Strategies for Reducing Medical Errors: HIM's Role

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Medical errors are a problem of national concern. How can HIM professionals improve documentation and prevent errors? This article offers some risk management strategies.

Medical errors have been a hot topic since the release of last year's Institute of Medicine report "To Err is Human," which spurred interest in finding ways in which healthcare organizations can identify and rectify systems failures that lead to patient injury. Because clear, accurate, and timely written communication is key to preventing patient injury, medical information documentation is ripe for scrutiny.

It is possible, however, to turn medical documentation into an error prevention tool. For such a system redesign to succeed, HIM professionals and healthcare risk managers need to collaborate. Such an effort would require shared learning about system failure identification methods, education, and persistent monitoring with a view to corrective action. In this article, we'll describe some useful strategies—and offer suggestions for improving your documentation processes.

Perpetuating Bad Habits

Failure to correct poor documentation practices can lead to serious patient injury. Accordingly, failure to record information in a timely manner can lead to needless and serious risk exposure. For instance, a patient may receive repeated medication therapy if his record does not have a timely notation that treatment has been delivered. In integrated delivery systems in which patients may have multiple encounters with providers, the absence of a clear, concise, yet comprehensive medical record can result in critical information not reaching caregivers.

Such "bad habits" are not restricted to paper records. A lack of familiarity with voice-activated recording and transcription or inexperience with online medical record keeping can have similar consequences in the realm of medical error.

Moving Away from System Failure

No single health professional discipline can single-handedly halt medical errors. Pinpointing and rectifying system failure requires a team effort. Risk managers can provide insights into the "types" of system failure that culminate in patient injury; they also can help develop strategies that reshape current systems. HIM professionals, however, have the expertise to redesign flawed record methodologies. They also have the opportunity to monitor for system failure. Together, both professions can provide critical orientation and ongoing education to prevent improper use of health information documentation. Together, they have a great opportunity to turn documentation into a potent tool for averting medical error.

A facility aiming to transform medical documentation into an error prevention tool can use five broad strategies:

- risk identification
- risk prevention
- delegation and dissemination of risk management responsibilities
- surveillance
- corrective action

Strategy One: Identifying Error and Error Potential

Several indicators can identify both potential and actual risk-prone practices in medical documentation. (See "Risk Indicators in Documentation.") Using customized screening tools, members of the quality improvement, utilization review, health information,

and risk management departments can identify problem areas and processes. Sample problems might include:

- illegibility of medical order entries followed by a series of unsuccessful telephone calls to obtain "clarification"
- incomplete weight, fluid, and food intake entries in a long-term care resident's record correlated with "change of status" due to poor hydration and resulting hospitalization
- misdiagnosed heart attack in a case in which accurate diagnostic information on EKG strips was not entered into standard medical documentation

Once identified, risks should be evaluated from a systems perspective to determine what causes the failures. It may be helpful to diagram processes for medical record documentation to visually pinpoint system failures or events that set the stage for possible failure.

Comparing how documentation is completed and used with processes anticipated in policy and procedure is another useful way to identify risk. Examining orientation and in-service education materials may also identify misinformation that leads to system failures in the generation or use of medical documentation.

Strategy Two: Risk Prevention

Using data pinpointed through risk identification, a facility can take several steps to use patient record documentation to prevent medical error. See "An Ounce of Prevention," below, for key measures.

Remember, prevention requires careful planning for what needs to be documented and how information is recorded. This means reviewing systems to ensure that the process is reasonable and supports the delivery of patient care.

Strategy Three: Delegating and Disseminating

Preventing documentation error is a team effort shared by physicians, nurses, physical therapists, nutritionists, pharmacists, and other caregivers. Your educational efforts should not be restricted to healthcare risk managers. HIM professionals should be front-line educators on error prevention in documentation, using case studies, rounds, or other forums for educating staff.

Creating a culture of trust and respect is important. Staff should understand that questioning unclear notations, incomplete entries, and flaws in mandatory documentation is not only acceptable but expected. Role playing can help make this point. Part of preventing errors effectively is making staff comfortable in a risk management role. At the same time, training helps ensure that staff members can challenge a documentation practice without causing conflict.

But error prevention goes still further. Another important step is disseminating risk management activity to coders who identify incongruities in codes used for billing patients. Although this activity takes place after the fact, it may indicate process problems in documentation practices. This kind of trending can reveal serious concerns relating to patient care, service utilization, and poor clinical outcomes.

