifically cites illegibility as a factor in poor communication among healthcare providers.

Legal Implications

The patient record may be the most important evidence in defense of a claim when healthcare organizations are involved in litigation. Without a legible patient record, efforts of defense against allegations of improper care may be weak.

An illegible record demonstrates compromise of clear communication between clinical and professional staff. It may create suspicion in the minds of jurors that an entry was improper and thereby weaken the hospital's defense. A connection between the poor quality of the record and the quality of patient care administered might also be made. Illegible writing will not help to refresh the memory of a caregiver when he or she is obligated to recall a case, especially if years have elapsed.

Resource Drain

The time and talent of clinicians and allied healthcare professionals could be better spent delivering patient care than clarifying illegible entries. Often, readability issues trigger a series of unsuccessful telephone calls to obtain clarification from the author. Significant time can be spent by any number of professionals polling coworkers, discussing and guessing what an entry might say. Nurses spend much time clarifying handwritten orders. Many coder queries involve clarification of record entries before accurate codes can be assigned, resulting in delayed submission and billing.

In addition to time spent by coding professionals in querying physicians and deciphering unclear documentation, errors or omissions in coded data due to illegible entries may result in lost revenue to the organization through missed legitimate DRG assignment and denied claims. Claims should be submitted only when appropriate supporting documentation is present in the health record and available for audit and review. When coding practices are compromised by inability to read supportive documentation of symptoms, conditions, and delivered treatment, case mix index and reimbursement is harmed.

Manual Systems

As healthcare organizations adopt more sophisticated technology, illegibility issues are reduced through production of printed documents. Handwritten reports and entries present the problem. Discharge summaries, operative reports, narrative interpretations of diagnostic tests (such as radiology reports), autopsy reports, and pathology reports are frequently word-processed. A number of organizations transcribe consultation and history and physical examination reports as well.

However, many other medical record forms, or portions of them, are completed manually. Thus, a large part of the patient record can be vulnerable to legibility issues depending on the degree of progress toward an electronic environment. (See "Patient Record Forms Typically Handwritten," below.)

Patient Record Forms Typically Handwritten

Records of history and physical exams	Physician orders
Nursing assessment	Progress notes
Functional status assessments	Nursing notes
Problem lists	Consultation reports
Care plans	Discharge instructions

Abbreviations

Despite timesaving benefits, use of abbreviations in medical records presents potential quality issues through legibility challenges. Even when documented clearly, abbreviations may have several different definitions contributing to misinterpretation. When complicating illegibility factors are added, the operational result can jeopardize patient safety. Organizations are encouraged to forbid the use of abbreviations that are known trouble spots as they develop standardized data definitions for abbreviations, acronyms, and symbols as directed by the Joint Commission.

Regulatory Implications

Legibility is recognized as a critical issue in health record documentation and patient care management and is addressed in healthcare regulations and accrediting standards.

Conditions of Participation

The Conditions of Participation for Hospitals: Medical Record Services (§ 482.24 [c] [1]) state that "all entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished."

It should be noted that the conditions of participation for hospitals apply to hospital-based outpatient, emergency, and rehabilitation services and the medical records generated in these departments.

State Regulations

Criteria for quality medical records are commonly addressed in state licensing acts. When considering influencing factors for committing organizational resources toward legibility efforts, this source should be reviewed by healthcare organizations.

Legibility and Accreditation

The Accreditation Handbook for Ambulatory Health Care standards state: "Entries in patients' clinical records are legible to the clinical personnel in the organization."

Standards for the accreditation of managed care organizations from the National Committee for Quality Assurance state: "The record is legible to someone other than the writer."

The Healthcare Facilities Accreditation Program of the American Osteopathic Association is succinct in standard 10.00.24: "All entries shall be legible."

The Joint Commission addresses legibility in several core standards and corresponding intents within its *Comprehensive Accreditation Manual for Hospitals*:

Medical Staff Standards

- MS.8 - MS.8.1: The medical staff has a leadership role in organization performance improvement activities designed to ensure that the medical staff participates in the measurement, assessment, and improvement of other patient care processes. The processes include, though are not limited to, those related to accurate, timely, and legible completion of patients' medical records.

Management of Information Standards

- IM.5: Transmission of data and information is timely and accurate.

  Intent: Internally and externally generated data and information are accurately transmitted to users. The integrity of data and information is maintained and adequate communication exists between data users and suppliers. Specific attention is directed to the processes for ensuring accurate, timely, and complete verbal and written communication among caregivers and all others involved in the utilization of data. The timing of transmission is appropriate to the data's intended use.

- IM.5.1: The format and methods for disseminating data and information are standardized, whenever possible.

  Intent: The format and methods of disseminating internal data and information are tailored to the needs of the user and the hospital. Dissemination methods and formats provide for easy retrieval. The way data and information are exchanged is standardized whenever possible to facilitate interpretations.

Specific attention must be directed to the process for ensuring accurate, timely, and complete verbal and written communication.

Performance Improvement Standards—Ongoing Review

The Joint Commission standard for ongoing medical record review offers a comprehensive tool for assessing the quality of documentation in patient records:

- IM.7.10: Medical records are re-viewed on an ongoing basis for completeness and timeliness of information, and action is taken to improve the quality and timeliness of documentation that impacts patient care.
- IM.7.10.1: A representative sample of records is included in the review process.

Intent: The review of medical records addresses the presence, timeliness, legibility, and authentication of data and information, as appropriate to the hospital's needs. See "Elements for Ongoing Review of Medical Records," below for a list of data and information that should be reviewed.

