

## **Partnership for Health IT Patient Safety**

Partnership Update February 2016

### **We Look Forward to Seeing You in Las Vegas at HIMSS16!**

**The Partnership for Health IT Patient Safety invites you to the following activities at HIMSS16:**

- **Partnership's Planning Meeting**  
March 1st from 3-4 PM  
Strategic Relations Room, Zeno 4804
- **Top Ten Health IT Safety Hazards...and What to Do about Them**  
March 2nd from 8:30-9:30 AM  
Sands Expo Convention Center Rock of Ages Theatre

*Join us for a Panel with Ronni Solomon, JD, William Marella, MBA, MMI, Amy Tsou, MD, MSc, and Patricia P. Sengstack, DNP, RN-BC, CHPHIMS who will discuss what can be done today to address issues with copy and paste, patient identification, weight-based dosing, and other hot topics.*

- **Official Launch! Partnership's Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste**  
March 2nd at 4:00- 4:45 PM  
HIMSS Spot in the Exhibit Hall

### **HIMSS16 Preconference Session:**

- **Patient Safety Organizations: the Engine for Collaboration**  
February 29th from 10:45-11:45 AM  
Marcello 4401

The Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste is available March 1 at [www.ecri.org/hitpartnership](http://www.ecri.org/hitpartnership). The Partnership thanks all of those supporting and endorsing the safe practice recommendations for copy and paste.

The Partnership is working on the next set of Health IT Safe Practices. The Patient Identification Workgroup began meeting in November 2015 and continues to meet monthly. The next monthly meeting is February 19, 2:00-3:00 p.m. eastern time.

### **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  
Patricia P. Sengstack, DNP, RN-BC, 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) • Alliance for Quality Improvement and Patient Safety (AQIPS) • Association of Medical Directors of Information Systems (AMDIS) • American Medical Informatics Association (AMIA) • American Nursing Informatics Association (ANIA) • American Organization of Nurse Executives (AONE) • American Society of Anesthesiologists (ASA) • Association for Healthcare Documentation Integrity (AHDI) California Hospital PSO • College of Healthcare Information Management Executives (CHIME) • Constellation • Council of

## Coming in 2016:

- *Coming Soon*: Proceedings from the October 16, 2015, face-to-face meeting, Partnering for Action: Applying What We've Learned
- Health IT advisories
- Health IT Safe Practices for Patient Identification

### ***Data Snapshot: We have technology - now is it working so that we can?***

Data Snapshots provide lessons learned from patient safety reports submitted to the *Partnership*. In this edition of Data Snapshot, we look at safety issues related to the clinical users' sometimes unquestioning reliance on the technology and its unexpected performance.

#### **Background**

As health information technology plays a greater role in daily workflow, so does the dependence on the technology. Users have come to rely on the technology for correct and up-to-date calculations, for timely reminders, for accurate alerts, and for the ready availability of information across care settings. However, for multiple reasons this may not always occur. During the 2014 Partnering for Success meeting, Dean Sittig and Hardeep Singh categorized HIT (health information technology) safety concerns as those associated with: (1) HIT System failures; (2) an HIT system working as designed, but not meeting expectations; (3) the HIT system working as designed, but not configured correctly; (4) the HIT system working as designed and configured correctly but interaction with another system causes problems; and (5) HIT safety features or functions not implemented or unavailable. None of the following events involve HIT system failures; rather, these events result from the sometimes unquestioning reliance on the technology, problems with information flow, and unexpected consequences.

#### **Events Reviewed**

In the first events, the technology was working as designed, but the technology did not meet the user's expectations or include the appropriate safety measures. Here, the issues involve electronic reminders, alerts, and automatic scheduling. Providers have come to rely on all of these functions in routine patient care.

- A patient received two of the three doses of a hepatitis B vaccine. The recommended vaccine schedule is that the second dose of this three-dose series is given one month after the first dose of the vaccine and the third dose in the series is given six months after the first dose. No reminder was made available to trigger the third dose of the vaccination.
- The vaccine reminder indicated that the patient was "current." It was unclear what "current" meant. Although interpreted that the patient did not require

Medical Specialty Societies (CMSS) • Health Care Improvement Foundation (HCIF) • Healthcare Information and Management Systems Society (HIMSS) • Institute for Safe Medication Practices (ISMP) • Kentucky Institute for Patient Safety and Quality • MCIC Vermont, LLC • MHA Keystone Center • Midwest Alliance for Patient Safety • National Patient Safety Foundation (NPSF) • Ohio Patient Safety Institute • PIAA • PSO of Florida • Tennessee Center for Patient Safety • Virginia PSO

The *Partnership for Health IT Patient Safety* is sponsored in part through a grant from the Jayne Koskinas Ted Giovanis (JKTG) Foundation for Health and Policy.



