Naming Clinical Forms

Table of Contents

Introduction.................................................................................................................................................................... 1
    The Need for Identifying Clinical Forms – A Historical Introduction......................................................... 2
    Identifying Clinical Forms in Electronic Systems .......................................................................................... 3
    Identifying Clinical Forms in a Hybrid Environment at Fraser Health Authority .............................. 4
Naming Convention for Clinical Forms – Fraser Health Authority (FHA)......................................................... 6
    Overview .......................................................................................................................................................... 6
    Naming Convention for Clinical Forms ......................................................................................................... 7
The Role of the HIM Professional..................................................................................................................... 11
References ............................................................................................................................................................ 12

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Introduction

Technology has always played an important role in health information management. Technology determines how we store, retrieve, access and analyze the information clinicians, as well as the clinical support and administrative staff need for their daily work. The advent of electronic systems has had a profound impact on health information management and hence, the required skill set for the profession. But there are core skills that have not changed and that remain of paramount importance in supporting the quality information needs of the Canadian health care system. In this Professional Practice Brief (PPB), we assert that the skill set of HIM professionals, especially in regards to records management techniques are still of great importance today, in spite of the technological advances we have and continue to evolve through.

Regardless of format (paper or electronic), the HIM skill set of accurately and consistently naming clinical forms is one records management technique that is still critically important. Correctly and consistently naming clinical forms ensures they are easy to locate in a multitude of computerized systems. This supports both the documentation needs of the clinicians in their role as care providers, as well as the administrative needs of the facility through the subsequent collection and analysis of data. In addition, quality of data is dependent on the consistent and accurate naming of the records being evaluated and compared. In other words, in order to identify and compare like data sets for meaningful data analysis, identifying the form by its name is the first step toward achieving that goal.

Health information management has traditionally paid attention to the naming of clinical forms, but the advent of electronic systems seems to have shifted the attention in a different direction. It is important to remember basic record management techniques that guided the HIM profession in paper-based systems because this very same skill set will assist clinicians and clinical support staff to find what they need in the most effective and efficient manner in the electronic and hybrid system as well.

In the following pages we will share a short historical introduction to the topic of naming forms. We will then discuss briefly why naming still deserves the HIM professionals attention and why it is still relevant for electronic systems. In fact, it has never been more important. To illustrate our claims, we have provided examples from Fraser Health Authority to consider this PPB case study. The clinical forms naming we have authored for use in Fraser Health Authority is intended to illustrate our claim that naming still needs the attention of the HIM professional. The HIM profession has worked on data quality standards related to records management practice since 1928. With the introduction of
the fourth HIM professional domain of practice, HIM standards, data quality issues related
to the naming of clinical forms would fall under this fourth domain. Our skill set is
transferable from the hybrid to the electronic environment - across all levels of care - and
we need to apply them to the emerging changes that are taking place in health care,
including to the role of providing leadership in naming clinical forms. Looking back and
learning from the past of our profession enables us to actively shape its future.

The Need for Identifying Clinical Forms – A Historical Introduction

“Every form1 should have a name so that whenever reference is made to it there will be no
doubt as to which one is meant.”2 This advice given by the author Wallace Clark in his Shop and Office Forms: Their Design and Use from 1925, is as timely today as it was at
the beginning of the twentieth century. In addition to the purpose of identification for
communication, Clark also mentions retrieval and providing access as the purpose of
naming forms properly. The form should be designed to make “sorting easy, i.e., one form
should be differentiated from another by having a name printed on it as well as by color,
size, or general appearance.”3

Clark’s book arrived at a time when there was a greater need for forms which required
proper management.4 The same holds true for health care: structured and preformatted
forms did not only proliferate in the business environment but also in the hospital. The
historian of medicine, Joel D. Howell noted in his Technology in the Hospital. Transforming
Patient Care in the Early Twentieth Century, that health care professionals in the United
States saw a “438-fold increase in the use of forms”5 from 1900 to 1925. For Howell, this
“reflected an increasingly specialized medical world.”6

Forms needed to be organized to be ready for use by clinicians as well as the
administrative staff. But equally important was the organization of the medical records, i.e.
organizing the forms once their data collecting fields had been populated by relevant care
providers. And this is where the Medical Records Librarian came into existence, as Edna
Huffman in an article from 1947 observed: “A medical records librarian is one trained to

