



## SAVE THE DATES:

### I. Quarterly Meeting, July 25, 2017, 3 p.m. ET

- Topics: Transformational panel, workgroup updates, further discussion on implementation of *Partnership* Safe Practice Recommendations.

### II. *Partnership* In-Person Meeting, November 15, 2017

- Where: ECRI Institute headquarters, Plymouth Meeting, PA
- Topics: 2017 Workgroup updates, Transformational Leadership Summit; and additional discussion on implementation projects for *Partnership* safe practices, preparing for 2018 activities

## Partnership Workgroup Update:

**Partnership Workgroup 3, on Developing, Integrating, and Maintaining a Health IT Safety Program, continues to meet.** The next workgroup meeting is July 19 at 12 p.m. ET.

**Participate in *Partnership* Workgroup 4, Closing the Loop – using health information technology to close the loop and mitigate delayed, missed, and incorrect diagnoses.** Meetings are July 11, August 15, September 19, and October 17 at 10 a.m. ET. For more information, contact the *Partnership* at [hit@ecri.org](mailto:hit@ecri.org).

## Expert Advisory Panel

David W. Bates, MD, MSc  
Kathleen Blake, MD, MPH  
Pascale Carayon, PhD  
Tejal Gandhi, MD, MPH  
Chris Lehmann, MD  
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The *Partnership for Health IT Patient Safety* is sponsored in part through a grant from the Jayne Koskinas Ted Giovanis Foundation (JKTG) and in part through funding from the Gordon and Betty Moore Foundation.



## Are You Implementing Safe Practices Within Your Organization

In April at the *Partnership* Quarterly meeting, we initiated a discussion of safe practice implementation. At that meeting, we discussed how several recent HIMMS Davies winners implemented various safety practices. This was one approach to explore ways to implement the *Partnership's* safe practice recommendations. You may also recall that during that April call, we asked for your responses to a survey question about your specific implementations. Several of you indicated that you were in the process of, or that you had implemented safe practice recommendations for copy and paste, or for the

## SAVE THE DATES:

**Quarterly Meeting**  
Tuesday, July 25, 2017  
3:00 - 4:00 PM ET

***Partnership* for Health IT Patient Safety In-Person Meeting**

safe use of health IT in patient identification. We would like to hear about those implementations! More specifically, tell us what recommendations that you have implemented, what process you may have used to roll out these recommendations, what barriers you may have faced, how you overcame them, and what you are doing now.

E-mail us at [hit@ecri.org](mailto:hit@ecri.org) and we can identify time to discuss what you are doing to make healthcare safer in your organization. By sharing those stories, we can make healthcare safer together!

November 15, 2017

## Data Snapshot: Inadequate Drug Allergy Alert

### Background

You take a drug. Something unexpected happens. Perhaps it is a rash, maybe it is a sick feeling, worst yet is evidence of cardiovascular collapse. Could this have been prevented? How do we alert providers and patients to the risk of drug allergies and interactions?

Allergies may not appear in the record because the patient did not report it or because the allergies were not recorded in the correct field to transfer from the medical history section of the electronic health record (EHR) to the computerized provider order entry (CPOE) section. CPOE functions can fire an alert only when information is in correct fields. Even if alerts appear, they may be overridden by the physician.

### Events Reviewed

The following events reveal some common food-drug interactions. In these instances, human diligence and intervention prevented an adverse event from occurring. Being aware of the potential for error allows your organization to evaluate the risk of a similar occurrence.

- *The physician ordered an anticoagulant medication (enoxaparin) for a patient. The patient asked if it was made with pork. After a call to the pharmacy, it was confirmed that the drug was indeed made with pork. The patient is highly allergic to pork. This allergy was documented in the patient's electronic health record (EHR). The drug allergy alert did not fire when the drug was ordered nor when it was scanned into the electronic medication administration record (eMAR) prior to administration. This near miss was thwarted by the patient's proactive inquiry.*
- *The patient had orders written for a sedative medication (propofol), which was contraindicated with an egg allergy. The patient had an active egg allergy listed in the EHR. The nurse discovered the error and alerted the ordering clinician, thereby saving the patient from a possible adverse event.*
- *An allergy alert for IV [intravenous] contrast dye did not show up when a computerized tomography (CT) scan with IV contrast was ordered. The patient was allergic to shellfish and IV contrast dye. The physician caught the error upon questioning the patient and checking the EHR.*

### Contributing Factors

In these scenarios, the medications contained a food derivative that the patients were allergic to—pork, egg, and shellfish.

The allergies may have—

- Been entered into an incorrect field in the EHR
- Been recorded in free text that cannot transfer in the EHR
- Been miscommunicated because of incomplete data transfer in the EHR

If allergies need to be entered as free text, there should be a process to reconcile allergies, establish accountability, and communicate the allergies to clinicians and dietary and other necessary personnel.

Other possible contributing factors to an inadequate drug-allergy alert include poor medical history taking and other factors, including inadequate end-user training.

There may be multiple reasons why electronic systems are insensitive to particular allergy information. It is imperative that patients and providers be alert, even if they do not receive electronic warnings.

## Lessons Learned

Allergy alert inadequacies and their underlying causes are often difficult to detect, until an error occurs. An urgent need exists to improve the accuracy and relevance of drug or food allergy safety alerts.

Drug allergy checking occurs during the entry of new allergies as well as new medication orders. The variety of interactions, sensitivity of alert triggers, and ability to override are important considerations.

A standardized process and location for documenting dietary-, environmental-, and drug-allergy information is necessary so that care is not compromised.

## In the News

The **CHIME** National Patient ID Challenge, a global competition to create a solution ensuring 100% accuracy in identifying patients, has completed the final innovation round. The four finalists will enter the prototype testing round of the competition, which is expected to last for several months. The goal is to announce a final winner in November 2017.

According to a report, *Patient Safety and Information Technology: Improving Information Technology's Role in Providing Safer Care* (May 2017), released by the **Bipartisan Policy Center**, resolving medical errors and patient safety issues generated by health technology require buy-in from a broad number of stakeholders. The recommendations were derived from information obtained while interviewing a diverse group of stakeholders that included members of the *Partnership's* Expert Advisory Panel as well as *Partnership* collaborators. The recommendations are as follows: (1) using data in a coordinated effort to set priorities; (2) accelerating the dissemination of best practices and addressing gaps; and (3) continuing to establish and promote adherence to standards.

**AHIMA, a *Partnership* Collaborating Organization, invites you to submit your comments through July 24, 2017.**

Integrating the Healthcare Enterprise (IHE) and American Health Information Management Association (AHIMA) invite you to submit comments on the White Paper entitled Patient Registration Demographic Data Capture and Exchange.

The White Paper was developed by the IHE Patient Care Coordination (PCC) Committee with participation of the AHIMA Standards Task Force. It is based on the AHIMA Patient Registration Use Case and specifies the requirements and constraints for patient demographic data that should be collected and exchanged for patient registration during an emergency department visit at a healthcare organization.

These data requirements may be proposed to be published as future IHE Technical Framework Volume 4: United States National Extension to the IHE ITI Patient Administration Management (PAM) Profile for the message-based data exchange.

Please download the White Paper [here](#).

Please download the Public Comment Form [here](#).

*The form contains instructions for recording and submitting your comments.*

## Collaborating Organizations



## Working Together:



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### Need to Submit an Event?

Partnership participants can submit events through your [membership portal](#).

If you need assistance, please contact us at [hit@ecri.org](mailto:hit@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). 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](mailto:hit@ecri.org).

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