



Partnership for Health IT Patient Safety's 4th Annual In-Person Meeting

Transforming Health IT by Embedding Safety

Wednesday, November 15, 2017

8:00 a.m. to 4:30 p.m.

ECRI Institute (suburban Philadelphia)

Please join us for an extraordinary day of collaboration, interaction, and shared learning about ways to advance our common goal of transforming health information technology (IT) safety. This year's annual meeting discusses the importance of "embedding" safety as a key driver to health IT transformation.

A brief overview of our agenda:

- Kenneth W. Kizer, MD, MPH, on transformational safety initiatives
- A panel discussion addressing "closing the loop" workgroup findings, this group was chaired by Christoph U. Lehmann, MD, FAAP, FACMI
- A panel discussion addressing integrating Health IT safe practices, a workgroup chaired by Patricia P. Sengstack DNP, RN-BC, CPHIMS
- Our Breakout Sessions on standardizing for safety includes these areas patient identification (ID), clinical decision support, and documentation
- And we are launching our implementation projects

This is our only face-to-face meeting of the year, so take advantage of the opportunity to interact with others in shaping and transforming health IT safety.

[Register today!](#)

Partnership Workgroup Update:

There is still time to **participate in Partnership Workgroup 4, Closing the Loop – Using Health Information Technology to Close the Loop and Mitigate Delayed, Missed, and Incorrect Diagnoses**. This workgroup continues to meet. The next meeting is scheduled for October 17 at 10:00 a.m. ET.

THANKS!

Expert Advisory Panel

David W. Bates, MD, MSc
Kathleen Blake, MD, MPH
Pascale Carayon, PhD
Tejal Gandhi, MD, MPH
Chris Lehmann, MD
Peter J. Pronovost, MD, PhD
Jeanie Scott, MS, CPHIMS
Patricia P. Sengstack, DNP, RN-BC, CPHIMS
Hardeep Singh, MD, MPH
Dean Sittig, PhD
Paul Tang, MD, MS

The *Partnership for Health IT Patient Safety* is sponsored through funding from the Gordon and Betty Moore Foundation.

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Partnership Workgroup 3, on Developing, Integrating, and Maintaining a Health IT Safety Program, held its last meeting on July 19. A big thank you to the workgroup chair Patricia Sengstack and all the *Partnership* collaborators who participated in this workgroup. The workgroup is currently reviewing the safe practice recommendations and toolkit.

Data Snapshot: UPDATE – Copy and Paste

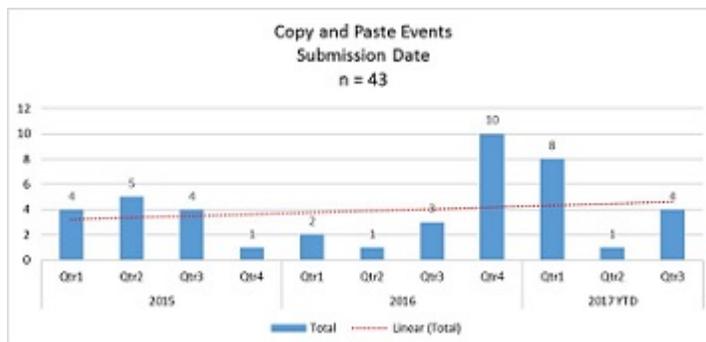
Copy and Paste – A Health IT-related Risk or a Necessary Workaround?

The following case studies illustrate issues that arise with copying and pasting data in the electronic health record (EHR).

