

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

Partnership Update  
April 2015

The copy and paste workgroup is moving forward and meeting monthly to make copy and paste activities safer. Look forward to a preview of this information at the next quarterly meeting. Also refer to issue 10 of Joint Commission's [Quick Safety](#), "Preventing Copy-and-Paste Errors in EHRs," as well as the recent Joint Commission Sentinel Event Alert on the safe use of health IT.

As always, we welcome all of your contributions to the *Partnership Update* and to the *Partnership*. Please submit Update items with the subject line "Partnership Update" to [hit@ecri.org](mailto:hit@ecri.org).

### **Data Snapshot: Critical Data not Carried Forward**

Data Snapshot information is deidentified and comes from reports to the *Partnership* and all-cause harm databases.

#### **Background**

Copy and paste is defined in several different ways and encompasses multiple terms. These terms include the following: copy functionality, cloning, carry or copy forward, autocomplete, autofill, data replication, and reuse.

Generally, this functionality involves moving data from one place to another place within a record, between systems, or between records. Whole-note-cloning is defined as copying notes from one visit to the next with little or no editing. Carry forward automatically drops a previous note into a new encounter. Autofill automatically draws data from another part of the record and inserts it on a specific command, and autocomplete automatically matches text and provides one or more options. However, this functionality is also used in other ways.

The copy functionality (copy forward) is useful in many areas involving patient care. One area where significant information is pulled forward to communicate information about a patient in SBAR (situation, background, assessment, and recommendation).

#### **Event Review**

The event involved communication between the emergency department and inpatient units. Here, the patient being admitted had suicidal ideation. The significant information

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

was not pulled into the SBAR. There was no visible indication that the patient needed a 1:1 (one-to-one observation to monitor behavior).

### **Contributing Factors**

One of the dangers with the electronic record is that providers fail to continue to verbally communicate with one another due to the belief that all of the relevant information resides in the electronic communication. Copying large amounts of information between various parts of the record is often seen as a means of communicating the complete picture. However, as in this event, copying (carrying forward) information and making it electronically available is not a substitute for verbal communication (verbal handoffs) between providers and between those in different care areas.

Moreover, not every provider may have access to each part of the record, or providers may not know where to find specialized information in the record. And as seen above, there may be times when relevant or significant information is not carried forward as expected.

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

Pulling information into another part of the record is often an organization-based custom setting in the electronic record. However, it is important that organizations ensure that relevant fields are appropriately populated so that information may be carried forward. Information from free-text entries may not carry forward. If providers are not aware of proper documentation techniques to facilitate this process or are unaware of what needs to be completed, there may be ineffective communication.

### **Lessons Learned**

There are multiple reasons to utilize the copying functionality, including carry forward. Copying facilitates complete documentation, saves time, and is an efficient way to avoid transcription errors. But while copying may ensure the completeness of documentation, it can also overwhelm a reader (note bloat), lead to inconsistencies, contain repetitious or irrelevant information, or potentially interfere with effective communication.

Some suggestions for dealing with copy and paste issues have included using medical scribes, training providers, providing suggestions for better methods of documentation, and determining what information is acceptable to copy (carry forward) from one encounter to the next.

Just as those of us with teenagers know that you must text them to be certain that they “hear” you (rather than calling, e-mailing, or speaking to them), we must be certain that providers hear one another by effectively and efficiently using the electronic record and its functionalities to communicate.

Please send your comments and suggestions to [hit@ecri.org](mailto:hit@ecri.org).

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.



## **Alerts**

Joint Commission’s Sentinel Event Alert: [Safe Use of Health Information Technology](#)

## **Upcoming Partnership Events:**

**Proceedings:** The proceedings from Partnering for Success, including video interviews and a PDF version of the proceedings, are available from [the Partnership website](#) or from the [Partnership landing page](#).

**Quarterly Meeting:** The next quarterly meetings of the *Partnership* are May 19 at 3:00 p.m. ET and July 28 at 3:00 p.m. ET by conference call. Find more information on the *Partnership* password protected landing page. If you don’t already have access, please write to us at [hit@ecri.org](mailto:hit@ecri.org).

**HIMSS:** Meet us at HIMSS Wednesday, April 15<sup>th</sup> 2:00 - 4:00 p.m. McCormick Place, Room S106

**Copy and Paste Workgroup:** The next meeting is May 4th. Please continue to submit copy and paste events through the *Partnership* portal.

Remember, if you are submitting events, please use your secure communication portal.

## Joint Commission Sentinel Event Alert Addresses the Safe Use of Health IT

The Joint Commission released Sentinel Event Alert 54, "Safe Use of Health Information Technology," on March 31, 2015. The alert suggested that organizations focus actions on safety culture, process improvement, and leadership. Improving safety culture includes increasing mindfulness in identifying, reporting, analyzing, and reducing health IT-related hazards, near misses, and errors. Processes to ensure that health IT is implemented appropriately, used correctly, and monitored to improve safety are proactive steps to decrease patient safety events. Continuing to involve leadership and multidisciplinary representatives not only in the oversight of health IT planning, implementation, and evaluation but also in evaluating health IT in relation to Joint Commission requirements increases awareness of the potential safety risks and helps identify areas of focused improvement.

The alert contains useful resources, including information about a free online course, "Investigating and Preventing Health Information Technology-Related Patient Safety Events."

### Quarterly Meeting Dates Set

The *Partnership's* next quarterly meeting dates have been set. Join us for the second quarterly meeting on Tuesday, **May 19 at 3:00 p.m. ET** and for the third quarterly meeting on Tuesday, **July 28 at 3:00 p.m. ET**.

### Preparing for a New Initiative

In addition to the data collection, *Partnership* analysis, and workgroup focus, we are identifying areas where events are occurring that may be suited to patient safety innovations in the technology. Be alert, more information will be forthcoming.

#### 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)!

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