Elements for Ongoing Review of Medical Records

Identification data
Medical history
Psychosocial needs
Physical examinations
Conclusion or impressions from admission history and physical
Course of action planned
Diagnostic and therapeutic orders
Informed consent
Clinical observations
Progress notes
Consultation reports
Operative reports
Reports of diagnostic and therapeutic procedures
Transplant/implant donation records
Final diagnoses
Conclusions at termination of hospitalization
Clinical resumes and discharge summaries
Discharge instructions
Autopsy results

In conducting ongoing record review, every hospital should review the level of legibility of record entries. Reviewing the 19 elements listed in the Intent for standard IM.7.10.1 against the criterion for legibility will determine readable qualities of documentation within the medical record.

Definition of Legibility

Although assessment of legibility may be subjective to a degree, the criterion for readability is simple: a notation can either be clearly and easily read or not. One performance improvement assessment approach is initial review by the medical record review team, followed with a second review by other evaluators including:

- physician members of the review committee
- the author of the illegible entry
- the author's department chief or administrator
- healthcare professionals and unit staff

Healthcare providers who work together regularly may become accustomed to each other's handwriting. Even though a record may be decipherable between healthcare coworkers, the same concessions may not apply in legal actions. Records must be objectively reviewed for legibility.

If a record fails to be readable at any level, hospital policy and medical staff bylaws should guide resultant actions. Offenders should be formally notified, corrective action taken, and improvement monitored.

It is important that an organization's governing body support the legibility of records. Illegibility patterns in patient records should be seriously considered during re-credentialing activities for credentialed and professional staffs.

Although legibility is addressed primarily as a physician issue, a number of allied health professionals have record documentation authority as well. Among them are nurses, therapists, and technicians. Legibility should be objectively measured in performance improvement activities and addressed in performance reviews as appropriate for all responsible health professionals.

Documentation Improvement Initiatives

Whether illegibility is a widespread problem or plagues only a few authors, several initiatives can be considered to improve the quality and readability of record entries.

Policies and Procedures

Develop and publish policies and procedures for illegible entries in all clinical areas of the organization. Strengthen existing policy enforcement to address this element of quality documentation. Mandate printed entries if handwriting is illegible.

Education

The HIM department should provide mandatory education on the proper use of health facility patient documentation systems. Educational sessions held during orientation and routinely for all individuals with record documentation privileges should emphasize the organization's policies and rationale for record documentation requirements. They should also explain the consequences of poor documentation, provide tools and tips for documentation improvement, and address ongoing review practices for monitoring compliance.

Internal publication of real-life examples of illegible entries can be an effective teaching approach. Some organizations have published actual scribbles in internal newsletters distributed to the hospital and medical staffs. These samples can be enlarged to poster-sized signs and posted throughout the facility. Some HIM departments have gone so far as to mandate handwriting lessons for chronic offenders.

Technology

The application of technology, including word processing, computer-generated reports, order-entry systems, and voice recognition technology are reducing the number of handwritten entries made in medical records through printed text. Consider the use of these various technologies to generate readable reports in patient records, if feasible.

Mandate Dictation of Critical Documents

Review existing documents and consider whether to expand transcription services to include additional reports. When determining whether HIM resources can support increased transcription services, consider the following:

- Will the time of transcription turnaround meet the needs of healthcare providers?
- Will extra staffing be needed to concurrently file hard copy reports in the active patient record on the nursing units?
- If transcribed entries (such as progress notes) are typed onto self-adhesive strips, will transcriptionist productivity be affected if paper, forms, and self-adhesive strips must be constantly changed in the printer or typewriter?
- Because handwritten notes are usually signed immediately, will transcribed reports add another delay in record completion, requiring authentication at a later time?

Forms Design

Align record and forms design with clinical treatment practices to improve the quality to read and use information for patient care. The number of narrative handwritten record entries can be minimized through the use of forms containing checklists and blanks to record patient data. Analyze existing documents used in the patient record and apply forms design concepts to reduce the number of lengthy narrative entries.

Integrated Progress Notes

The organization may consider streamlining record entry requirements using integrated progress notes. In this format, all information is arranged chronologically, with all healthcare team members sharing common progress notes. Through meaningful information charted by nursing and allied health personnel in sequence with the physicians' notations, the "story" of the patient unfolds as his or her hospitalization progresses.

Integrated progress notes help ensure that all observations are reviewed by the patient care team and make gaps in one provider's documentation less obvious. The system helps reduce illegibility concerns when the observations of all providers are together, for one may be able to use the notes of nurses or other health professionals to decipher physicians' notes.

Leadership Support

All organization staff should be encouraged to question incomplete or ambiguous notations and refrain from guessing about the meaning of unclear or illegible handwritten entries.

Healthcare staff may be reluctant to contact physicians with legibility questions. Organization philosophy must create a safe environment to investigate uncertainties and convince employees that hospital and medical staff leaders will back them up.

With its potential effect on patient care and safety, legal protection, reimbursement, and resource usage, legibility of patient record entries should be a focus of ongoing performance improvement efforts in every healthcare organization. Objective, routine review of patient record entries to identify record readability problems must be a priority.

Documentation improvement can be achieved through education of healthcare professionals with patient record documentation privileges; systems and record design to facilitate a complete, accurate, timely, and legible patient record; and medical staff and administrative support of efforts to improve record documentation.

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