HIM Professionals Key to Patient Safety

Save to myBoK

by Cheryl Servais, MPH, RHIA

In January 2003, the Joint Commission made 11 recommendations for patient safety. HIM professionals play critical and supporting roles in implementing these recommendations. This article will discuss some of the recommendations, with examples of their use in various aspects of an HIM department.

HIM's Critical Roles

In the following scenario, HIM departments make corrections to the master patient index and changes are not communicated with ancillary systems using the medical record number as a key identifier for patients.

Recommendation 1a: Use at least two patient identifiers whenever taking blood samples or administering medications or blood products.

Recommendation 1b: Prior to starting any surgical or invasive procedure, conduct a final verification process to confirm the correct patient, procedure, and site using active, not passive, communication techniques.

One way to verify patient identity is to match the medical record number on the patient's wristband with the paperwork accompanying the patient. The accuracy of this number depends on the accuracy of the MPI. HIM professionals are generally responsible for verifying the accuracy of the medical record number. Two types of errors may affect patient safety:

- Two patients accidentally may be assigned the same medical record number. In this instance, the previous history, diagnostic conditions, surgical scars, medications, and allergies (including those to medications) would be erroneous and could lead to errors in medical decisions
- A patient may be assigned multiple medical record numbers. In this case, the patient's prior information may not be available to caregivers. Unless the duplicate number issue is resolved, the patient would continue to have medical information located in multiple records, all of which would be incomplete

Many hospitals, recognizing the serious implications of MPI errors, perform MPI "cleanup." Such projects look for multiple medical record numbers assigned to the same patient or multiple patients assigned the same number. The results of cleanup projects must extend to any ancillary systems, such as lab, radiology, or pharmacy, which use the medical record number to identify patients. If these systems are not included in the MPI cleanup process, the potential exists that incorrect medical record numbers will be used and increase the risk of medical decisions being made on incomplete or inaccurate historical data.

Act as Interpreter

Recommendation 2b: Standardize the abbreviations, acronyms, and symbols (AAS) used throughout the organization, including a list of AAS not to use.

The compilation of a standardized list of AAS often falls to the HIM department. As HIM staff review records from all disciplines and specialties, they are familiar with the AAS used within the facility and the ways in which they are used. In consultation with representatives of medical, nursing, and ancillary staffs, HIM professionals can determine the list of AAS to use and a list of those that could prove confusing because of inconsistent or unclear interpretation.

HIM staff may perform documentation audits to validate that only approved AAS are used. HIM staff may also review forms and other documents to be sure they contain only approved AAS.

Checklists, Please

Recommendation 4a: Create and use a pre-op verification process such as a checklist to confirm that appropriate documents are available.

HIM professionals can assist with the development of checklists used for confirmation of document availability. In addition, HIM staff is responsible for ensuring the patient's prior medical records and documentation for the current record are available for this verification process.

To improve record availability, facilities should analyze the filing processes and storage media used. In addition to filing using traditional shelving systems, paper records may be converted to microfilm, CD-ROM, or optical disk, or replaced by electronic data in an electronic health record (EHR). Alternatively, patient data may be scanned or transmitted to a Web-based server for electronic off-site storage.

HIM professionals should encourage providers to plan for and implement an EHR to improve data availability to many people simultaneously in a variety of locations. EHRs reduce lost documentation, improving the completeness and accuracy of patient information.

HIM's Supporting Roles

Seven other recommendations call for additional processes ensuring patient safety. To validate that such processes are working, the medical record must clearly document all treatments, services, and protective measures taken. Audits must validate medical record information and data must be collected and analyzed. HIM professionals support these activities in a variety of ways.

Documentation Education, Audits

Sound documentation is critical to reducing medical errors. HIM professionals provide education regarding good documentation practices and audit medical record documentation to verify that policies and procedures related to documentation are being followed, orders are legible, and physicians authenticate orders and other entries in a timely fashion. HIM professionals also help craft policies and procedures related to orders and documentation.

Dictation, Transcription

The use of transcription services is increasing as physicians and caregivers seek more efficient ways to provide complete, legible patient documentation. Transcription must be done quickly and accurately to support quality patient care.

Coding, Abstracting Patient Data

All episodes of care are coded and have data abstracted from the record. This creates a rich clinical database that can be used to analyze trends in patient care utilization and quality. Codes for medical errors and complications can be summarized to indicate if patient care safety activities are effective or to discover an area where additional measures are needed.

Some states collect coded data to provide indicators of patient severity and to provide consumers with comparative report cards that grade a facility's patient care quality. The same codes used for billing are used for quality reporting purposes and must be correct for an accurate comparison of a facility to its peers.

More Recommendations on the Way

These Joint Commission recommendations are critical to patient safety. While they are the first recommendations, other programs will follow. The House and Senate recently passed legislation to improve patient safety (HR 663 and S 720). These bills have significant implications for healthcare documentation and statistical reporting. The Centers for Medicare & Medicaid Services has also launched a quality initiative using Quality Improvement Organizations (QIOs). HIM professionals will continue to play a key role in patient safety activities by collecting, monitoring, storing, and analyzing patient information.

Reference

Joint Commission on Accreditation of Healthcare Organizations. “2003 National Patient Safety Goals.” Available at www.jcaho.org/accredited +organizations/patient+safety/npsg/npsg_03.htm.

Cheryl Servais *(cservais@precyse solutions.com) is vice president, compliance, and privacy officer of Precyse Solutions.*

Article citation:
Servais, Cheryl. "HIM Professionals Key to Patient Safety." *Journal of AHIMA* 74, no.8 (September 2003): 63-66.