Partnership for Health IT Patient Safety
Partnership Update April/May 2016

Join us for a free Webinar

Health IT Safe Practices – Safe Use of Copy and Paste
Thursday, May 19, 2016
1:30 to 2:30 p.m. (Eastern time)

Please register here

Overview:
Learn more about safe practice recommendations for copy and paste developed by the Partnership for Health IT Patient Safety. Experts will provide information from an evidence-based literature review and from hazard and safety events. Additionally, presenters will discuss implementation strategies and tools developed to encourage the safe use of copy and paste. A comprehensive toolkit will be made available.

Objectives:
► Define copy and paste in documentation
► Identify the potential patient safety risks and concerns associated with copy and paste
► Review safe practice recommendations for copy and paste
► Utilize implementation strategies and tools developed by the Partnership to apply the safe practice recommendations for copy and paste

Presenters:
• Ronni P. Solomon, JD, Executive Vice President and General Counsel, ECRI Institute
• Tejal Gandhi, MD, MPH, CPPS, President, National Patient Safety Foundation
• Amy Tsou, MD, MSc, Sr. Research Analyst, Health Technology Assessment, ECRI Institute
• Jeremy Michel, MD, MHS, Physician Consultant, Technology Assessment, ECRI Institute
• Lorraine Possanza, DPM, JD, MBE, Senior Patient Safety, Risk and Quality Analyst, ECRI Institute
• Robert Giannini, NHA, CHTS-IM/CP, Patient Safety Analyst/Consultant, ECRI Institute

Data Snapshot: Misleading Headlines – What’s in the Patient Header?

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 to ensure patient safety is highlighted.
Background
Patient headers/banners provide demographic information (name, date of birth, age, gender, patient photograph) as well as visit-specific information, such as visit number, diagnosis, allergies, fall risk, isolation precautions, and code status. This information is used to communicate pertinent patient information to health care providers in a timely manner to provide safe and effective care.

Events Reviewed
ECRI Institute PSO has received and reviewed several events related to missing, confusing, or inaccurate information in the patient header/banner.

In one event, the patient had multiple allergies and the allergy information was incomplete when hovering over the allergy section in the header.

In another event, the most current weight did not appear in the header. Updated weight information did not appear in the header until the screen was refreshed.

A third event revealed that after an update to the electronic health record (EHR) software, the patient header was cutting off key information from displaying. To see all of the patient header information, the user was required to scroll down.

In a fourth event, the header information did not clearly differentiate the medical record number from the specific visit number. This created confusion for the staff, who needed to enter this information into a point-of-care testing device, and results were not being documented in the EHR.

Contributing Factors
Information in patient headers creates situational awareness for the staff providing care to the patient. The header is an at-a-glance “snap shot” of relevant information. If this data is not correct or timely, significant unintended consequences can happen as identified in the events above.

Health IT–Related Risk Factors
Access to clinical information for the right patient at the right time can impact safe patient care. Contributing factors identified by the reporters were Usability - confusing information display; Data Quality - discrepancy between database and displayed, printed, or exported data; Vendor Implementation - faulty vendor configuration recommendations; and Local Implementation - faulty local configuration and programming.

Lessons Learned
Front-line providers of health care are on information overload. To present information effectively, pertinent health information in the header needs to be clear, complete, and timely. Facilities should also limit and prioritize information that is included in the header.

Improvement Foundation (HCIF) • Healthcare Information and Management Systems Society (HIMSS) • Institute for Healthcare Improvement (IHI) • Institute for Safe Medication Practices (ISMP) • Kentucky Institute for Patient Safety and Quality • MCIC Vermont, LLC • MHA Keystone Center • Midwest Alliance for Patient Safety • National Patient Safety Foundation (NPSF) • Ohio Patient Safety Institute • PIAA • PSO of Florida • Tennessee Center for Patient Safety • 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.

Upcoming Partnership Events:

Webinar:
Health IT Safe Practices – Safe Use of Copy and Paste
May 19, 2016 1:30 to 2:30 p.m. Eastern time

Upcoming Quarterly Meetings:
July 19, 2016 3:00 to 4:00 p.m. Eastern time
When updating the template for information in the header, testing should be conducted before and after the changes are put into production. The testing should include representatives of all stakeholders, ensuring flow of the most current and significant information to the header. Facilities should also conduct ongoing HIT education related to computer system updates to staff.

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.

**Partnership Call for Action: Submit 5 Events on Usability Issues**

EHR usability is a high priority for developers and users. The Partnership intends to examine this area more closely, and seeks your help in understanding the most frequent and critical usability issues that you experience. **Please submit five new usability issues using the HIT Hazard Manager Taxonomy by May 31.**

Usability is "the extent to which a product can be used by specified users to achieve specified goals with effectiveness, efficiency and satisfaction in a specified context of use” [ISO9241]. Poor usability may include confusing information display, mismatch between real workflows and HIT, mismatch with user expectations, hard-to-find information, and difficult data entry.

Please submit these events directly into the database or, if you prefer, call ECRI Institute PSO at (610) 825-6000, ext. 5650. Should you need assistance, please contact us at hit@ecri.org to obtain additional information.

Remember when submitting data, root cause analyses, and help desk logs, please use the event reporting system or secure communication through the Partnership web portal.

**Save the Date!**

**Partnership In-person Meeting (suburban Philadelphia)**

September 16, 2016

Information to follow

**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. 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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