Chapter 8

Evolution of the Health Record as a Communication Tool to Support Patient Safety

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ABSTRACT

This chapter provides a brief history of health records development through the ages, from ancient Mesopotamian clay tablets through to today's electronic health record. An understanding of where we have come from informs future direction and enhances knowledge. While the content and method has evolved, the need to document health information has been consistent for over 4000 years. The central premise has always been to support quality health care through quality information. This chapter will explore the link between health records and patient safety.

INTRODUCTION

Health records are created by clinicians globally to record information generated from providing care to patients. This is information is built on over time to provide a chronological history of a patient's illness, diagnosis and treatments. This text will be of interest to the specially trained workforce that handle the growing expanse of knowledge within the healthcare system – health information management (HIM) professionals.

This chapter provides a summary of the relevant history of health records and their evolution from ancient case notes to today's electronic health records (EHR). There have been several common elements to record keeping across time, which can be attributed to the relationship between patient safety and health records. The reason why clinicians document today is informed by the past, with this chapter exploring several examples from history.

The objective of this chapter is to provide a critical evaluation of the origins, development, and the elements that have remained consistent over time with capture of health information. An analysis of the important relationship between patient safety and health records to understand how documentation elements and structure can support the minimisation of patient harm.

BACKGROUND

The Institute of Medicine (IOM) Report *to Err is Human* highlighted the extent of harm that occurred in the healthcare setting as a result of medical errors. The extrapolated data from 1997 identified medical errors as the eighth leading cause of death in USA estimating between 44,000 – 90,000 people, which was greater than motor vehicles, breast cancer and AIDS. (Committee on Patient Safety and Health Information Technology & Institute of Medicine, 2011; Kohn, Corrigan, & Donaldson, 2000). In European hospitals every tenth patient experiences preventable harm or an adverse event (WHO, 2019). While the IOM report is considered ground-breaking, and lead to action to protect patients from injury, patient safety itself is not a new concept. The term 'do no harm' dates back to the time of Hippocrates(Yapijakis, 2009).

Patient safety is associated with health records through documentation errors (Jylha, Mikkonen, Saranto, & Bates, 2017), medication errors(Al-Sarawi, Polasek, Caughey, & Shakib, 2019); missing clinical information (Burnett, Deelchand, Franklin, Moorthy, & Vincent, 2011) as well as the benefits of improving communication, sharing of information and implementation of EHRs (Alanazi, Butler-Henderson, & Alanazi, 2019; Sittig, Belmont, & Singh, 2018). It is important to understand the relationship between these two components to appreciate the value of health information for patient safety and to learn for the future. This is reflected in the quote "One main thread continues to bind the past to the future – the goal of supporting quality health care through quality information" (Abdelhak, 2016, p. 41).

HISTORY OF HEALTH RECORDS

Health records are used by clinicians when delivering care to patients. They are the repository of information from past presentations and the current episodes of care which is then used to plan future care. Health records now contain a vast amount of information on individual people, but this was not always

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