HIM Professionals and Patient Safety: How to Positively Influence Change

by Julie Holland

What are some of the common and not-so-common errors regarding patient safety known to HIM departments? Here are some of the most frequently seen errors and ways HIM professionals can contribute to a downturn in the number of adverse incidents attributable to problems involving documentation or information availability.

Published in 1999, the Institute of Medicine's (IOM) report, "To Err is Human-Building a Safer Health System," unleashed a torrent of controversy. (At press time, a follow-up report from the IOM, "Crossing the Quality Chasm," had just been released.) This controversy encompassed the quality of statistical data captured, the actual definition of the term "error," and a plethora of articles and books recapping horror stories about wrong limbs being amputated, patient overdoses due to illegibility, and poor placement of drugs on crash carts.

The IOM suggests that the cost of medical errors, including lost income and productivity, is between $17 and $29 billion. With this type of information being actively discussed not only in medical circles, but also at the governmental level and in the consumer press, all healthcare providers are under tremendous pressure to decrease the incidents of adverse events due to medical error.

HIM professionals have long been aware of some of these issues in terms of errors that are a result of poor or unclear documentation, illegibility, and transposition of numbers. The list can go on indefinitely, as each institution has unique dynamics that influence the types of processes that lead to medical errors. Each HIM professional, whether in a leadership, analyst, support, or advisory role, has undoubtedly recognized errors in the medical record and developed tools to either correct known deficiencies or put monitors in place to attempt to reduce errors or identify trends.

What more can we do? This article looks at some common trouble spots, including issues in documentation, record availability, and duplication of medical record numbers, and suggests ways HIM professionals can positively influence change.

First Do No Harm

The "do no harm" statement of the Hippocratic Oath is a basic tenet of modern healthcare practice. Yet with all of our knowledge, tools, and resources, the number of adverse events documented in healthcare today is staggering. HIM professionals are all too familiar with the role that poor documentation plays in undermining healthcare's ability to uphold this important oath.

Whether it be illegibility, incorrect use of abbreviations, or unclear or nonexistent policies on documentation, most institutions can point to an adverse event that is directly attributable to a written error or the inability of staff to decipher the written word, thereby either delaying care or resulting in incorrect care.

On the other side of this coin, it is also important to remember that what is recorded in the medical record is the definitive account of the care a patient received. Sloppy, indecipherable, or incorrect documentation can be perceived to reflect the type of care patients receive in a given facility. Therefore, it behooves HIM professionals to do everything possible to assist healthcare providers in ensuring that documentation in the medical record is beyond reproach.

Here are three common documentation issues over which an HIM professional can exert positive influence. You will undoubtedly recognize these issues as having been identified in the Joint Commission on Accreditation for Healthcare Organizations' Information Management standards:

• use of approved abbreviations only

• legibility of documentation

• timeliness of documentation

The Dreaded Abbreviation List

Everyone hates the abbreviation list, but it is a necessary evil to avoid using duplicate abbreviations, a logical breeding ground for documentation-based errors. The most efficient way to manage this list is to require that all requested abbreviations be compared to the approved list and that the final decision rests with the medical staff committee assigned responsibility for medical record documentation issues. This is typically the medical record committee.

If you don't currently have an abbreviation list and want to know where or how to get started, consider adopting national standards for your approved list. You might also consider purchasing a text that outlines standard abbreviations used in medicine. Some books have abbreviations specific to a certain type of practice (e.g., psychiatric). In addition, it is easy to standardize laboratory test abbreviations by defaulting to abbreviations built into your lab order entry/results reporting system.

Using properly designed forms is another way to guard against abbreviation problems. Do some research to determine who uses the most abbreviations and when. For example, the History and Physical (H&P) is a standard documentation that everyone must use.

Consider a standard abbreviation like "CC," which usually stands for "chief complaint," unless you are a cardiologist and have just documented your fifth cardiac catheterization (also "CC"). Each discipline has its own set of preferred abbreviations, so why not create a prompted H&P form that prints "chief complaint" and avoid confusion? If you closely examine your records, you should find other duplications that a well-designed form can eliminate. As a last resort, allow duplicate abbreviations to be used in forms only when an explanation indicating what the abbreviations mean is also included.

You may find that once your institution understands the need for standardized abbreviations and the fact that the use of abbreviations is monitored, most departments will adhere to the rules that have been established in terms of using and adding abbreviations. As an added bonus, HIPAA regulations already mandate standardization of electronically transmitted data (such as faxes). You will already be ahead of the game.

Legibility and Timeliness

Legibility and timeliness should be monitored no less than monthly, in order to meet Joint Commission I.M.3.2.1, which states: "Medical records are reviewed on an ongoing basis for completeness of information, and action is taken to improve the quality and timeliness of documentation that impact patient care." Further, I.M.5 states: "Transmission of data and information is timely and accurate." That's strong support for the HIM professional to institute monitors and report findings on a regular basis.

These issues can be efficiently monitored via quarterly review of medical records and the monthly delinquency count. Pay specific attention to the timeliness of the entry of the H&P and operative note. Results of these reviews should be reported directly to the medical record committee or your institution's equivalent committee. Corrective measures should be put into place as needed. Following this guideline will allow you to not only effect positive change in documentation but to meet an important Joint Commission standard.

Focus on HIM Leadership

When it comes to issues involving record availability and duplicate medical record numbers, the HIM department must take direct responsibility.

