

REPAIR OF CATASTROPHIC EDITS TO PATIENT IDENTITY

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook establishes standard procedures for the consistent and timely correction of inaccurate electronic health record information and mitigation of risk associated with clinical and administrative decisions based on erroneous data as a result of catastrophic edits.
- 2. SUMMARY OF CHANGES.** This is a new VHA Handbook, which provides procedures for the correction of electronic health record data due to catastrophic edits to patient identity.
- 3. RELATED ISSUES.** VHA Handbook 1907.01 and VHA Handbook 1605.1.
- 4. FOLLOW-UP RESPONSIBILITY.** The Office of Health Information (19) is responsible for the contents of this Handbook. Questions may be referred to the Director, Health Data and Informatics at 202-461-5848.
- 5. RECISSIONS.** None.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for recertification on or before the last working day of July 2014.

Gerald M. Cross, MD, FAAFP
Acting Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publication Distribution List 7/29/09

CONTENTS

REPAIR OF CATASTROPHIC EDITS TO PATIENT IDENTITY

PARAGRAPH	PAGE
1. Purpose	1
2. Background	1
3. Definitions	1
4. Scope	2
5. Responsibilities of the National HC IdM Program	2
6. Responsibilities of the Veterans Integrated Service Network (VISN) Director	2
7. Responsibilities of the Facility Director	2
8. Responsibilities of the Facility Chief, Health Information Management (HIM)	3
9. Goals	3
10. Building Blocks to Accomplish Goals	3
APPENDIX	
A Checklist for Catastrophic Edit Repair	A-1

REPAIR OF CATASTROPHIC EDITS TO PATIENT IDENTITY

1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures for correcting health and demographic information contained within electronic databases when health or administrative data are erroneously associated with a patient as a result of a catastrophic edit to the identity of one patient record to that of another patient record. This Handbook provides standard procedures for the consistent and timely correction of inaccurate electronic health record information and mitigation of risk associated with clinical and administrative decisions based on erroneous data as a result of catastrophic edits.

2. BACKGROUND

The implementation of the Master Patient Index (MPI) in 1998 provided the ability to link all active patient records across the VHA enterprise and facilitated the sharing of patient electronic health information. The establishment of the Health Care Identity Management (HC IdM) Program in 2001 allowed for monitoring of changes to identity in existing records and has revealed a recurring issue of catastrophic edits to patient identity traits. When edits are made to the identity traits of a patient's record in the local Veterans Health Information Systems and Technology Architecture (VistA) system, the MPI is alerted of potential catastrophic edits. These alerts are reviewed by the HC IdM Program staff to determine if a catastrophic edit has in fact occurred.

3. DEFINITIONS

a. **Catastrophic Edit.** For the purpose of this Handbook, catastrophic edit includes changes to a patient's electronic health record that result in the record being changed to that of another patient, caused by, but not limited to, edits to patient identity data (such as name, Social Security Number (SSN), date of birth, gender) and/or erroneous merging of two or more distinct patient records into a single record within VistA.

b. **Catastrophic Merge.** Catastrophic merge occurs when different patients' electronic health records are merged using the Duplicate Record Merge software, resulting in a change in the patients' identities.

c. **Duplicate Patient Merge.** Duplicate Patient Merge is the commonly used name for the Duplicate Record Merge application. The Duplicate Record Merge is a VistA software application with functionality to merge two records from within the same file in VistA. The application allows the user to select which data will be preserved in the surviving record.

d. **Master Patient Index (MPI).** The MPI is a database that contains over 14 million patient entries populated from all VHA facilities nationwide. The MPI provides the access point

mechanism for linking patient's information to enable an enterprise-wide view of patient information.

e. **Integration Control Number (ICN)**. The ICN is the Universal Health Identifier (UHID) assigned and maintained by the MPI to each unique patient.

4. SCOPE

This VHA Handbook defines common causes and provides procedures for the remediation of catastrophic edits, including those caused by patient record merges. It establishes timelines and criteria for data repair activities, and assigns roles, responsibilities, and tasks for data repair in effected software applications and files.