1 Clark differentiates two functions of a form: “Forms and the information they bear are the
mechanisms […] to express […] two purposes […]: 1. Give instructions as to what is to be done, or, 2.
Record what has been done.” (Clark, 1925, 2) Examples for forms in health care would be: algorithms,
checklists and flowcharts instruct whereas assessment records and nursing flowsheets record what
has been done or has been observed.
2 Clark, 1925, 21.
3 Clark, 1925, 17.
6 Howell, 1997, 45.
co-ordinate and to organize all data submitted by the various departments of the hospital, so that an adequate and accurate medical record for each patient is readily available at all times for the use of the properly qualified person.\textsuperscript{7} That hospitals needed data was obvious from the outset, as this comment from 1933 makes clear: “a hospital without records is like a clock without hands, still running but giving out no information as to whether it is right or wrong.”\textsuperscript{8} Or, as the chapter on “Forms Design and Control” in Huffman’s \textit{Health Information Management} stated in a different metaphor: “Data are the lifeblood of health care facilities.”\textsuperscript{9}

By the end of the century, effective forms control programs within hospitals had been established to help to tame the ever increasing amount of forms being created. This included how they were named for the purpose of “Identifying the Form” (a chapter title of Morris H. Moriuchi’s \textit{Forms: Control, Analysis, Design}) which remained an important topic for health information management professionals.\textsuperscript{10} Vocabulary control in naming forms was facilitated by assigning the responsibility of forms control to one person or a committee. Moriuchi deemed the value of a committee to be of paramount importance and he identified the first step in the forms control process to be the selection of a committee to manage the process.\textsuperscript{11} This would provide not only accountability for forms control but also consistency in naming forms.

\textbf{Identifying Clinical Forms in Electronic Systems}

The advent of electronic systems in the hospital in the second half of the twentieth century made the task of forms control more difficult. This has several reasons:

1. Most electronic systems provide access not only to the health information management professional but also to the clinician. Instead of having a bundle of relevant forms printed out for documenting the patient encounter, clinicians who are using electronic systems need to find the right form before they can begin to document and subsequently collect and review their data. While full-text search and metadata are, of course, options for retrieval in electronic systems, the most common way of accessing a form in most cases is still by the name of the form.

2. Electronic systems pose a challenge to forms control because it is unlikely that only one particular system is used to collect all the patient information. This is not only

\begin{itemize}
\item \textsuperscript{7} Huffman, 1947, 209.
\item \textsuperscript{8} Quoted in Black, 1933, 12.
\item \textsuperscript{9} Cof, 1994, 247.
\item \textsuperscript{10} Moriuchi, 1969, 21: “Every form should have a title which would indicate its purpose and function.” See also Whitlock, 1994, especially 265-273 on forms control.
\item \textsuperscript{11} Moriuchi, 1969, 4–5.
\end{itemize}
because hospitals and health authorities will employ various systems but also because primary and secondary health care providers are not using the same system. Today, it is most likely that we will encounter one or more core electronic systems with several satellite systems in each hospital setting. Each of these systems is likely to be owned – and its forms named – by different units, programs or services within the hospital or health authority.  

Thus, not only interoperability deserves our attention but also the efficient management of naming these forms. Without this effort towards synchronization, relevant data will not be retrievable in a consistent and timely way resulting in lost, error prone or incomplete analysis.

(3) While there is most likely more than one electronic system in place in various stages of implementation, the reality is we most often face a hybrid environment where various electronic systems interface with paper-systems. This hybridity is rarely acknowledged but in reality will not go away very soon.

With the advent of electronic systems, health information management professionals are not the only guardians and gate-keepers of clinical information anymore. It is a sad reality, as Howard has put it, that “records managers remain sidelined from strategic information decisions.”  

By providing a blueprint for a common vocabulary we can once again be part of and lead new developments in the field of health information management. The benefits are still the same as they were at the beginning of the twentieth century: to identify, communicate and provide access to forms which are an integral part of health care delivery. HIM professionals not only understand the importance and have the know-how for vocabulary control and classification as well as interoperability frameworks, but also understand that this is crucial for patient safety and quality of care.

Identifying Clinical Forms in a Hybrid Environment at Fraser Health Authority

The term “hybrid records management” has been introduced to describe the fact that in most organizations today both electronic records as well as paper records have to be managed. Fraser Health Authority is an example of such a hybrid health records environment. Fraser Health is the largest health care region in British Columbia, serving one third of the province’s population of more than 1.6 million people, across a large geographic area that includes both urban and rural areas. It is comprehensive and encompasses twelve (12) acute care hospitals, and other care facilities including: mental

12 Stephen Howard has observed that with the introduction of electronic systems “the traditional records centre has tended to be bypassed” (Howard, 2002, 4).
15 CHIMA, 2012.
health and residential care. Public health, home and community care programs are also included for a current total of 7487 care beds. This means Fraser Health must manage an extensive variety and quantity of paper based forms, including a vast quantity of over 4000 different clinical forms. Added to that is the numerous electronic systems housing electronic form views with the entire hybrid system not being overseen by one single committee or entity within the health authority which presents a very complex form management challenge.\footnote{It is thus difficult to determine the exact number of the different electronic systems.}

The following naming convention was developed as a guideline for form developers of paper forms as well as electronic forms at Fraser Health to assist in managing this complex health care system. It is also used for educational purposes, to inform users on how to find and access clinical forms.
Naming Convention for Clinical Forms – Fraser Health Authority (FHA)

This naming convention assists form developers and form reviewers in the process of naming or renaming clinical forms. It consists of a one-page overview as well as the more detailed naming convention.