## **Upcoming Partnership Events:**

**Upcoming Quarterly Meetings:** April 26, 2016, 3:00-4:00 p.m. eastern time

July 19, 2016 3:00-04:00 p.m. eastern time

**Patient Identification Workgroup:** Meets monthly, with the next scheduled call on February 19, 2016, 2:00-3:00 p.m. eastern time.

the vaccination, in this instance it meant that this patient was not eligible for the vaccination.

- An alert did not fire to the proper record when multiple records were open.
- An alert fired once for the patient record but did not fire in that same record for subsequent providers.

In the next examples it is unclear whether there were issues with the configuration or whether the interactions of the various systems resulted in the problems encountered.

- An incorrect body mass index (BMI) for an individual 5 foot 9 inches tall was obtained. The result was incorrect; the BMI had been calculated considering the height in feet only neglecting the height in inches.
- A weight recorded in pounds and no (0) ounces was not converted correctly to kilograms.
- A weight recorded in pounds and no (0) ounces was interpreted as having been entered in kg.
- Information in a newborn's chart could not be modified, modifications were only possible using the mother's record.
- A change made to the number of chemotherapy treatments in the progress notes was not reflected elsewhere in the chart.
- Results from two unrelated exams overwrote one another.

### **Contributing Factors**

Inappropriate calculations can create safety hazards. Technology ideally eliminates the human calculation errors previously seen. However, providers must be astute in recognizing that calculations are incorrect. The same is true for missing reminders. As we become increasingly dependent on the technology, it is important to continue to use critical analysis in evaluating results and interactions. Moreover, it is important to continue to recognize and report such occurrences so that changes can be made to the technology as is needed.

### **Health IT–Related Risk Factors**

Although errors in calculations occurred before the widespread implementation of technology, assuring that the appropriate fields are updated and available to make calculations depends on understanding the interactions of the technology and the provider, the flow of information, field transfer, and use. It is imperative that developers, IT specialists, and providers recognize what information is made available and adjust those parameters so that correct information is consistently obtained. Improper decimal placement was often tragic in paper, but it carries new implications in the electronic environment. Recognizing and educating users as to what fields transfer or what information is carried between records is essential in improving the usability of the technology.

### Lessons Learned

It is important to use advances in the technology to minimize the safety risks associated with information transfer, reporting, alerts, reminders, and calculations. As users grow increasingly dependent on technologies — with the expectation that the information viewed in one setting will be readily available in another setting or that changes made in one part of a record will flow correctly to another part of the record — those using systems must remain vigilant and recognize that when something seems inappropriate or incorrect, action is required. Safety involves participation by all stakeholders.

We invite you to send your events, suggestions, and strategies for safe patient identification so that these can be shared with others in the *Partnership*. 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.

**HIT Safety Advisories:** Health IT Safety Advisories are coming soon. In these updates you will find information about HIT-related issues that have come to the forefront for their ability to negatively impact patient safety. Submit your ideas for these advisories to [hit@ecri.org](mailto:hit@ecri.org).

### Your Submissions Are Always Welcome

The *Partnership* welcomes all of your continued contributions, including items for this publication. Please submit any items for the Update using the subject line "Partnership Update" to [hit@ecri.org](mailto:hit@ecri.org) and continue to submit data, RCAs, and help desk logs through the *Partnership* web portal.

### 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)!

The *Partnership for Health IT Patient Safety* is sponsored in part through a grant from the Jayne Koskinas Ted Giovanis (JKTG) Foundation for Health and Policy.



Please **do not** click the "One-Click Unsubscribe" link at the bottom of this e-mail. Doing so will prevent you from receiving **all** future communications from ECRI Institute. If you wish to stop receiving the

*Partnership for Health IT Patient Safety Monthly Update*, please send an e-mail to [communications@ecri.org](mailto:communications@ecri.org) and we will accommodate your request.

Copyright © 2016 ECRI Institute. All rights reserved.

The information obtained through this service is for reference only and does not constitute the rendering of legal, financial, or other professional advice by ECRI Institute. Any links to Internet sites other than the ECRI Institute site are intended solely for your convenience; ECRI Institute takes no responsibility for the content of other information on those other sites and does not provide any editorial or other control over those other sites.

This e-mail was sent by:  
ECRI Institute  
5200 Butler Pike  
Plymouth Meeting, PA 19462-1298  
USA  
Telephone: +1 (610) 825-6000



ECRI Institute Offices: [United States](#), [Europe](#), [Asia Pacific](#), [Middle East](#)

**Privacy:** We respect your need for privacy. ECRI Institute does not sell your information to third parties for their use. Any information you provide is stored in a secure environment designed to prevent misuse.

Copyright 2015 ECRI Institute. All Rights Reserved.