5. RESPONSIBILITIES OF THE NATIONAL HC IdM PROGRAM

The national HC IdM Program staff is responsible for:

a. Conducting a comprehensive review of any potential catastrophic edit. In the event a catastrophic edit has occurred, this team makes the initial determination as to which patient's record is restored and which patient will have a new record created. Normally, the original record will be restored and a new record created for the second patient.

b. Providing initial assistance to the facility in beginning the comprehensive review process of all affected data and monitoring restoration of the patient records until complete.

c. Ensuring, in conjunction with the National Patient Safety program, quarterly reviews of all catastrophic edits that are completed and evaluating findings for potential actions to be taken to reduce the occurrence of catastrophic edits to patient identity.

6. RESPONSIBILITIES OF THE VETERANS INTEGRATED SERVICE NETWORK (VISN) DIRECTOR

The VISN Director is responsible for:

a. Ensuring all data is accurate and complete and associated only with the patient for whom the data belongs within each medical facility within their purview, and

b. Ensuring that consistent and appropriate policies and procedures are implemented within each facility.

7. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The facility Director is ultimately responsible for ensuring all data is accurate and complete and associated only with the patient for whom the data belongs, and is responsible for ensuring that:

a. All facility staff involved in the editing or alteration of the electronic health record exercise care and caution when making changes to identity traits of patients and report any suspected catastrophic edits to their designated facility MPI Point of Contact (POC).

b. A local Catastrophic Edit Repair Team is established that, at a minimum, includes a Program Application Specialist (PAS) or Automated Data Processing Application Coordinator (ADPAC) with VistA expert user skills, the MPI POC, an Information Resource Management (IRM) or Information Technology (IT) programmer, Clinical Application Coordinator (CAC) for affected applications, a site Patient Safety Officer, and a Health Information Management (HIM) representative. *NOTE: The Catastrophic Edit Repair Team may delegate tasks to other facility personnel, who must work with an HC IdM staff member, a Patient Information Management Systems (PIMS) Specialist and potentially other Product Support (PS) teams as needed.*

c. A staff member (facility, HC IdM, PS Specialist) is designated who initially identifies catastrophic edits and is responsible for entering a Remedy ticket and corresponding Patient Safety Incident Report.

d. PS staff provide support to the facility through all steps of the resolution process using the REMEDY ticket and assist in data repairs as needed (for example the PIMS Specialist and other ancillary package support staff assist as needed).

e. A local MPI POC is designated to act as the primary liaison between facility staff and the HC IdM staff for all issues related to catastrophic edits.

8. RESPONSIBILITIES OF THE FACILITY CHIEF, HEALTH INFORMATION MANAGEMENT (HIM)

The Chief, HIM, equivalent position, or designee, is responsible for maintaining the integrity of the electronic health record and ensuring all catastrophic edits, changes, and corrections are completed within the timeframes defined (see par. 9c).

9. GOALS

The key goals are to maintain the integrity of the electronic health record, to minimize patient safety risk, to support health care for patients, and to ensure catastrophic edits to patient records are addressed in a consistent, timely and comprehensive manner.

10. BUILDING BLOCKS TO ACCOMPLISH GOALS

The primary building blocks to accomplish the goals are:

a. **Local Monitoring.** Building block I is the local monitoring of all edits to patient identity traits and the review of potential catastrophic edits to determine what, if any, action is required based on appropriate criteria. This includes:

(1) Ensuring staff is assigned to monitor the VistA bulletins “SSN CHANGED” and “PATIENT NAME CHANGED” to monitor possible catastrophic edits as they occur. This is a

key function that provides responsible staff the information to address problems quickly and to minimize the impact of potential catastrophic edits. **NOTE:** For further information see: [http://www.va.gov/vdl/documents/Clinical/Admis_Disch_Transfer_\(ADT\)/reg.doc](http://www.va.gov/vdl/documents/Clinical/Admis_Disch_Transfer_(ADT)/reg.doc)