Strategy Four: Surveillance

A successful approach to preventing patient injury involves ongoing surveillance of risk-prone situations. This is as true for clinical therapies as it is for medical record documentation. Two examples illustrate this point:

- A 79-year-old man at risk for elopement is found scratched and bruised in a parking lot adjacent to the skilled nursing facility where he is a resident. A multidisciplinary team reviews the case. Included in the analysis is an in-depth review of the resident's medical record. The record contains a brightly colored label stating "elopement risk." The care plan indicated that the resident was to be monitored at regular intervals during the daytime hours when he was at particular risk of wandering. Monitoring activities were to be logged in a document in the record. The record showed noticeable gaps in the recording process. Given the elopement in this case, surveillance measures were implemented for six other at-risk residents. They included close observation of residents and documentation indicative of the resident "watch" program. At the same time, a team evaluated observation and documentation practices at the skilled nursing facility with a view to pinpointing systems failure. Several flaws were identified related to staff education, communication, and documentation.

- A hospital experienced a series of "near miss" situations involving possible wrong-side surgery. An ongoing surveillance program had been implemented for the surgical unit. It identified inconsistent practice in documenting the side of the body that was targeted for surgery. Policy and procedure was delineated in this area. A review of the systems used at the facility for recording "correct side" surgery information disclosed a series of process failures, including findings that staff were not recording "correct side" surgery information in the most appropriate location in the record. Further analysis showed that surgeons did not always review the record prior to commencing surgery.

As these cases demonstrate, surveillance practices are potent tools in risk prevention. Gaps in documentation, an inability to verify that medical documentation is reviewed by the surgeon prior to commencing an operation, and other at-risk processes can be detected early enough to avert patient injury. In cases in which harm does occur, systemic change may be necessary, and lessons learned from the experience may drive such refinements as a focus on quality improvement and reducing patient injury.

Evidence-based outcome assessment measures put surveillance in a new light. Looking at data trends puts the emphasis on medical record content rather than the absence of anticipated documentation.

For example, a patient who undergoes a total hip replacement has a care plan based on a evidence-based outcome algorithm. Through routine post-discharge or concurrent review of the documentation, utilization management and quality improvement personnel determine that the outcome is a substantial outlier relative to expected results.

The medical record is reviewed to determine if the variation from expected outcome is within acceptable parameters. The record contains no information regarding adverse effects. However, it does reveal evidence of "early" indications of infection that were not acted on in accordance with the post-surgical algorithm. Similar records are examined to see if there is a pattern or trend of similar diagnostic issues. The trended information pinpoints a systems failure in the algorithm that can be modified and improved.

Surveillance can be part of standardized record screening methods. It can also be part of a quality improvement initiative that randomly or selectively samples medical documentation for in-depth review. The concept is not based on a "gotcha" approach but on a quality improvement model that continuously seeks ways in which documentation can be used to enhance patient care.

From a medical error prevention standpoint, quality-oriented record surveillance activities can generate critical information on system failure. Once in hand, such data can be used to successfully address the challenges of medical errors.

Strategy Four: Corrective Action

Identifying medical error (or its potential) is not enough. Facilities need to develop practical steps to rectify documentation system failures that lead to adverse events. (See "Ten Ways to Improve Documentation.") It is not enough for one person to take corrective action, either. While it is laudable for a physician to upgrade the timeliness of treatment entries, this effort is of little help if nursing staff do not read the information before providing care to a patient. A reengineered and streamlined medical documentation program will be fraught with flaws if staff members are not appropriately trained in the new process.

Success demands a team effort by all healthcare professionals. It also requires a system analysis that considers several factors, such as:

- seeking the input of "front line" professionals regarding what types of systems should be implemented to improve care and reduce the potential for medical error
- impact analysis of proposed improvements or changes on existing documentation, communication, and treatment systems
- a determination that the process redesign does not increase the potential for systems-related flaws or patient injury
- piloting proposed improvements or systems enhancements prior to full implementation
- education for those who will use the new process for documentation
- careful monitoring of post-implementation practices
- reviewing post-implementation analysis results and using the information to improve the documentation

Examples of corrective action abound. Some involve simple but useful measures such as programming electronic medical record warnings to appear in red on the top right-hand side of each page of a patient document.

