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PARTNERSHIP for HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update
May 2015

Mark your calendars.

3rd Quarter Conference Call: July 28, 2015; 3 p.m. ET

Full-Day Annual Meeting: October 16, 2015, at ECRI Institute

Copy and Paste Workgroup Meetings: June 1, July 6, and August 3. The workgroup is currently reviewing exemplars and best practices. Watch for an opportunity to provide input on best-practice recommendations.

As always, we welcome all of your continued contributions to the *Partnership*. Please submit any Update items with the subject line "Partnership Update" to hit@ecri.org and continue to submit data, RCAs, and help desk logs through the Partnership web portal.

Data Snapshot: Newborn's Weight Not Carried Forward to Pharmacy System

Data Snapshots provide lessons learned from deidentified events reported to the *Partnership*.

Background

This near-miss event demonstrates the importance for providers to understand which fields carry forward and which do not in order to ensure timely, accurate, and safe care.

Event Review

In this event, antibiotics were needed for a newborn. The newborn's weight was recorded at the time of birth and written in the record in grams (metric). The newborn's height was recorded at the time of birth and written in the

record in feet and inches (English). In ordering intravenous (IV) antibiotics for this patient, the dose of the antibiotics was ordered in milligrams per kilogram (mg/kg). The pharmacist received the order in the pharmacy system and needed to calculate the appropriate dose of each antibiotic prescribed for this patient.

The newborn's height carried forward and was available in centimeters (cm) in the pharmacy system. The newborn's birth weight did not carry forward into the pharmacy system. However, the system automatically calculated and displayed an ideal body weight (IBW) for this patient in the pharmacy system. The weight field in the pharmacy system remained blank, as the birth weight was not carried forward into the pharmacy system's weight field.

The pharmacist used the IBW to calculate the dose of the ordered antibiotics. This calculated dose was more than twice that for the actual body weight of the newborn. The incorrect dose of antibiotics was not administered. Upon receiving the medications, the bedside nurse rechecked the dose calculations of the ordered antibiotics and discovered that the dosages were incorrect. She immediately contacted the clinician and the pharmacist and then entered the actual weight in kg into a weight field so that the appropriate doses based on actual weight could be calculated.

Contributing Factors

The facility reporting this event used the HIT Hazard Manager, which provides fields for the facility to identify contributing factors, detect discovery and causation issues, and identify the hazard control plan. They listed the system's function and design, the data availability, and communication among staff members as some of the contributing factors in this near-miss event. Staff were unaware that the birth weight did not carry forward into the weight fields of the pharmacy system. The event report indicated that the pharmacist was waiting for a weight for this newborn, but it is unclear how this was communicated.

Health IT–Related Risk Factors

This event was categorized by the facility as a usability error. Aspects of usability include difficult data entry, confusing information display, a mismatch between the real workflow and the health IT, and a mismatch between user expectations and the health IT. The facility additionally identified a data quality issue, noting a discrepancy between the database and the exported data, as well as faulty reference information. Limitations in these categories of

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Upcoming *Partnership* Events:

In-Person Meeting Date Set: Mark your calendars for Friday, October 16, 2015, for the full-day, in-person *Partnership* meeting at ECRI Institute's headquarters in Plymouth Meeting, PA**.**

Quarterly Meeting: The next quarterly meeting of the *Partnership* is 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.

data capture may be something to examine as we learn more about the use of these fields.

The facility reported several steps that were taken or suggested to address this issue. The steps in order of priority were: (1) local configuration changes, (2) training for end users, and (3) a vendor software fix.

Lessons Learned

While communication and critical thinking are essential to mitigating medication errors, other factors such as understanding the appropriate units for data entry (e.g., kg, g, lb, cm, in), knowing what values are utilized in auto-calculations, and knowing what fields carry forward between systems are vital in ensuring the safe use of this technology.

Please send your comments and suggestions to hit@ecri.org. Remember, if you are submitting events, please use your secure communication portal.

Pediatric EHRs May Have Unique Features

In a recent **report** from AHRQ, the unique documentation needs of the pediatric population were addressed by looking at features of pediatric electronic health records (EHRs). This technical brief identifies the core functionalities that would be beneficial in pediatric EHRs, including but not limited to vaccination records, developmental milestones, pediatric medication calculations, and pediatric disease management. While many of these are not exclusive to this population, specific attention to these and other population health measures will improve the safety and quality of care.

Partnership Holds Networking Meeting at HIMSS15

The *Partnership* held an informal meeting in April in Chicago at HIMSS15, where participants had the opportunity to discuss the *Partnership*'s activities since its launch in Orlando at HIMSS14.

Since its launch, the *Partnership* has brought together an important group of stakeholders (vendors, providers, organizations, and experts in the field) to identify issues,

Copy and Paste Workgroup: The next meeting is June 1st. Please continue to submit copy and paste events through the *Partnership* portal.

Education

The Joint Commission has a training module titled Investigating and Preventing Health Information Technology-Related Patient Safety Events. You can also find this link on the *Partnership's* web page.

gather data, analyze identified issues, and ultimately make health IT safer. The HIMSS15 discussion provided the opportunity to review and expand new areas of safety focus. Participants agreed that the group's work is important in making health IT safer.

Partnership Works on Copy and Paste

The Partnership's first workgroup, convened in February 2015, has been meeting on a monthly basis to identify safety issues associated with the use of copy and paste. The workgroup, led by Tejal Gandhi, MD, MPH, president and CEO of the National Patient Safety Foundation and Partnership Expert Advisory Panel member, includes providers and provider organizations, EHR vendors, academic researchers, and collaborating organizations. The group began by defining the scope and focus of copy and paste activities that impact patient safety. To date, the group has completed a literature review, identified the benefits and risks of copy and paste, reviewed current practices, and begun to prioritize strategies to address ways to handle copy and paste within organizations. Recommendations for exemplars and best practices are among the expected outcomes.

Preparing for a New Workgroup

The *Partnership* is preparing to look at a new workgroup based on data collected, *Partnership* analysis, and issues identified by the *Partnership's* stakeholders. Keep watching; more information will be available in the near future.

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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