(2) Assigning the VistA DG CATASTROPHIC EDIT security key to the responsible PAS or ADPAC, their alternates, and supervisor, so they are recipients of the POTENTIAL CATASTROPHIC EDIT OF PATIENT IDENTIFYING DATA alerts. These alerts, generated within the Registration Intake process, ensure that users are fully aware of potentially catastrophic changes made to patient identity traits. Patient identity fields are Name (first and/or last), SSN, date of birth, and sex (gender). A warning message appears to the user during the registration process when the edits indicate the potential for a catastrophic edit. If the user proceeds to make changes to the patient's identity fields, the alert is triggered with the potential patient catastrophic edit information, and is sent to the individuals assigned the DG CATASTROPHIC EDIT security key. Designated staff need to review these alerts on a routine, timely basis to ensure that catastrophic edits are reported and resolved and that any issues with staff performing catastrophic edits are addressed.

(3) Establishing a process for daily review of the REPORT- PATIENT CATASTROPHIC EDITS option and ensuring that all potential catastrophic edits listed on the report have been reviewed. **NOTE:** Only those with the DG SUPERVISOR key have access to run this report.

b. **Definition Of Roles And Responsibilities.** Building block II is ensuring that the definition of roles includes responsibilities of local and national personnel to identify, remediate, and restore data.

(1) The national HC IdM Program is responsible for conducting a comprehensive review of the potential catastrophic edit (see par. 5).

(2) The VISN Director is responsible for ensuring all data is accurate and complete and associated only with the patient for whom the data belongs within each medical facility within their purview and for ensuring that consistent and appropriate policies and procedures are implemented within each facility (see par. 6).

(3) The facility Director is ultimately responsible for ensuring all data is accurate and complete and associated only with the patient for whom the data belongs (see par. 7).

(4) The Chief, HIM or equivalent position, or designee, is custodian of the patient health record at each facility and has the day-to-day responsibility for an accurate and complete record (see par. 8).

(5) The facility Privacy Officer is responsible for addressing any identified privacy violations that may result from catastrophic edits to patient records.

(6) The facility Chief Business Office (CBO), or designee, is responsible for identifying the members of the specified mail groups and recipients of the necessary security keys to monitor for potential catastrophic edits.

(7) The MPI POC is responsible for facilitating the resolution of any catastrophic edits identified through daily maintenance activities, including but not limited to, processing of MPI exceptions, review of alerts and bulletins, and other related tasks.

c. **Timelines and Priorities.** Building block III is the establishment of timelines and priorities for catastrophic edit resolution activities.

(1) Once discovered, each involved patient record is to be flagged immediately, using a Category II Patient Record Flag (PRF), indicating that the record may contain compromised data. All PRF require an accompanying progress note and the HIM representative, designee, or person responsible for setting the flag must document what steps will be taken to restore the information. Once the catastrophic edit is resolved, the PRF must be removed. *NOTE: For instructions on how to set the PRF, refer to the PRF User Guide at: http://www.va.gov/vdl/documents/Clinical/Patient_Record_Flags/dg_53_650 Ug.pdf.*

(2) Timelines for data correction:

Conditions	Timeframe
(1) Current inpatient(s) affected.	Immediately, but no later than 1 working day, on discovery or notification from HC IdM Program.
(2) Current outpatient with active prescriptions, future appointments, and pending consults.	Within 5 working days or before the next scheduled appointment; whichever comes first.
(3) Outpatient with no activity within the last 3 years.	1-15 working days.
(4) Patient is deceased, had never received care or had no future care scheduled.	1-25 working days.

d. **Effective Communication and Training Strategies.** Building block IV is the establishment of effective communication and training strategies for the prevention, identification, and resolution of catastrophic edits to patient identity, including, but not limited to, front line staff, providers, and other members of the health care team.

(1) **Communication Strategy.** It is imperative that there is effective communication between all appropriate staff to alert them of catastrophic edits and to begin the necessary correction process.

(a) The local catastrophic edit repair team must notify and advise the affected health care team of the status of the clean up of the electronic health record until all issues have been resolved.

(b) An effective method for communicating catastrophic edits is the use of the Category II PRF. When the record has been completely restored, the PRF must be inactivated. The HIM designee must document an administrative progress note within the electronic health record

outlining the steps taken to restore the record and the staff involved. *NOTE: In the event that all issues can not be resolved, the PRF must remain active.*

(c) The HC IdM Program provides guidance to the MPI POC on how to proceed, identify, and initiate steps to begin the resolution process, which is to be accomplished using e-mail and telephone calls.