Record Availability

The HIM department must assume a leadership role in setting policy for record availability. If you are fortunate enough to work in an institution that gives one department sole responsibility and power to control record access, the more stringent the

policy on records leaving the department, the better. A good rule of thumb to follow is that records leave the department for patient care only. (This policy assumes that you have plenty of room for hospital staff to review, complete, abstract, and analyze the medical record within your own department. If not, an alternative solution must be found.)

Of course, the HIM director should pick and choose battles carefully. For example, certain review functions must take place to ensure hospital payment (e.g., utilization review). Most utilization review departments do not have seven-day-per-week coverage; therefore, they cannot realistically review weekend discharges prior to their surrender to the HIM department. The wise leader identifies the departments that do not have the ability to do the reviews pre-discharge and whose review directly affects either hospital operations or reimbursement and works out a palatable solution to record sharing and tracking.

A good compromise may be that records leave the department in the morning and are returned by 5 p.m. every day. The director needs to be very selective about who receives this privilege. If you work in an organization where leaders have determined that records are communal property, consider referencing Joint Commission standards regarding availability and security, HIPAA regulations regarding patient confidentiality, and physician completion requirements to gain better control of records.

In the event that the institutional culture makes it difficult for you to control record movement, work with the leadership of departments that most frequently request and keep records to set up a basic framework for record retention and return.

Record availability also assumes that the HIM department has a chart-tracking process in place that assists in identifying the location of the record at all times. This system can be as manual as the use of outguides to indicate when a record is out of its "home" or as elaborate as electronic tracking systems.

Some institutions fall prey to the misconception that if the record is available, all is well. What about the documentation that the record contains? In most cases, final lab reports, ancillary documentation, and other miscellaneous paperwork arrive in the HIM department in bundles. In some cases, this paper documentation is the only record of results or care given and may not be useful if it has not been filed on the record in a timely manner.

Virtually all HIM professionals have dealt with this time- and resource-intensive issue. Most choose to throw additional staff at the issue to try to keep backlogs at a minimum. However, it makes more sense to try to reduce the amount of loose paperwork received rather than manage the filing of it after the fact.

Again, if the information is not available to the caregiver in a timely manner, it’s not useful in ensuring the safety of the patient. Monitor not only the amount of loose material received but the type and age of the material to determine the reason for the delay. Share the information with department directors who can help make a difference.

The HIM department also generates transcribed documents that require accuracy, timeliness of turnaround, and expedited processing. Think of the potential impact if H&Ps are not available prior to surgery due to a transcription delay, or continuing care being compromised because the discharge summary isn’t typed for an extended period of time. Remember, patient safety depends not only on what information is documented, but how and when it is available.

Duplicate Medical Record Numbers

Probably one of the most important and difficult issues to control is the issuance of duplicate medical record numbers. The misidentification of patients at admission or registration is a huge problem in most healthcare organizations and is sure to increase as more computerization and mergers occur.

How does this affect patient safety? Think of the instance where the wrong patient is registered and, consequently, the wrong chart is sent for reference. If the caregiver trusts the support systems of the facility-and most do-the information in the record may not be scrutinized thoroughly enough to quickly determine that the information may not belong to the patient being currently treated. The potential for either misdiagnosis or mistreatment automatically increases exponentially, all because adequate care wasn’t taken in the proper identification of patients upon registration.

Another interesting situation occurs when the blood bank gets involved. Most blood banks will refuse to release blood for transfusion unless certain identification criteria are met (patient name, medical record number, and date of birth). If any of the

three are in conflict, blood will not be released and must be redrawn. In this instance, the duplicate must be corrected immediately upon notification, which means any time of the day or night.

The most effective way to combat the problems brought about by the issuance of duplicate medical record numbers is to monitor, monitor, monitor. It is important to identify any trends in registration, personnel, or systems that cause duplicate numbers and report the findings to the appropriate department head. In some extreme cases, HIM directors have even assumed oversight responsibility for personnel who assign the numbers in an effort to gain control and ensure a clean master patient index. In any event, all HIM personnel must be trained in identifying duplicates and correcting them at a moment's notice.

We Can and Must Make a Difference

As care delivery becomes more complex and interactive, the imperative for patient safety also becomes more complex and difficult to achieve. HIM professionals must play an aggressive role in understanding the multitude of medical error origins, learning about HIPAA regulations and other government mandates, monitoring incidents of error-producing events, escalating issues to the appropriate decision-makers, educating staff in HIM and related departments, and taking the lead to head off documentation and information errors before they cause problems in patient care.

Whether we are directly involved in patient care and create documentation or manage it, HIM professionals are responsible for ensuring that our corner of the world supports all of the processes that combine to keep patients safe.

information that's hard to ignore

The human costs of medical errors are high, as statistics cited in this excerpt from "To Err is Human: Building a Safer Health System" indicate:

"Two large studies, one conducted in Colorado and Utah and the other in New York, found that adverse events occurred in 2.9 and 3.7 percent of hospitalizations, respectively. In Colorado and Utah hospitals, 6.6 percent of adverse events led to death, as compared with 13.6 percent in New York hospitals. In both of these studies, over half of these adverse events resulted from medical errors and could have been prevented.

"When extrapolated to the more than 33.6 million admissions to US hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors. The results of the New York study suggest the number may be as high as 98,000. Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the eighth leading cause of death. More people die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516)."

Read the text of "To Err is Human," edited by Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, at the National Academy Press Web site at www.nap.edu.

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