Data Snapshot: Reducing the Burden of Daily Tasks

BACKGROUND

Difficulties placing orders using technology are frequently reported as safety events. A multitude of factors contributes to the patient safety risks associated with these events. While medication orders may predominate, there are some common elements among all of the various types of orders being placed and the issues that arise. It is important to recognize these issues and to take steps to mitigate their occurrence.

What are some examples of orders that may be related to the reported safety events? Ordering medications through either CPOE or e-prescribing often is reported as a source of safety events. Diagnostic test orders such imaging orders, genetic testing, or lab orders are also found associated with safety events. Referral requests, nutrition, physical therapy, and any of the diagnostic or treatment protocols that apply to clinical care can be related to these frequently reported events.

WHAT IS BEING REPORTED

In one event, the ordering provider could not clearly document the patient’s special needs prior to diagnostic imaging. Because these needs were not communicated, the site executing those orders was ill-prepared to readily address the patient’s needs, delaying the patient’s testing and timely evaluation.

A medication was prescribed for a patient as one tablet every four hours. Also within the record was an order for the same medication, one tablet every six hours. No duplicate medication alert fired.
Another report reflected that the clinician could not enter orders remotely; orders had to be communicated as verbal orders.

Following a system downtime not all systems came back online. This was not clear from attempted use of that system that it remained offline and not communicating as intended.

In yet another event, the patient’s medication was administered in the PACU. Subsequently the patient was transferred to another unit. Once reaching that unit, the patient received another dose of the ordered medication. However, this resulted in an “extra” does of the medication being received.

CONTRIBUTING FACTORS

There are multiple factors that contribute to the above events. While technology can address some of these, it is not always the sole remedy. Often the communication of orders that are clear and readily understood remains a factor. How is the information being exchanged, how did the clinician or patient anticipate the receipt of that information, and what are the mitigation strategies in place? For example, when a patient requires special accommodations because they are blind, confined to a wheelchair, are infirmed, or have a condition that may require processes outside of the normal workflow, how is this communicated. Is the expectation that this information is communicated during a screening process? Should the information be documented during ordering? Technology can be the tool used to facilitate this exchange of information. An inability to communicate this information can occur because the clinician is unsure of where to document that information may be at issue. Additionally, in some instances there may not be a clearly distinguishable field available to document that information so that it will transfer.

LESSONS LEARNED

It is important that training and retraining occur as needed so that users know the optimal way to capture and share information. While we seek systems that are connected, we need to be able to verify these connections so that the exchange of information can occur. It is also important to clearly understand when changes whether minor (change in patient location) or major (downtime), occur that the potential consequences are understood and therefore able to be mitigated.

CONCLUSION

While technology has facilitated communication, issues remain. Are we clearly identifying the needed information? Are fields available and apparent to record
that information? When downtimes occur, is it clear that systems are then functioning and communicating as anticipated? Should we assume all is clear when no alert is received? How do we verify that timing of medication dosing is communicated appropriately during transitions of care? It is important that we are aware of the issues that exit in order to take the appropriate steps to mitigate them.

Key Happenings

New workgroup announced

A new workgroup is forming. If you are interested in working on, and participating in, a workgroup to derive Safe Practices to Reduce Alert Fatigue through Monitoring, Analysis, and Optimization drop us an email at hit@ecri.org. The first scheduled meeting is on April 1, 2020 at 3:00 p.m. ET. These virtual meetings will continue monthly until September 2020. Our goal is to obtain multi-stakeholder input, learn about the solutions you have deployed, and identify ways in which the technology can better assist in addressing the alerting issue. John McGreevey, MD, University of Pennsylvania and Adam Wright, PhD, Vanderbilt, will be the Partnership collaborators co-chairing the workgroup. You can direct questions either to hit@ecri.org or to Rob Giannini at rgiannini@ecri.org.

Getting your input on projects driving sustainability

Following our quarterly call, we received several suggestions for topic areas work moving forward. The responses received highlighted: timing issues, alert fatigue, AI, patient preferred names, technology’s ability to influence diagnostic errors and transition of care issues. If you have additional projects that you are working on, or that you would like to see as subjects for additional focus, please provide that information to us using the email address hit@ecri.org. We look forward to hearing from you!

Gathering EHR data directly to drive safety-- White paper released

In a collaborative prototype project, the Partnership for Health IT Patient Safety recently released findings from an evaluation of the use of systems or
transactional data from the electronic health record across a number of organizations. This examination was undertaken to determine the feasibility of (1) applying algorithms for analysis across facilities and organizations with different platforms; (2) gathering data in a federated model; and (3) determining if safety learnings could be derived from this type of data. While individual organizations have successfully used their systems data to drive action, it was important to examine what efforts would be required to execute these determinations in health systems across the country. The report’s findings are publically available. More information about the Partnership’s work is available at hitsafety.org and questions can be directed to hit@ecri.org.

Interested in being a beta test site?

We will be deploying an electronic version of SAFER Guides. The nine guides have been incorporated into an electronic format. Organizations and practices can use these assessments to monitor their progress, evaluate issues they are having and identify areas for further work. But before we can do this, we need your help and conducting a beta test of this format and the presentation of results. If you are interested in testing this electronic assessment format, please contact us at hit@ecri.org.

ECRI Institute will be at HIMSS20

HIMSS20 is the can’t-miss health information and technology event of the year. Join nearly 45,000 changemakers from 90+ countries for the education, innovation and collaboration you need to reimagine health and wellness for everyone, everywhere. Experience 300+ education sessions, innovative products and services from 1,300+ exhibiting companies, hundreds of specialty education programs and endless networking opportunities with global colleagues. Be part of it all and be the change. HIMSS20 takes place Monday, March 9 – Friday, March 13, 2020 in Orlando. Member discount available. Register now at www.himssconference.org.
Quarterly Meetings

Our latest quarterly meeting was held on January 22nd. A recording of this and all previous quarterly meetings are available here on the Partnership's member-facing website. We do not post the quarterly meetings on the public site. If you don't have access, contact us at hit@ecri.org.

We Want to Hear from You

It is important not only to develop safe practices, but also to implement them. To that end, it is important that we all learn from what you are working on, how you are incorporating technologies into daily workflow (AI, telehealth, mhealth) and what you might be looking to do? If your organization/practice has implemented any of the Partnership's health IT safe practice recommendations, or if you have begun to use technologies in an innovative manner, we would like to hear from you! Start the conversation by emailing hit@ecri.org. This information provides great discussion at the quarterly and annual meetings!

Advisory Panel

- David W. Bates, MD, MSc
- Kathleen Blake, MD, MPH
- Pascale Carayon, PhD
- Tejal Gandhi, MD, MPH
- Chris Lehmann, MD
- Peter J. Pronovost, MD, PhD
- Daniel J. Ross, MD, DDS
- Jeanie Scott, MS, CPHIMS
- Patricia P. Sengstack, DNP, RNBC, CPHIMS
- Hardeep Singh, MD, MPH
- Dean Sittig, PhD
- Paul Tang, MD, MS

The Partnership for Health IT Patient Safety is sponsored through funding from the Gordon and Betty Moore Foundation.

Collaborating Organizations
Submit an Event?
Partnership participants can submit events through your membership portal.
If you need assistance, please contact us at hit@ecri.org.

Get in Touch
Do you have questions about any of these articles? Get in touch with us today by emailing hit@ecri.org. If you wish to submit information for this publication, please submit items using the subject line "Partnership Update" to hit@ecri.org.

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