(d) Appropriate communication mechanisms, including face-to-face meetings, conference calls, and e-mails (when using e-mail, encryption must be used if patient personally identifiable information is included) need to be used by all parties to facilitate the resolution of the data being corrected.

(e) The national PS team communicates with site staff to identify and provide guidance on the necessary corrective actions. The Remedy ticket is the primary communication mechanism between local facility and PS staff.

(f) The HC IdM staff, Medical Center staff, or PS must enter a Patient Safety Incident (PSI) report to advise the National Patient Safety Workgroup that a catastrophic edit has occurred.

(g) In the event a merge of patient records is required, prior to the actual merge of potential duplicate records, the facility POC responsible for merge activities must communicate with the HIM representative and appropriate clinical ancillary reviewers to ensure the proposed merge is an actual duplicate. All proposed merges must be reviewed and approved by the clinical ancillary package experts and the Chief, HIM, or equivalent.

(2) Training Strategy

(a) All individuals with the ability to enter, edit, and merge patient identity data (such as name, date of birth, SSN, and gender) specifically, those individuals who have been given the privilege of being assigned to the Vista "DG Load Edit Key," or a local equivalent, are required to complete and document all required training including, "Preventing Catastrophic Edits (PCE) to Patient Identity" (available on VistAU: <http://vaww.vistau.med.va.gov/VistaU/PCEI/default.htm>). This training is required prior to the assignment of the key to the individual. Supervisors are responsible for ensuring this training is successfully completed and documented by the employee, as this is a key competency for patient selection. Any individual who does not demonstrate competency of this skill must re-take the training until core competency is established. Any individual who mis-selects a patient and generates a catastrophic edit to a patient record must re-take the training and provide evidence of successful completion to the individual's supervisor and the HC IdM Team. Supervisors must monitor employee work quality and ensure that employee achieve and maintain core competency of this skill; failure to achieve competency can lead to a patient safety issue.

(b) Additional Training Resources include:

1. "Joe's Data Meets the MPI" video.
2. Administrative Data Quality Tips of the Month.

NOTE: All resources are available on http://vista.med.va.gov/mpi_dqmt/training_docs.htm. This is an internal web site and is not available to the public.

e. **Resolution Process.** Building block V is the definition of the overall resolution process to correct data (see App. A for a checklist of tasks that need to be completed).

f. Ensurance that all impacted electronic systems have been addressed, including Commercial Off-the-Shelf (COTS) applications, enterprise data repositories, inter-agency data exchanges, and others where mechanisms exist.

f. **Impacted Electronic Systems.** Building block VI is ensuring that all impacted electronic systems have been addressed, including COTS applications, enterprise data repositories, inter-agency data exchanges, and others where mechanisms exist. Local facilities are responsible for taking appropriate action to restore the record including COTS applications, administrative data, and clinical health data; this includes:

(1) Ensuring a log or trail of corrections and "who corrected the data and why" is available. For example, older appointment data may be re-entered on a progress note rather than through the Scheduling Application, but the data must be complete, contain explanations, dates, and times of care.

(2) Establishing and implementing of a systematic process for data restoration.

(3) Maintaining an audit trail or log of corrections and who corrected the data.

CHECKLIST FOR CATASTROPHIC EDIT REPAIR

*NOTE: Under the Responsible Staff column, Product Support marked with ** can provide guidance when requested.*

