Partnership for Health IT Patient Safety

Partnership Update

March 2017

Partnership Issues Recommendations for the Safe Use of Health IT for Patient Identification

New patient identification toolkit is available. *Health IT Safe Practices: Toolkit for the Safe Use of Health IT for Patient Identification*

Special Report: *Patient Identification Errors*

The Partnership completed an in-depth analysis of patient identification events reported to ECRI Institute PSO. Eight safe practice recommendations detailing how health information technology (IT) can facilitate patient identification were established in two key areas:

Attributes: the information-gathering aspects of patient identification, including the fields and the formats that are available.

Technology: new technologies to improve identification and ways to leverage existing technologies for safe patient identification.

Expert 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
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Dean Sittig, PhD
Paul Tang, MD, MS

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

Partnership Workgroup Update:

***Partnership* Workgroup 3, Developing, Integrating, and Maintaining a Health IT Safety Program, continues to meet.** The next workgroup meetings are: April 19, May 25, June 14 and July 19 at 12:00 PM ET.

Participate in ***Partnership* Workgroup 4, using health information technology to close the loop and mitigate delayed, missed and incorrect diagnoses.** Meetings are: May 9, June 13, July 11, August 15, September 19 and October 17 at 10:00 AM ET.

SAVE THE DATES:

***Partnership* Quarterly Conference Call**
Tuesday, April 18, 2017
3:00 - 4:00 p.m. ET
Register Here

ECRI Institute PSO Webinar
Health IT Safe Practices:The Safe Use of Health IT for Patient

For more information, contact the *Partnership* at hit@ecri.org.		*Identification* Thursday, April 20, 2017 1:30 - 2:30 p.m. ET Register Here

Data Snapshot: Is This a Health IT Issue?

Please use the check boxes with each narrative to indicate whether the event is a health IT issue.

1. A nurse entered a patient identification number and recorded the blood glucose results from the bedside glucose meter. The results were posted on the wrong patient chart. The correct patient was treated appropriately because the blood glucose results were immediately available at the bedside. □Yes □No □Unsure
2. A surgeon tried to access a patient's radiology study from the PACS system in the OR [operating room]. The display would show only a blue screen. The patient's time under anesthesia was extended due to trying to access the results. Yes □No □Unsure
3. A chest x-ray for the wrong patient was ordered when the wrong room number was selected. Staff noticed this right away and reordered the test for the patient in room 225 instead of the patient in room 224. The order was promptly discontinued but not in time for the x-ray technician to see that the order was withdrawn. The technician performed the test on the wrong patient. No notification was made to the x-ray department to communicate the cancellation of the test. Notification of the error was made to the doctor and the patient. □Yes □No □Unsure
4. A physician ordered that the patient's anticoagulation medication be discontinued after reviewing results for the patient's prothrombin time. The order did not cross over to the pharmacy system, and the patient received eight extra doses of the medication before it was discontinued. Sporadic occurrences of medication orders not being received by the pharmacy system have been reported. The IT department is planning an upgrade that will address the problem. □Yes □No □Unsure

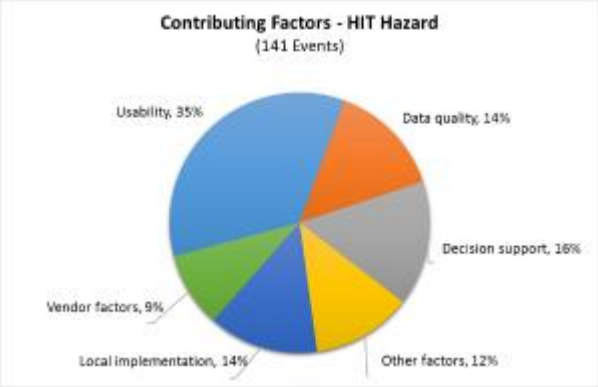
Background

Whether HIT is involved in an event is not always apparent. Individuals reporting errors might ask themselves whether the technology was a part of the issue and whether it contributed to what occurred. Mitigating and correcting issues that lead to errors depends on properly identifying the issue and communicating that information appropriately to internal departments and to vendors.

Events Reviewed

In a review of 2,071 events that had a health IT–related component submitted by members of the *Partnership* and participating Patient Safety Organizations (PSOs), 68% of the events were not classified in a health IT-related event category. Analysis of the top five event types revealed that Medication or Other Substance, with 571 events (28%) was the most prevalent event type selected. The other top event types were Device or Medical/Surgical Supply, including Health Information Technology (HIT), with 527 events (25 %); Other, with 416 events (20%); Laboratory Test/ Radiology, with 333 events (16%); and HIT Hazard, with 141 events (7%). Other Miscellaneous Event Types, with 83 events (4%), included the following event types: Blood or Blood Products, Healthcare-Associated Infection (HAI), Fall, Security/Safety, Surgery or Anesthesia, Pressure Ulcer, Emergency Services, and Perinatal.

Contributing Factors - Health IT-Related



In a small subset of this data using the HIT hazard taxonomy, reporters identified Usability as the most common health IT–related contributing factor.

Usability	n
Confusing information display	24
Mismatch between real workflows and HIT	17
Mismatch with user expectations	11
Information hard to find	6
Inadequate user feedback	5
Other	5
Difficult data entry	4
Excessive demand on human memory	3
Suboptimal support	3

Lessons Learned

The ability of health IT users to recognize, react to, and report health IT-related events for analysis and action is the foundation of a health IT safety program. Within a provider organization, a health IT safety program requires support from all levels of the organization, including leadership and patients, as well as vendors. Such proactive knowledge can help prioritize safety interventions and vendor actions and should be intertwined into an organization's comprehensive patient safety program.

Partnering for Transformation: Making a Positive Impact

Partnership Proceedings Available

The *Partnership* for Health IT Patient Safety convened its third annual meeting on September 16, 2016.Topics addressed at this meeting included an update on implementing and testing the recommendations included in the copy and paste toolkit, as well as the *Partnership's* new safe practice recommendations for the use of health IT in patient identification and corresponding implementation toolkit. In addition, this year's breakout sessions led to the development of tools for assessing three common health IT safety issues: the use of automated end times, preparedness for unexpected health IT system downtimes, and the development of a health IT safety program. Finally, the group focused on evaluating issues for future investigation.

Read the proceedings

Collaborating Organizations

Need to 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 with the Partnership

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

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Jayne Koskinas Ted Giovanis Foundation for Health and Policy

Gordon and Betty Moore Foundation

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