

## Partnership for Health IT Patient Safety

Partnership Update  
Winter 2014-2015

### Proceedings from Partnering for Success Available



Proceedings from the *Partnering for Success* meeting will be available at the end of January at <https://www.ecri.org/resource-center/Pages/HITPartnership.aspx>. The proceedings are also available on the [member home page](#). The report summarizes the sessions from the September 23, 2014 multi-stakeholder conference that explored the barriers and challenges of a learning system and examined ways in which stakeholders can improve health IT patient safety. Video commentary from the Partnership's Expert Advisory Panel will also be posted with the report. We encourage collaborating organizations and others to distribute the proceedings to members and colleagues.

As always, we welcome your input. Please provide any updates that you have by submitting them with the subject line "Partnership Update" to [hit@ecri.org](mailto:hit@ecri.org).

### Expert Advisory Panel

David W. Bates, MD, MSc

Pascale Carayon, PhD

Tejal Gandhi, MD, MPH

Terhilda Garrido, MPH, ELP

Omar Hasan, MBBS, MPH,

MS

Chris Lehmann, MD

Peter J. Pronovost, MD, PhD

Jeanie Scott, CPHIMS

Hardeep Singh, MD, MPH

Dean Sittig, PhD

Paul Tang, MD, MS

### Collaborating Organizations

Association for the Advancement of Medical Instrumentation (AAMI)

• American Association for Physician Leadership (AAPL, formerly ACPE) • American Health Information

Management Association (AHIMA) • American Medical Association (AMA) •

Association of Medical Directors of Information Systems (AMDIS) •

American Medical Informatics Association (AMIA) • American

Organization of Nurse Executives (AONE) •

American Society of Anesthesiologists (ASA) •

California Hospital PSO •

College of Healthcare Information Management Executives (CHIME) •

Council of Medical Specialty Societies (CMSS) •

Healthcare Information and Management Systems

Society (HIMSS) • Institute

## **Data Snapshot: The Challenge of Perinatal Charting**

This event was submitted through the Partnership's online reporting system and examined by patient safety analysts. All identifying information has been removed. Typically, rich information is available in the text fields of the event submissions.

### **Background**

This event illustrates the importance of appropriate documentation for the mother and neonate. OB care, by its very nature, includes multiple records: in-office records, in-hospital records, and more importantly, a maternal record and a neonatal record. Often, the mother's and the newborn's records are comingled temporarily.

### **Facts**

In this OB-related event, cord blood gases were ordered and the test was performed. However, the order and the test results appeared in the mother's chart instead of the newborn's chart, despite the fact this test was clearly not ordered for or performed on the mother. This can result in a delay of care for the newborn and other risks, particularly in emergent situations. It was only following discharge in this case that the charts were able to be separated.

### **Contributing Factors**

In OB, there is a rapid transition from addressing and documenting conditions for one patient, the mother, to then having to address two (or more) patients, the mother and newborn(s). In this example, in order to have the results attributed to the proper patient, a correction to the electronic record had to be requested.

### **Health IT-Related Risk Factors**

Delays in care and testing can occur when no chart exists for the new patient. New charts need to be electronically created prior to entering orders, notes, or results. Moreover, conditions and follow-ups can be overlooked when notes are made in the chart of the mother or the newborn(s) but the recommendation applies to the other patient (e.g., recommendations for follow-up for mother written in

for Safe Medication Practices (ISMP) • Kentucky Institute for Patient Safety and Quality • MCIC Vermont, LLC • Michigan Hospital Association PSO • Midwest Alliance for Patient Safety • National Patient Safety Foundation (NPSF) • Ohio Patient Safety Institute • Physicians Insurance Association of America (PIAA) • PSO of Florida • Tennessee Center for Patient Safety • Virginia PSO

## **Upcoming Partnership Events:**

**Proceedings:** At the end of January, proceedings from Partnering for Success, including video interviews, will be available at <https://www.ecri.org/resource-center/Pages/HITPartnership.aspx>.

**Quarterly Meeting:** January 20, 2015, at 2:30 ET (by conference call). If you have not received call-in information, please contact us.

**HIMSS: Meet us at HIMSS in April 2015:**  
*Wednesday, April 15<sup>th</sup>*  
*1:30 - 4:30 PM*  
*McCormick Place, Room S106*

**Workgroup forming on "cut/copy & paste":**  
Please contact us to join.

newborn's chart, treatments for newborn written in mother's chart).

### **Lessons Learned**

Protocols for creating new charts need to be in place so that orders and results can be appropriately and immediately documented. Corrections to chart entries need to occur in a timely manner, and procedures should be available that ensure proper patient care and follow-up. As organizations continue to discover and address similar issues, sharing solutions and best practices will facilitate safer care and efficiencies in using this technology.

Please send your comments and suggestions to [hit@ecri.org](mailto:hit@ecri.org). Remember, if you are submitting events, please use your secure communication portal.

## **Copy-and-Paste Safety Workgroup to Be Convened**

Workgroup topics are being discussed in greater detail at the January 20, 2015, quarterly meeting. The Partnership's first workgroup will focus on improvements in the use of copy and paste in order to mitigate safety issues. We need your participation and contributions to this topic-driven workgroup. Your participation may be by contributing your event submissions or by actively participating in one of the areas of focus for the workgroup. We anticipate meetings will occur telephonically on a monthly basis over the next six months. The mitigation strategies and safety goals related to copy and paste aim to make health IT safer now and in the future.

### ***Call to Action: Request for Data Submission***

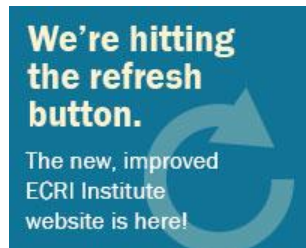
In preparation for workgroups focused on ways to make health IT safer now, we ask all of you to increase your data submissions by **five new events/issues!**

Please enter these events using the AHRQ Common Formats for Health IT and the HIT Hazard Manager or submit nonstandard reports through secured communications also available on the Partnership landing page. Be certain to identify issues with copy/paste, cut/paste, autofill, and carry

forward. Submit these reports as you would your regular reporting, by using the standardized reporting tools or secured communications.

Thank you for all of your hard work! It's making a difference!

## New Web Design:



The Partnership's landing page has a new look. We hope that you like these exciting changes. You have the same functionalities, only better.

### Need Help Logging In?

Have a question that we can answer? Please contact Lorraine Possanza at 610-825-6000 ext. 5634 or at [lpossanza@ecri.org](mailto:lpossanza@ecri.org).

### Get in Touch with the Partnership

Do you have questions about any of these articles? Get in touch with us today by e-mailing [hit@ecri.org](mailto:hit@ecri.org)!