Overview

By naming a clinical form, the following points should be kept in mind:

- **Informative titles**
  The title should clearly indicate what the form is about and for which purpose the form is created.

- **Required title elements and order of title elements**
  The description of the content of the form should come first, followed by the document type.

  Title = (1) Content Description - (2) Document Type

- **Further title elements and order of further title elements**
  In order to differentiate the form from other forms it might be necessary to include more than the two required title elements (content description, document type) in the title.

- **Canadian Spelling**
  Each form title should follow Canadian spelling, for example “anaesthesia” instead of “anesthesia”.

- **Abbreviations and acronyms**
  Only safe abbreviations and acronyms should be employed.

- **Hyphens and symbols**
  Hyphens and symbols should be avoided.

- **Medication names**
  Medication names should follow Fraser Health’s TALLman Lettering Policy.

- **Referrals**
  Referrals need to include “to” and/or “from” in the title.

- **Forms that are not scanned into the electronic health record**
  Forms that do not become part of the patient’s legal health record must be clearly identifiable.

- **Revising a form and renaming a previous title**
  During the form development process, it is necessary to consider previously named forms and the way they currently sort in the electronic system.
• **Glossary and further explanation** (Underlined terms with an asterisk are defined in greater detail).

**Naming Convention for Clinical Forms**

**Informative titles**

Each clinical form* [for underlined terms with an asterisk refer to the Glossary at the end of this document] should have a unique and informative title. The title should consist of as many title elements* as necessary to differentiate one form from another and a minimum number of title elements to accurately describe the form.

**Example:** The form title “Mom’s Record” is not informative as it does not inform what the form is about. Analyzing the content, purpose and function of the form, the title “High-Risk Pregnancy Monitoring Sheet” is a better description of the form and purpose. Thus, “Mom’s Record” should be “High-Risk Pregnancy Monitoring Sheet”.

**Required title elements and order of title elements**

Each form should have at least two title elements: (1) content description* and (2) document type*. These title elements should display in the following order.

Title  = (1) Content Description - (2) Document Type

The purpose behind describing the content of the form is first to improve findability and accessibility. This is due to the fact that software applications such as FormImprint are sorting documents alphabetically by initial letter. If the content is being described first, forms can be found more easily within the FormImprint job tree hierarchy, and like forms will be grouped together.

**Example:** There are 120 forms with “admission” in the title currently in use at Fraser Health but only 30 of these form titles are starting with the term “admission” (i.e. only 25%). Current form titles are, for example:

- “ACAHP Admission Assessment”
- “Community ICU Admission”
- “General Admission – SSDTU”
- “ICU Admission BH”
- “NICU Admission”
Since FormImprint (and all other software applications dealing with form titles) sort alphabetically, these admission forms will not be in close proximity. In changing the order of the title elements, admission forms could be brought together to facilitate their retrieval and access.

Further title elements and order of further title elements

To differentiate forms, it might be necessary to include title elements as well. These terms should come after the content description and the document type in the title, i.e. be in the third position of the title. If there is more than one title element from this category required, the order follows either natural language (i.e. English grammar rules) or historical usage. Examples of further title elements might be:

- Clinical Program (e.g. “Surgical Services”)
- Profession (e.g. “Respiratory Therapy”)
- Population (e.g. “Adult”, “Newborn”)
- Hospital and Unit (e.g. “RCH”, “NICU”)
- Level of Care (e.g. “Emergency”, “Ambulatory Care”)

Canadian Spelling

Canadian spelling should be followed, e.g. “colour” instead of “color”, “anaesthesia” instead of “anesthesia”. It is important to be consistent with spelling since FormImprint and other software applications are not able to retrieve a form if the search term does not match the title element. For example, a search for “anaesthesia” would not retrieve “anesthesia” and vice versa.

Abbreviations and acronyms

Do not use abbreviations or acronyms. If required to use abbreviations or acronyms, use abbreviations or acronyms from the Clinical Abbreviations, Acronyms and Symbols List\(^{18}\) (e.g. patient location within a hospital or the hospital itself: “NICU”, “RCH”). It cannot be assumed that the meaning of an abbreviation or acronym is known to every healthcare provider dealing with the form.

Hyphens and symbols

Hyphens and symbols should be avoided as they influence sorting and retrieval. For example, instead of “Gastro-Intestinal” use “Gastrointestinal”; instead of “Non invasive” or “Non-invasive” use “Noninvasive”, “Bowel Resection / Post-op” use “Bowel Resection

\(^{18}\) FHA, January 2014.
Postop" instead. If symbols cannot be avoided, please refer to the Clinical Abbreviations, Acronyms and Symbols List\textsuperscript{19}. 