Other actions may require a total change in documentation practices. A good illustration might involve a move away from charting by exception to an integrated progress note system. Instead of a "silo" approach, with professional personnel recording entries in various parts of the record, the integrated approach brings all salient treatment information into one location. Each healthcare professional is responsible for treating the whole patient. The input from varying perspectives then becomes a powerful error prevention and risk identification tool. Observations that might otherwise remain unread by a colleague are presented in a context that may indicate complications, drug sensitivities, or food-drug interactions that could lead to adverse outcomes. It's important to note that corrective action will not be successful if it is a tool for singling out individuals for blame. There is a difference between corrective action and discipline. Error reduction strategies recognize that professional incompetence in documentation practices necessitates education, training, and demonstrated competencies. However, blatant disregard for patient well-being and turning a blind eye to proven systems for documentation come within the scope of disciplinary action. It's critical to keep this distinction in mind.

The Importance of Being Vigilant

These issues will continue to be important in the future. New legislation and regulations will demand process changes in documentation systems. The confidentiality and security regulations of the Health Information Portability and Accountability Act, new state-based requirements for error disclosure, and patient grievance procedures involving patient documentation will all compel the healthcare system to change.

With each change will come the potential for risk-producing systemic failure. Avoiding the possibility of error will require both HIM professionals and risk management experts to remain vigilant.

For example, just as healthcare facilities review new equipment acquisition, they should similarly examine the risk potential of new documentation practices in all sectors, including off-campus facilities such as urgent care centers, wellness offices, and day-surgery units. Areas such as telemedicine initiatives, electronic messaging, or computerized diagnostic devices that generate reports for inclusion in patient care documentation should also be reviewed carefully.

With care and caution, facilities can recognize the potential for system failure and address it in its early stages, avoiding adverse events. HIM and risk management professionals should take this opportunity to forge a partnership to share their knowledge and expertise. Working together, they can reposition medical record documentation as a powerful tool for preventing and addressing medical error—and turn risk-producing systems into systems crafted to prevent process failure.

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Risk Indicators in Documentation

How can you identify potential and actual risk-prone practices in your documentation? Here are some red flags to look for:

- nonchronological order entries
- inexplicable gaps in expected documentation
- late or incomplete entries
- self-serving entries
- second-hand entries based on observations or treatments provided by other healthcare personnel
- illegible handwritten orders
- obliterated entries or missing pages
- inconsistent information about blood type
- inconsistent documentation of "right" side or "left" side surgery site

- incomplete consent documentation
- improper error correction
- noncompliance with state or federal documentation requirements
- inconsistent abbreviation use

An Ounce of Prevention

There are many ways to use patient record documentation to prevent medical errors. Here are some steps to include in your preventive strategy:

- revise flawed documentation practices
- develop a standardized definition for the patient record (paper-based, electronic or both)
- test revised documentation systems prior to implementation
- provide practical orientation programming for documentation systems used by clinical, coding, and utilization personnel
- incorporate "demonstrated competencies" based on documentation processes, especially for high-risk system failures such as late entries and recording errors in documentation
- provide regular in-service education programs, including information learned from system failures and near-miss situations
- provide mandatory education for new computer software or voice-activated or paper-based documentation systems
- provide mandatory education on acceptable documentation practices as part of training programs
- provide mandatory education for supplemental staffing personnel
- implement effective paper-based back-up systems for computer down times
- establish a "chain of command" policy for questioning entries

Ten Ways to Improve Documentation

It's not enough to identify the potential for error—facilities need to take steps to prevent it. Rectifying problems in documentation systems is an important part of the process. Here are 10 ways to improve your documentation:

1. streamline record entry requirements using an integrated progress note
2. indicate appropriate chronological order for reading notations in the record
3. question incomplete or ambiguous notations
4. refrain from guessing about the meaning of unclear or illegible hand-written entries
5. enter concise, factual, and accurate information in the patient documentation system
6. align record design with clinical treatment practices to enhance the opportunity to read and use information for patient care
7. standardize a taxonomy of terms and terms for use throughout healthcare system patient documentation
8. provide mandatory education and on proper use of health facility patient documentation systems
9. standardize the method used to correct errors in patient documentation entries
10. develop and use effective systems failure analysis profiles for detecting actual and potential process problems with a view to corrective action

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