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PARTNERSHIP for HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update June 2016

Join the next *Partnership* Quarterly Call JULY 19, 2016

The next *Partnership* Quarterly Call will be held on July 19, 2016, 3:00-4:00 p.m. eastern time. The agenda includes:

- Review and discussion of draft Safe Practice Recommendations for the Use of Health IT in Patient Identification

The draft Patient Identification (ID) recommendations will be e-mailed for review before the meeting to spark discussion. We want to hear your thoughts on ease of implementation and potential barriers that may be present for each stakeholder group.

Please click here to register for this important call.

***Partnering for Action*: Applying What We've Learned Meeting Proceedings Available**

Proceedings from the *Partnership* for Health IT Patient Safety's in-person meeting, Partnering for Action: Applying What We've Learned, held Friday, October 16, 2015, are now available at https://www.ecri.org/components/hrc/pages/Proceedings2016.aspx.

This interactive meeting reported on the *Partnership's* progress and allowed attendees to design solutions and share practices for advancing the safety of health information technology (IT). Agenda highlights included:

- Safe Practices Forum: Reporting and Best Practices from the *Partnership* Copy and Paste Initiative
- Safe Practices Forum: Partnering on New Solutions for Patient Identification
- Interactive Shared Learning Forum: Hot Topics in Health IT Safety

Save the Date: In-Person Meeting at ECRI Institute on Friday, September 16, 2016

Data Snapshot: Allergy Documentation is Nothing to Sneeze at

Data Snapshots provide lessons learned from patient safety reports submitted to the Partnership. This edition of Data

Snapshot highlights the importance of recognizing provider needs to ensure patient safety.

Background
Documentation of a patient's allergies is an important step in patients' medical history and medication reconciliation. This information communicates allergies (medications, environmental, and dietary) to the appropriate healthcare staff. It is also used to enable clinical decision support to notify staff of potential adverse reactions to medications and food substances.

Events Reviewed
ECRI Institute PSO reviewed several events related to inaccurate, incomplete, or conflicting allergy information. Issues surrounding "free-text" allergies have also been identified.

In one event, allergy information conflicted because charts had been merged. One chart had "No known drug allergies" documented. The other chart had the patient's listed allergies. The merged charts contained all of the allergies plus the "no known allergies" listed in the electronic record.

In another event, the allergy information was incomplete when hovering over the allergy section in the header.

A third event showed that when the patient presented to the Emergency Department, penicillin was documented as a "free-text" allergy. The patient was admitted to the hospital and given IV antibiotics. The ordering practitioner was unaware of the allergy, did not review the list, and no alerts triggered.

In a fourth event, a patient was allergic to mushrooms. This information did not transfer to the dietary computer system.

Contributing Factors
Allergy information that is omitted, incorrect, or not up to date can compromise patient care processes. A compromised care process is any care-process abnormality that has the potential to contribute to patient harm. Care processes typically involve more than one person (e.g.., a physician prescribing a medication, a pharmacist dispensing the mediation, a nurse administering the medication to the patient). When a breakdown in communication of allergy information occurs, the potential for patient harm increases.

Health IT–Related Risk Factors
Incomplete documentation of a complete list of allergies or miscommunication of that clinical information through electronic means can have a serious impact on safe patient care. Contributing factors identified by the reporters were: *Usability* – inadequate user feedback; *Data Quality* - discrepancy between database and displayed, printed, or exported data; *Decision Support* – missing safeguard; *Vendor Implementation* - faulty vendor configuration recommendations, faulty software design;

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 Foundation (JKTG) for Health and Policy.

Upcoming *Partnership* Events:

Quarterly Meeting:

July 19, 2016 3:00 to 4:00 p.m. Eastern time

Save the Date!

***Partnership* In-Person Meeting at ECRI Institute**

September 16, 2016

Information to follow

Local Implementation - faulty local configuration and programming; and Other – inadequate training.

Lessons Learned
A systematic approach needs to be taken for allergy reconciliation and documentation. The first step is collecting a complete and accurate allergy list. This step should include patients and families as a source of information. Additional sources, such as health care practitioners and providers throughout the continuum of care, need to be considered to capture allergy information.

Processes associated with data collection and input of allergy information within each facility need to be standardized. The process should identify the person who is accountable for collecting and documenting the initial allergy information.

Additional processes are also needed for allergy reconciliation (documenting, confirming, and updating) throughout each episode of care. Staff education needs to be role-specific, based on their part in allergy reconciliation.

Facilities should have a plan to handle "free-text" allergies. Encourage and educate staff on how to properly enter allergies, avoiding free-text if possible. Free-text allergies that are not codified are rendered useless for drug-drug or drug-food interactions. Processes should be developed and accountability should be established on how to handle and resolve allergies that are not coded.

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 Presents at NPSF Patient Safety Congress

On Tuesday, May 24, 2016, the *Partnership* presented at the 18th Annual National Patient Safety Foundation (NPSF) Patient Safety Congress in the track called optimizing the benefits and minimizing the harm of health technology. The panel presentation included: Mary Beth Navarra-Sirio, MBA, RN, Vice Chair, NPSF Board of Directors, former Vice President and Patient Safety Officer, McKesson Corp.; Lorraine Possanza, DPM, JD, MBE, Senior Patient Safety, Risk, and Quality Analyst, and HIT Safety Liaison, ECRI Institute; and Ronni P. Solomon, Esq., Executive Vice President and General Counsel, ECRI Institute.

The panel discussion, Partnering for Action: The *Partnership for Health IT Patient Safety*, presented the findings and best practices from the *Partnership*, including the Best Practice Recommendations for Copy and Paste and the current work on Patient Identification. The panelists also discussed learnings and interventions to prevent HIT-related hazards and adverse events that cause injury to patients and undermine an organization's reputation. Emphasis was

placed on high-priority issues and ways to eliminate safety barriers.

Partnership Call for Action: Submit Five Events on Usability Issues

Electronic health record (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 June 30.**

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.

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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