- *Staff identified copy and paste within the progress notes. The doctor copied a note from a few days prior and did not appropriately update the note prior to finalizing it. In the note, the physician documented that the patient had a Nasogastric Tube (NGT) however; the NGT had been removed the previous day. Two days after the tube was removed, the PA (physician assistant) also copied a note without review, which also referenced the patient having a NGT.*
- *Nursing notes, documented under “skin assessment,” identified a lesion of the right lower extremity (RLE) and right hip on patient since admission. The patient had no skin related issues of right hip or RLE. The patient had a left hip fracture that required an open reduction internal fixation (ORIF) with pinning and the dressing is in place to the left hip. Upon review, it appeared that copying and pasting occurred.*
- *The patient's glucose level came back with morning laboratory results and revealed the patient was hypoglycemic. When report was given, the previous RN stated she was not aware that the lab was low. The patient's blood sugar was re-checked and the results were even lower. The patient was administered dextrose 50% and returned to normal range. The glucose results in the patient's chart appear to have been copied and pasted from the previous day-shift documentation.*

Background

The term *copy and paste* refers to data that is reused from other areas (either in the same system [e.g., clinical notes] or in different systems [e.g., laboratory]) but most explicitly, data that is volitionally obtained and used elsewhere without having to retype it. The American Health Information Management Association (AHIMA) defines copy functionality as reproducing text or other data from a source to a destination. Copy and paste, as identified in ongoing event review, continues to be an issue and is trending upward



Events Reviewed

A review of events submitted to the ECRI Institute PSO database revealed 43 events involving copy and paste. The analysis of events was conducted using regular expression-based key-word search with context-based filters from February 2015 through August 2017. Identification of where the information was copied from and pasted to was conducted.

This analysis revealed that a majority of the data was copied from progress notes, diagnostic test results, and nursing documentation, as the table below-left shows. It was most often pasted into progress notes, nursing documentation and discharge documentation, as the table below-right shows.

Healthcare providers most often using the copy functionality included physicians (44%), nursing (19%), clinical staff (5%), diagnostic testing staff (5%), residents (5%), scribes (5%), and unknown (19%).

This analysis provides insight about where organizations may find copy and paste information, where workflow surrounding documentation can be redesigned or enhanced, and which healthcare professionals need to be aware of the risks and benefits associated with copy and paste.

COPIED FROM	%	PASTED TO	%
Progress note	23	Progress note	47
Diagnostic test results	16	Nursing documentation	12
Nursing documentation	16	Discharge documentation	7
Medication documentation	7	Assessment	7
Admission documentation	7	Diagnostic test results	7
Vital signs	5	History & Physical	7
Clinical staff notes	5	Patient information	2
Patient information	2	Operative report	2
Assessment	2	Admission documentation	2
Problem list	2	Treatment plan	2
Treatment plan	2	Medical record	2
Erroneous data	2	Medication documentation	2
Medical record	2		
History & Physical	2		
Discharge documentation	2		
Operative report	2		

Contributing Factors

The safety risks of copy and paste are seen in a number of ways.

- Some records contain so much copied and pasted information that timely or accurate interpretation of the information is difficult, if not impossible.
- Inaccurate information can impede correct and timely treatment, further delay diagnosis, or potentially negatively affect care if incorrect information is not removed from the record.
- Problems can also occur with using information that is later identified as being erroneous because it resulted from inadvertent copying and pasting of old information or information from another patient's medical record.
- The ability to see what information has been copied and where it originated, as well as confirmation can be challenging, especially when multiple providers are working with a patient's record.

Lessons Learned

The reasons for using copy and paste are diverse; the solutions must be as well. To mitigate the safety risks that occur when materials are copied and pasted and in an effort to make the practice safer, the workgroup identified the following four safe practice recommendations:

- **Recommendation A:** Provide a mechanism to make copy and paste material easily identifiable.
- **Recommendation B:** Ensure that the provenance of copy and paste material is readily available.
- **Recommendation C:** Ensure adequate staff training and education regarding the appropriate and safe use of copy and paste.
- **Recommendation D:** Ensure that copy and paste practices are regularly monitored, measured, and assessed.

