

Partnership for Health IT Patient Safety

Partnership Update March 2016

Join us for the next Partnership Quarterly Meeting:

The next *Partnership* Quarterly meeting will be held on **April 26, 2016 from 3:00-4:00 p.m. eastern time**. The agenda will include hearing from our partners on:

- Implementation of the copy and paste recommendations
- Health IT-related sentinel events
- Update on Patient Identification
- A call for usability-related events
- Health IT Advisories

Partnership's Copy and Paste Recommendations/Toolkit Launched at HIMSS16! Share with Your Network!

A big thank you to the Partnership Collaborators for support in launching the Partnership's first set of safe practices, *The Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste* such a success.

Think these tools are valuable? Please consider sharing them with your colleagues, members, and user groups. If you would like ideas for dissemination, we have put together a template newsletter announcement and social media posts to make sharing easier. You can find these resources below along with the safe practice recommendations, evidence-based literature review, and toolkit to assist at: www.ecri.org/hitpartnership.

The Partnership is seeking case studies and implementation strategies for copy and paste. If you have stories to share, please contact Lorraine Possanza at hit@ecri.org.

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 April 15, 2:00-3:00 p.m. eastern time.

Data Snapshot: Information must be available to ensure safe patient care.

Data Snapshots provide lessons learned from patient safety reports submitted to the *Partnership*. In this edition of Data Snapshot, the importance of recognizing provider needs in order to ensure patient safety is highlighted.

Background

Health information technology is becoming, and in many geographic areas is, fully embedded in patient care regardless

Expert Advisory Panel

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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 Medical Specialty Societies (CMSS) • Health Care

of the care setting. But, is the technology being optimized to limit or prevent patient safety issues?

Events Reviewed

In a recent event submission, a hazardous condition was identified because no post-operative orders for a patient were available in the electronic health record. Upon investigation the surgeon had not entered any orders. In this case, the surgeon did not regularly perform procedures at the particular facility. As such, the surgeon was unfamiliar with the system and did not know how to interact with the record in order to place the appropriate post-operative orders.

In another event, which was also identified as a hazardous condition, doses of insulin were administered to a patient but were not documented in any of the ED notes. The patient presented to the ED with an extremely high blood sugar (greater than 800mg/dl). Insulin was required to lower the blood sugar levels. Upon the patient's transfer to the floor, he had a much lower blood sugar (less than 160mg/dl) but subsequent review of the ED record indicated that no insulin had been administered to the patient (0 units/hour). Knowing this was likely incorrect, the admitting nurse queried the ED staff who reported that the patient had in fact received insulin. The insulin infusion had been started at 3 units/hour, titrated up to 12 units/hour and then later reduced to 3 units/hour. Without this personal query, this information would not have been available to those who cared for this patient.

In other example, a patient's discharge was delayed. This resulted when the physician neglected to enter a diagnosis in the discharge orders. When queried, the doctor indicated that he was not going to return to the facility to complete the documentation and instructed the nurse to enter the diagnosis information. The nurse explained that she was unable to enter this information into the appropriate field of the record for him.

Contributing Factors

Proper, timely, and complete documentation remains a problem for safe patient care despite the intervention of technology. What should be the timely exchange of information about patients is sometimes hampered by the provider's unfamiliarity with or perceived inconvenience in using the technology. This may arise due to differences among the various modules used, differences when moving between different physical locations (different hospital systems) or differences seen in systems used in different care settings (inpatient, long term care, ambulatory care). In other instances, documentation may be hampered by the fast pace of a unit and the relative slowness of a system, leaving little time to stop, wait for a system to respond, and then find the location in the EHR to document care provided.

Health IT-Related Risk Factors

Although electronic records have generally made information

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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 April 15, 2016, 2:00-3:00 p.m. eastern time.

more accessible, providers frequently express their dissatisfaction. This dissatisfaction in part is expressed in the need for additional time to complete documentation. Others struggle with difficulties identifying where required fields are located, or from lack of familiarity with systems following changes or upgrades. Providers are often unaware that different care providers have different access to sections of the EHR and therefore see information differently. Moreover, the inability to readily communicate and exchange information completely and correctly between care settings (ED to inpatient, inpatient to clinical provider) also contributes to provider dissatisfaction.

Lessons Learned

Walk-arounds are just one way to identify some of these issues. It is important that staff are regularly trained to utilize the electronic health record and that they are familiar with the record prior to providing care. It is important to review documentation practices and where the fields appear. If providers are unable to use systems, providing scribes as an alternative is one possibility. Additionally, if an organization has chosen to limit views and entry by provider, this too needs to be reviewed with the staff at orientation and during yearly updates.

To ensure safety, those responsible for data capture must be held accountable when information is incomplete or lacking. Finally, facilitating interoperability between the systems used in various care settings needs to be an ongoing process. While most would agree that the return to paper records would be a nightmare, using technology to mitigate hazards and promote safety should be more than merely a dream.

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

Partnership Call for Action: Submit 5 Events on Usability Issues

EHR usability is a high priority for developers and users. **Please submit five new usability issues using the HIT Hazard Manager Taxonomy by April 22.** Please be certain to submit these events directly into the database. Should you need assistance, please contact us at hit@ecri.org to obtain

additional information. If you are submitting information for this publication please submit those items for the Update using the subject line "Partnership Update" to hit@ecri.org. Remember when submitting data, RCAs, and help desk logs please do this 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.

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!

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