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
1	Notify Appropriate Staff of Discovery of Catastrophic Edit.	Medical Center Staff, Health Care Identity Management (HC IdM) Staff or Product Support (PS) Staff		
2	Create Remedy ticket.	Medical Center Staff, HC IdM or PS Staff		
3	Triage Remedy ticket and Assign to appropriate PS team.	PS Staff		
4	Create Patient Safety Incident (PSI).	Medical Center Staff, HC IdM or PS		
5	Create new patient record(s), correct patient identity, and demographics information per HC IdM instructions; note actions and initial list of applications affected on Remedy ticket.	Medical Center Staff, HC IdM Staff		
6	Direct ticket to PS Patient Information Management Systems (PIMS) Support.	HC IdM Staff		
7	Flag patient records to alert providers of potential record issues.	Medical Center Staff		
8	Determine if patient(s) are currently receiving in- or outpatient treatment and/or have future appointments.	Medical Center Staff, **PS Support		
9	Verify that correct wristbands are on inpatient(s).	Medical Center Staff		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
10	Assess data affected at a high level: Print a detailed Health Summary from the “Range of Dates Patient Health Summary” option; for example: Select health summary type “Remote Clinical Data (4YR)””; enter a date range of 1980 through current date; save output to a file. Note on Remedy ticket all applications where the data exists.	Medical Center Staff, **PS PIMS Support		
11	Assess data affected at a detailed level, including enrollment and eligibility: With the health summary as a “roadmap”, use Computerized Patient Record System (CPRS) for example: “Order Summary for a Date Range” on the CPRS Reports tab), other application displays, and FileMan to find details. An example: some laboratory tests results (including pathology reports) have a significant diagnosis with a long-term impact on the care of a veteran; these need to be carefully reviewed and moved to ensure they are not left in the wrong record.	Medical Center Staff, **PS PIMS Support		
12	Assign additional support teams as needed.	PS PIMS Support		
13	CAUTION: Do not delete, cancel, or discontinue anything appearing on the wrong record before re-entering data on the correct record. Keep records of changes so they can be documented in an audit trail progress note.	All Staff involved in catastrophic edit repair		
14	Review Pharmacy prescriptions and Inpatient Meds and alert staff to prevent giving patient(s) the wrong medications. CPRS Reports tab displays outpatient orders by issue date and Inpatient Meds by start date. Work from screen capture lists that have start and end dates and prescription numbers which can be entered in “View Prescription” to get details.	Medical Center Staff, **PS Clin 1 Support		
15	Review Adverse Reaction Tracking (ART). Mark items as retracted as needed and re-enter on correct patient.	Medical Center Staff, **PS Clin 1 Support		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
16	Assemble site-staffed repair team (Program Application Specialist (PAS) or Automated Data Processing Application Coordinator (ADPAC), Master Patient Index (MPI) Point of Contact (POC), Information Resource Management (IRM), Clinical Application Coordinator (CAC), Health Information Management (HIM)) to work with support team(s) to repair data and track progress on Remedy ticket(s) (Medical Center, HC IdM, PIMS Support team). Hold conference calls on a regular basis if needed for complex repairs.	Medical Center Staff, PS Support Teams		
17	Determine which Health Summary data belongs to which patient by reviewing audit trails (Single Patient Audit File Print [RGMT AUDIT SINGLE]), mirror test account data, paper records, Veterans Information Solution/Hospital Inquiry (VIS/HINQ), Merge Images file 15.4 entry for a merge-from record, known providers, etc.	Medical Center Staff, **PS PIMS Support		
18	Identify staff involved in catastrophic edit and follow up with additional training to prevent future catastrophic edits/merges.	Medical Center Staff, HC IdM		
19	Verify that the Patient Record Flag(s) (PRF) are associated with the correct patients and correct if necessary.	Medical Center Staff, **PS PIMS Support		
20	<u>Admissions:</u> Re-enter admissions, movements, and discharges. Wait until associated clinical data is repaired before removing patient movements from the other record and submitting Patient Treatment File (PTF) 099 transactions.	Medical Center Staff, **PS PIMS Support		
21	<u>Scheduling:</u> Re-enter appointments and related data and reassign Text Integrated Utility (TIU) notes before backing out check-outs and cancelling on the other record.	Medical Center Staff, **PS PIMS Support		
22	Check AccuCare data for nursing home patients affected by the catastrophic edit.	Medical Center Staff, AccuCare Vendor		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
23	Confirm Veteran Identification Cards have been sent to correct enrolled patient.	Medical Center Staff		
24	Re-synchronize Health Eligibility Center (HEC) and local Enrollment/Eligibility data.	Medical Center Staff, **PS PIMS Support		
25	<u>Automated Medical Information Exchange (AMIE)/ Compensation and Pension Records Interchange (CAPRI):</u> Check for in-process exams during the time of the catastrophic edit/merge and correct if necessary.	Medical Center Staff, **PS PIMS Support		
26	<u>Beneficiary Travel:</u> Check for payments sent to wrong patient.	Medical Center Staff, **PS PIMS Support		
28	CAUTION: Orders must be repaired separately in CPRS and ancillary applications. <u>CPRS:</u> Cancel and/or discontinue orders as entered in error where needed; re-enter orders on correct patient. Request support assistance, where needed.	Medical Center Staff, **PS Clin 2 Support		
29	<u>Consult/Request Tracking:</u> Re-enter consult requests on correct patient. Disassociate results from incorrect patient, reassign result note to correct patient, then link to consult request using TIU MIS Manager Menus. Request support assistance with corrections requiring FileMan.	Medical Center Staff, **PS Clin 2 Support		