**Medication names**

If a Medication name is included in the title, it should be written following Fraser Health’s TALLman Lettering Policy\textsuperscript{20} – this is a patient safety requirement. In addition, please refer to the Fraser Health Pre-Printed Orders containing Medications Development Process.\textsuperscript{21}

**Referrals**

For referrals or transfers of care it is important to include the words “to” or “from” in the description as well as secondary terms that include both the starting point and end point location.

**Forms that are not scanned into the electronic health record**

Administrative and education forms as well as worksheets that do not become part of the patient’s legal health record must be clearly identifiable. These types of forms are not barcoded and would not be scanned into the electronic health record, but the intent should be clearly indicated in the content description and document type description within the title.

**Revising a form and renaming a previous title**

During the form development process, it is necessary to consider previously named forms and how they currently sort in the electronic system. If adjustments are required, this must be identified in the implementation and roll-out plan. If titles are extremely long, truncated display names and or mnemonics must follow current standards and should be pre-defined.

**Glossary and further explanations**

-Clinical form: “A basic standardized tool used to capture patient data.”\textsuperscript{22}

-Content description: The content description answers one (or more) of the following questions: *What is the form about? What condition does the patient have? What anatomical site is impacted? When is/was it occurring?*

\textsuperscript{19} FHA, January 2014.
\textsuperscript{20} FHA, September 2010.
\textsuperscript{21} FHA, May 2013.
\textsuperscript{22} FHA, November 2012.
For medical documents, this most likely includes the lead term* for the disease process (e.g. “Pneumonia”).

For surgical documents the lead term would be related to the anatomical site of the surgery (e.g. “Bowel”). In addition, it might be necessary to follow the lead term with secondary terms* that answer the question When does it occur? (e.g. “Preoperative” [or “Preop”], “Postoperative” [or “Postop”] after the lead term). Anaesthesia, for example would be considered a condition and is a very specific state the patient is in and should always stand alone (e.g. “Anaesthesia Postop” or “Anaesthetic Preop Questionnaire”).

**Document type:** The document type indicates what kind of document the document is and captures the function or purpose of the document, for example:
- Agreement
- Certificate
- Consent
- Contract
- Letter

In addition, the document type indicates how the data is being captured or requested within the document, for example:
- Checklist
- Flow sheet
- Questionnaire
- Survey
- Worksheet

**Lead term:** “Lead terms indicate the noun expressed as the name of a disease, injury or other condition”\(^{23}\). They should be considered terms that most clearly describe the content of the patient care form in order for the document to be easily retrieved for a multitude of purposes when electronically stored: (1) patient care; (2) release of information; (3) data reporting and (4) integration with other systems and services. See also secondary term*.

**Secondary term:** “Secondary terms are adjectives and are described as modifiers. They refer to the anatomical site, the variety or type of the disease or injury, etiology, or other special circumstances”\(^{24}\). These terms further define lead terms to support the retrieval of information from electronic systems for: (1) patient care; (2) data reporting; (3) release of information and (4) integration with other systems and services.

\(^{23}\) Fletcher et al., 2012, 2.7.
\(^{24}\) Fletcher at al., 2012, 2.7.
Secondary terms can become the lead term when a noun cannot be found to supersede the secondary term(s). See also lead term*.

**Title element:** A title element is any word that is used to describe the clinical form or order set within in the title.

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**The Role of the HIM Professional**

In summary, we have described one way HIM professionals can play a major role in the field of health information management. Using their expertise in records management fundamentals, HIMs have the skill set to lead and manage the process of naming and storing clinical documents.

HIM professionals understand the importance of vocabulary control and classification systems and how they impact interoperability frameworks. This understanding is crucial in supporting the interdisciplinary team in matters regarding patient safety, quality of care and the accurate and timely delivery of health care data for future decision making.

It is hoped that Fraser Health’s experience as described in this PPB will open the door for ongoing discussions on the transferability of our HIM skill set as we continue to migrate to a more electronic environment. It is paramount that HIM professionals step into their skill set and understand the role they continue to play in today’s evolving health care system.

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Fraser Health Authority (FHA). (May 2013). *Fraser Health Pre-Printed Orders containing Medications Development Process*. [This document for internal use only describes the process which needs to be followed to develop or revise Pre-Printed Orders.]

Fraser Health Authority (FHA). (January 2014). *Clinical Abbreviations, Acronyms and Symbols List & Do Not Use Clinical Abbreviations, Acronyms and Symbols List*. 

[This document for internal use only prescribes which abbreviations, acronyms and symbols should and should not be used within the organization.]


For more information

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