ECRI Institute
The Discipline of Science. The Integrity of Independence.

PARTNERSHIP *for*
HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update July/August 2016

Register now: In-Person Meeting at ECRI Institute on September 16, 2016

Click here to register.

The 2016 Partnership for Health IT Patient Safety in-person meeting *Partnering for Transformation: Making a Positive Impact* will be held on September 16. The meeting will build on last year's progress bringing together ideas from all of the stakeholders in the Partnership, including provider organizations, health information technology (IT) vendors, expert advisors, professional societies, patient safety organizations, and researchers.

The Safe Practice Recommendations for the Use of Health IT in Patient Identification, developed by the Patient ID Workgroup, will be discussed during the meeting.

This meeting gives attendees the opportunity to shape the future of health IT safety by directing future topics and activities to be addressed by the *Partnership.*

Date: Friday, September 16, 2016

Location: ECRI Institute, 5200 Butler Pike
Plymouth Meeting, PA 19462 (suburban Philadelphia)

Time: 7:30 a.m. to 3:30 p.m. (Eastern time)

Please complete a brief survey about the patient identification recommendations.

Click here for survey.

The Partnership Quarterly Call held on July 19, 2016, recording is now available by clicking here.
(Partnership log-in credentials required. Email us at hit@ecri.org if help is needed).

The *Partnership* Quarterly Call was held on July 19, 2016. The agenda included:

I. Welcome and update – Ronni Solomon, JD

II. Patient Identification Workgroup Report

Expert Advisory Panel
David W. Bates, MD, MSc
Pascale Carayon, PhD
Tejal Gandhi, MD, MPH
Terhilda Garrido, MPH, ELP
Omar Hasan, MBBS, MPH, MS
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

Collaborating Organizations
Association for the Advancement of Medical Instrumentation (AAMI) • American Association for Physician Leadership (AAPL, formerly ACPE) • Association for Healthcare Documentation Integrity (AHDI) • American Health Information Management Association (AHIMA) • American Medical Association (AMA) • Association of Medical Directors of Information Systems (AMDIS) • American Medical Informatics Association (AMIA) • American Nursing Informatics Association (ANIA) • American Organization of Nurse Executives (AONE) • Alliance for Quality Improvement and Patient Safety (AQIPS) • American Society of Anesthesiologists (ASA) • American Society for Healthcare Risk Management (ASHRM) • California Hospital PSO • College of Healthcare Information Management Executives (CHIME) • Council of Medical Specialty Societies (CMSS) • Health Care Improvement Foundation (HCIF) • Healthcare

- Why patient identification is an important topic – Dean Sittig, PhD
- Workgroup process – Lorraine Possanza, DPM, JD, MBE
- Experiences with the Patient Identification Workgroup – Trisha Flannigan, SMN, RN
- Events and their contribution to the draft recommendations –Robert Giannini, NHA, CHTS-IM/CP

III. Discussion of Recommendations - Ronni Solomon, JD

IV. New Business – Discussion

Partnering for Action: Applying What We've Learned 2015 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 available here.

This interactive meeting reported on the Partnership's progress and allowed attendees to design solutions and share practices for advancing the safety of health 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

ECRI Institute PSO Webinar:
PSO Deep Dive™ on Patient Identification
Thursday, September 22, 2016
1:30 to 2:30 p.m. (Eastern Time)

Please register here.

For its fifth PSO Deep Dive™ analysis of a patient safety topic, ECRI Institute PSO selected the topic of patient identification. Safe patient care starts with delivering the intended interventions to the right person. Yet, the risk of wrong-patient errors is ever present for the multitude of patient encounters occurring daily in healthcare settings.

Our presenters are ECRI Institute experts:

- Stephanie Uses, PharmD, JD, MJ, Patient Safety Analyst/Consultant

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 Foundation (JKTG) for Health and Policy.

Upcoming *Partnership* Events:

Partnership In-Person Meeting at ECRI Institute

September 16, 2016

7:30 a.m. to 3:30 p.m. (Eastern time)

Register here.

WEBINAR:
ECRI Institute PSO: Deep Dive Patient Identification

September 22, 2016

1:30 to 2:30 p.m. (Eastern time)

Register here.

- Robert Giannini, NHA, CHTS-IM/CP Patient Safety Analyst/Consultant

An application will be made for 1.0 nursing contact hour through our California state nursing contact hour provider. To be eligible, each attendee must log on separately.

Please forward this announcement to others in your organization who may be interested.

If you have any questions, please don't hesitate to contact the ECRI Institute PSO Help Desk (866) 247-3004 or email: psohelpdesk@ecri.org.

Data Snapshot:
Is there a reason to be alarmed by alerts?

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
Clinical Decision Support (CDS), specifically alerts, notifications, and reminders, are clinical decision-making tools intended to help providers ensure delivery of effective healthcare and to improve health outcomes. It has also been shown to be effective in detecting and mitigating adverse events.

Events Reviewed
ECRI Institute PSO reviewed several events related to alerts for which the safeguard did not function as expected, was not acknowledged or was bypassed, or was unavailable.

In one event in which the safeguard did not function as expected, nifedipine 60 mg XL tab was identified as being continued in the admission medication reconciliation record. The provider received a duplicate-dose alert because the medication had been ordered and administered in the emergency department (ED). The provider, assuming the ED order would persist in the inpatient electronic health record (EHR), chose not to continue because of a confusing clinical decision-support message. As a result, the patient missed several doses of this drug used in treating hypertension and angina.

In an event in which a safeguard was bypassed, ketorolac and ibuprofen were given together. Upon review, it was noted that the MD and RN had bypassed the alerts.

The safeguard was not available in another event in which a physician e-prescribed an order for oral chemotherapy for a child to the outpatient pharmacy. Unbeknownst to the

physician, the e-prescription did not go through, as there is no notification to the prescriber. Unfortunately, upon clarification of the order, verbal communication was inadequate, causing a 10-fold underdose of the medication.

Contributing Factors
Alerts are deployed to assist and remind healthcare providers to make the right decision at the right time. To understand the contributing factors to events related to alerts, we need to determine the "What, Who, How, Where, and When" alerts are implemented. What is the information needed to determine the right course of action? Who is the person who is responsible for the decision-making process? How is this information going to be presented (in what format)? Where is this information going to be presented? When is the right time in the decision-making workflow to present this information?

Numerous factors can contribute to alerts being ineffective. These contributing factors include alert fatigue, disruptions, constraints, and appearance.

Health IT–Related Risk Factors
Alerts that do not function as expected, were bypassed, or were unavailable can have an impact on patient safety. Contributing factors identified by the reporters were: Usability – mismatch between real workflows and health IT, inadequate feedback to the user, mismatch between user expectations (mental models) and health IT; Decision Support – missing recommendation or safeguard; Vendor Factors – Technical solution includes nonconfigurable warning message from vendor; Local Implementation – faulty local configuration or programming; Other Factors – inadequate training, compromised communication among clinicians (e.g., during hand-offs).

Lessons Learned
CDS, when thoughtfully implemented, can have a positive effect on health outcomes and healthcare delivery. However, unintended consequences can happen when implementation of CDS occurs without support structures in place. CDS oversight should be assigned to a multidisciplinary team to ensure appropriate planning, testing, training, implementation, and monitoring.

We invite you to send your events, suggestions, and strategies for safe use of clinical decision support, alerts, 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 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 September 7.**

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 health IT, 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.

If you wish to stop receiving the *Partnership for Health IT Patient Safety Monthly Newsletter*, please send an e-mail to hit@ecri.org and we will accommodate your request.

editorial or other control over those other sites.