30	<u>TIU:</u> Use TIU MIS Manager Menu to reassign notes to correct patient, which will leave the notes in a retracted status and unviewable in the incorrect patient. Request support assistance with repointing notes using FileMan as needed.	Medical Center Staff, **PS Clin 2 Support		
31	<u>Pharmacy:</u> Re-enter or back-date data as needed. Use Delete a Prescription [PSO RXDL] to delete prescriptions. Use the Non-VA Meds option to re-enter prescriptions more than 6 months old. Discontinue inpatient meds if needed.	Medical Center Staff, **PS Clin 1 Support		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
32	<u>Lab:</u> Re-enter orders on correct patient. Request support assistance with FileMan/M corrections to Lab.	Medical Center Staff, **PS Clin 2 Support		
33	<u>Radiology or Imaging:</u> Review all data on effected patients and request support assistance with FileMan/M corrections.	Medical Center Staff, **PS Clin 3 Support		
34	<u>Problem List:</u> Remove problems and re-enter on correct patient.	Medical Center Staff, **PS Clin 2 Support		
35	<u>Nursing:</u> Request support assistance with corrections to Nursing Text Orders. Nursing Patient Classification errors can be corrected via menu options.	Medical Center Staff, **PS Clin 2 Support		
36	<u>Medicine:</u> Request support assistance to determine where orders point and correct data.	Medical Center Staff, **PS Clin 2 Support		
37	<u>Mental Health (MH):</u> The MH manager Menu contains an option under "Psych Test Utilities to Delete Data." This allows prior administrations of instruments in the MH files to be deleted or marked as entered in error. Request support assistance as needed.	Medical Center Staff, **PS Clin 2 Support		
38	<u>Clinical Procedures:</u> Request support assistance with Fileman/M corrections.	Medical Center Staff, **PS Clin 3 Support		
39	<u>Vitals and Measurements:</u> Graphical User Interface (GUI) options should be used to mark vitals as entered in error and re-enter on correct patient.	Medical Center Staff, **PS Clin 2 Support		
40	<u>Intake and Output (I&O):</u> The Enter/Edit menu option within the I&O package allows a user to delete an entry made within the last 48 hours. Request support assistance with GMRY PATIENT I/O file #126 edits using FileMan.	Medical Center Staff, **PS Clin 2 Support		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
41	<u>Spinal Cord Injury</u> : Use the “Inquire to a Registry Patient” option to see if patient is in the database. If so, request support assistance with Fileman/M corrections to repair the pointer to the patient file.	Medical Center Staff, **PS Clin 3 Support		
42	<u>Quasar</u> : Use “Inquire – A&SP (Audiology and Speech Pathology) Patient” option to see if patient is in (A&SP). If so, request support assistance with Fileman/M corrections to repair the pointer to the patient file. Follow instructions for TIU corrections.	Medical Center Staff, **PS Clin 3 Support		
43	<u>Home Based Health Care (HBHC)</u> : Use the “Patient Visit Data Report” to see if patient is in the HBHC database. If so, request support assistance with Fileman/M corrections to repair the pointer to the patient file. Follow instructions for TIU corrections.	Medical Center Staff, **PS Clin 3 Support		
44	<u>Surgery</u> : Use the Delete Surgery Case action after selecting a patient under the Operation Menu [SROPER] as needed; signed TIU documents must be retracted; scheduled cases need to be edited and corrected.	Medical Center Staff, **PS Clin 1 Support		
45	<u>Dental</u> : Save all data before removing. The Dental Administrator or ADPAC is to find and delete encounter date/time for incorrect records in the Dental Records Management (DRM) Plus. Dental Administrator can remove a Dental Encounter (see DRM Plus Administrator manual). Deleting information from Dental History removes the entire encounter and it cannot be recovered. DRM Plus automatically updates PCE encounter entries and will delete them from Veterans Health Information Systems and Technology Architecture (VistA) as well. Enter encounter information on the correct patient.	Medical Center Staff, **PS Clin 1 Support		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
46	<u>Prosthetics</u> : If patient is listed in Prosthetics Patient file 665 and has prosthetics data, request support assistance.	Medical Center Staff, ** PS Financial Systems Support		
47	<u>Decision Support System (DSS)</u> : Request support assistance to update DFN (Data File Number) in IV Update Extract file.	Medical Center Staff, **PS Financial Systems Support		
48	<u>Women's Health</u> : Check data for female patients in Women's Health files. Request support assistance as needed.	Medical Center Staff, **PS Clin 2 Support		
49	<u>Bar Code Medication Administration (BCMA)</u> : Use BCMA GUI Medication Log option to decide which doses to mark as 'Not Given' using the GUI Edit Med Log option.	Medical Center Staff, **PS Clin 1 Support		
50	<u>Event Capture</u> : Delete encounters and re-enter on correct patient in Event Capture Patient file 721.	Medical Center Staff, **PS Financial Systems Support		
51	<u>Dietetics</u> : A Nutrition Profile should be printed to view what data exists in the record. Request support assistance if data exists.	Medical Center Staff, **PS Clin 2 Support		
52	<u>Visual Impairment Services Team (VIST)/Blind Rehabilitation</u> : Request support assistance if data exists.	Medical Center Staff, **PS Clin 2 Support		
53	<u>Social Work</u> : The Delete Record option can be used to delete records that were entered in error only. Request support assistance.	Medical Center Staff, **PS Clin 2 Support		
54	<u>Oncology</u> : Verify that records are associated with correct patient. Request assistance, if needed.	Medical Center Staff, **PS Clin 1 Support		
55	<u>BCMA Contingency</u> : If Pharmacy records were corrected, run the patient initialization to correct the workstation contingency reports.	Medical Center Staff, **PS Clin 3 Support		