Copy and paste is a timesaving function that clinical staff use to efficiently capture complex information. However, it also provides the risk of misinformation (duplication of information that may have changed) or too much information for staff to

synthesize. Organizational policies need to offer guidance to staff on how to appropriately use copy and paste and when it is unacceptable. Staff need to be informed as to what action steps are necessary to avoid the associated risks.

For the full recommendations and more information, visit the Partnership's [Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste](#).

The National Institute of Standards and Technology (NIST) released a paper, [NISTIR 8166—Examining the Copy and Paste Function in the Use of Health Records](#), with the findings obtained from a usability study of the copy and paste functionality in EHRs. The copy and paste function is intended to allow medical practitioners to easily and efficiently reuse information in patient EHRs without having to retype the information. However, in practice, current implementation of this function has introduced overwhelming and unintended safety-related issues into the clinical environment.

NIST recommends areas where copy and paste should be locked: The function must not be allowed when entering any information into a blood bank information system (because of the extreme risk involved in blood transfusion); demographic information should never be copied, but needs to be auto-populated in all the interfaces within a patient's chart; copying of demographic data from one chart to another should not be allowed; dates should never be copied and pasted.

NIST makes some additional human-factors recommendations for critical areas of documentation identified in the usability study where copy and paste could pose health IT safety risks. The critical areas include the following: vital signs, allergies, surgical notes, medication entry, discharge summary, and copying and pasting information from different departments or another patient's EHR. For more details regarding the usability study, read the full report at the link above.

In the News

AHIMA and ISO/TC 215 Health Informatics Announce New International Standard Health Information Privacy in Healthcare Organizations: Workforce Education Standard

AHIMA and the International Organization for Standardization Technical Committee 215 Health Informatics (ISO/TC 215) are pleased to announce the publication of a new educational standard, [ISO/Technical Report \(TR\) 18638:2017, Health Informatics — Guidance on health information privacy education in healthcare organizations](#) (URL: <https://www.iso.org/standard/63100.html>).

The standard covers (a) the concept of information privacy in healthcare; (b) the challenges of protecting information practices in the healthcare organization; and (c) the components of a healthcare information privacy education program. In addition, the standard specifies the essential educational components, within the context of roles and job responsibilities, required to establish and deliver a training program for supporting health information privacy in a healthcare organization. The standard is aimed at those responsible for planning, establishing, and delivering health information privacy education for healthcare organizations that are implementing privacy protection policies and practices.

New Interoperability Measurement Report Available from National Quality Forum

The Office of the National Coordinator for Health Information Technology (ONC) proposed that the National Quality Forum (NQF) develop a measurement framework that would identify key concepts critical to measuring interoperability and its impacts. NQF convened a committee consisting of stakeholders across the healthcare spectrum, including health IT, to develop the framework. Read the [final report](#) that can be used as a foundation to select and develop measures.

New Collaborating Organization: MAME – Mothers Against Medical Error

Mothers Against Medical Error is a group of parents whose mission is to promote safety in our medical system. The group provides support for victims of medical harm and is available to speak about medical error and patient safety. MAME works on a variety of projects to further the cause of safer, more effective medical care.

FROM: AHRQ Patient Safety Network

Perspectives on Safety—Health Information Technology and Safety

This month's [interview](#) features Andrew Gettinger, MD, the Chief Medical Information Officer and the Executive Director of the Office of Clinical Quality and Safety for ONC. He led the development of an EHR system at Dartmouth and was the senior physician leader during the organization's transition to a vendor-based EHR. The Association for Healthcare Research and Quality (AHRQ) spoke with him about safety and health information technology.

In an [accompanying perspective](#), Dean F. Sittig, PhD, of the University of Texas Health Science Center at Houston, and Hardeep Singh, MD, MPH, of Baylor College of Medicine, highlight four key lessons that they believe are useful for clinicians and health care organizations seeking to identify, prevent, and mitigate EHR-related safety issues.

Collaborating Organizations



PARTNERSHIP for
HEALTH IT PATIENT SAFETY
Making healthcare safer together

Working Together:



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