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PARTNERSHIP for HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update
Summer Edition 2015

The **3rd Quarter Conference Call** is Tuesday, July 28, 2015, at 3 p.m. ET. Your participation is important at this quarterly meeting! At this meeting, we will be seeking your input on the **Full-Day Annual *Partnership* Meeting at ECRI Institute headquarters** on October 16, 2015, discussing the best practices for the safe use of copy and paste and readying the launch of our next workgroup.

Copy and Paste Workgroup Meetings continue on August 3. The workgroup is currently refining recommendations and best practices in preparation for your input on July 28th during the quarterly call.

Save the Date! Full-Day Annual *Partnership* Meeting on October 16, 2015:

Partnering for Action: Applying What We've Learned

When: Friday, October 16, 2015
Time: 8:00 - 3:00 ET
Where: ECRI Institute Headquarters, 5200 Butler Pike, Plymouth Meeting, PA (suburban Philadelphia)

- Continental Breakfast
- Welcome and *Partnership* Progress Overview
- Safe Practices Forum: Reporting and Best Practices from the *Partnership Copy and Paste Initiative*
- Safe Practices Forum: Partnering on New Solutions for Patient Identification
- Networking Lunch
- Interactive Shared Learning Forum: Hot Topics in Health IT Safety
- Mapping Out Next Steps

You can register for this meeting by clicking on this link: https://www.ecri.org/Pages/Register-for-Partnering-for-Action.aspx

An e-mail announcement was sent on July 1st. If you have not received the announcement, please e-mail us at hit@ecri.org. We hope you will join us.

Data Snapshot: Medication and Treatment Timing Is Often a Challenge

Data Snapshots provide lessons learned from patient safety reports submitted to the *Partnership*.

Appropriate medication orders, dosing, and dispensing are patient safety issues that have been improved in many ways by health IT. However, how orders translate into the electronic environment; how electronic prescribing, processing, and dispensing systems interact; and how providers document the special circumstances of medication ordering for the appropriate and timely administration of medications and therapies often lead to unanticipated adverse events. Many of these events, as we will see below, come down to an issue of timing.

Background

"Timing events" are most frequently reported as medication errors; however, these issues also occur in therapy orders and treatments, as well as in laboratory orders. Fortunately, in most events, there was no reported harm despite the fact that events frequently reached the patient.

Untimely and incorrect receipt of appropriate medications is a safety issue because it can result in overmedication or delayed therapies. In these events, we see medications that are not being appropriately dispensed, duplicate doses of medications, missed doses, or medication protocols not beginning at the appropriate time(s) often because of the way in which a system was configured.

Event Review

Timing issues span multiple types of medication events, as well as others that are not detailed here. In this first event, a medication was ordered as a "daily dose." The time for administration of the medication defaulted to 9:00 a.m.; the patient did not receive the medication until the next day at 9:00 a.m. even though the ordering provider intended to have the medication begin on the date ordered.

In another example, antibiotics were ordered "after dialysis." However, even though the patient underwent regular dialysis, only one dose of the medication was dispensed. The intention was for the medication to be received after *every* dialysis treatment.

In yet another example, a patient underwent an orthopedic procedure and the provider ordered antibiotics (cefazolin 2 g IV q8h x 3 doses). The pharmacist verified the order. The doses of the antibiotic should have continued immediately following surgery; however, based on order start date/time logic, the start date was changed to the next day. Upon discovery, the pharmacist notified the provider, and it was decided to not dispense the antibiotics because it had been more than 24 hours after surgery.

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 Foundation (JKTG) for Health and Policy.

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. If you have not received your invitation for this interactive conference call, please e-mail us at hit@ecri.org.

Copy and Paste Workgroup: The next meeting is **August 3** at 12 noon ET.

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.

Contributing Factors
Understanding an organization's or a system's timing protocol(s) is important. Knowing the timing protocol allows the provider to know what the standard administration/therapy times are and when the patient will receive their first dose of the medication or receive their therapy.

Protocols involve both the times that orders are entered and the times that medications are dispensed. These protocols are set by the organization or programed as a default. For example, "once daily" medications may be given at 9 a.m. in one particular organization and dispensed at 8 a.m. elsewhere. Knowing the times that medications are dispensed for those received daily or every 8 or 12 hours is essential in the timing of the orders.

Further, it is important that the systems are synchronized so that the time when orders are entered is the same time when other systems view those orders.

Staff must be trained on special ordering protocols as well as routine protocols. Any specific instructions (e.g., "now and routine" or other special notations) that are needed to ensure that medications are received in an appropriate and timely manner are important to review as part of continuing education so that providers' intents and patients' needs are met.

Health IT–Related Risk Factors
Order start/date time logic, clock synchronization, special language, and system interoperability are potential IT-related risks. Protocols must be communicated to providers placing orders, the pharmacy, and those executing those orders, including the nurses dispensing meds/treatments, lab personnel performing lab draws, and respiratory, PT/OT, or speech/language pathologists starting or continuing treatments.

Lessons Learned
Timely administration of medications and treatments is important in patient care. Ensuring that providers understand the protocols and that they know how to address specific issues to make sure that patients receive medications or therapies as intended should be easy. However, events show us that this is not the case. All stakeholders—vendors, provider organizations, and providers—can and should work together to effectively standardize protocols to minimize timing events.

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

Thought Corner - Is Critical Data Visible?

After our last Data Snapshot—in which we pointed out that often various providers do not see the same information or even the same parts of the record (e.g., birth weight not seen by the pharmacist)—another event, with fatal consequences, again reminded us that parts of the record, such as nursing notes, are not always visible to others. In this event, the pharmacist did not see the patient's weight because it was recorded in a nursing notation (text box). The patient's weight had decreased significantly since an earlier admission. Thereafter, the patient received an inappropriate dose of an anticoagulant and suffered a terminal bleed.

It is important to evaluate what areas of the record are visible and consider whether all areas should be visible with some restrictions on whether a provider can modify those sections of the record. Food for thought.

Health IT Remains at the Forefront

The *Partnership* welcomes all of your continued contributions, including items for this publication. 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.

Our collaborating organizations, HIMSS, HIMSS EHRA, AMA, and MHA, along with others, including the American Association for the Advancement of Science (AAAS), are also working on various health-IT-related issues. If you have something that you would like to share with the *Partnership*, please e-mail it to hit@ecri.org.

Preparing for a New Workgroup

The *Partnership* is preparing for a new single-topic workgroup based on the data collected, *Partnership* analysis, and issues identified by the *Partnership's* stakeholders. Learn more about this new workgroup during July 28th's quarterly call.

Award Winner

The Association for the Advancement of Medical Instrumentation (AAMI), representing those professionals who support the development, management, and use of safe and effective healthcare technology, announced the winners of its annual awards saluting those leaders and

innovators. Included among the award recipients was Erin Sparnon, MEng, Health Devices Manager at ECRI Institute. Sparnon was awarded AAMI's Young Professional Award. This award is presented annually to a professional under the age of 40 with a record of exemplary accomplishments and who demonstrates a commitment to the healthcare profession. Sparnon serves on a number of AAMI committees, including the Infusion Devices Standards Committee and the Infusion Safety Steering Committee.

The winners received their awards at the AAMI 2015 Conference & Expo, which was held June 5 to 8 in Denver, CO.

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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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