STEP	DATA REPAIR STEP	RESPONSIBLE STAFF	COMPLETED BY	DATE COMPLETED
56	<u>Accounts Receivable (AR)</u> : Use AR menus/options only to correct any erroneous data.	Medical Center Staff, **PS Management Systems Support		
57	<u>Fee Basis</u> : Check Fee Basis Patient file 161 for erroneous data and request assistance if necessary to correct data.	Medical Center Staff, **PS Management Systems Support		
58	<u>Health Data Repository (HDR)</u> : There is currently no mechanism to correct this data.	Medical Center Staff, **PS Clin 2 Support		
59	<u>Care Management</u> : Delete or correct tasks within the dashboard application and re-set to the correct patient.	Medical Center Staff, **PS Clin 2 Support		
60	<u>Clinical Case Registries</u> : If patient is in registry, the Registry Coordinator can make some edits using menu options. Request support assistance with corrections requiring the use of FileMan.	Medical Center Staff, **PS Clin 2 Support		
61	Cooperate with HC IdM and Support Specialists if repair of data at other treating facilities is needed. Synchronization of data may be required.	Medical Center Staff		
62	Enter a TIU note documenting the audit trail. Everything that was on the wrong patient should be documented on that patient's note, and the re-entry of missing data should be documented on the other patient's note.	Medical Center Staff		
63	Notify PIMS Support Specialist when data repair is complete.	Medical Center Staff		
64	Request HC IdM review and verification of corrections made.	PS PIMS Support		
65	Review and either request additional repairs or advise PIMS specialist to close the Remedy ticket.	HC IdM Program		