

Partnership for Health IT Patient Safety

Partnership Update
Fall 2014

Welcome to the Fall 2014 edition of the *Partnership for Health IT Patient Safety Update*. In this edition, we provide information on upcoming meetings, proposed workgroups, ongoing data submission and analytics, and introduce a new feature, Data Snapshot, below.

The Data Snapshot provides selected cases from the Partnership and examines some lessons learned. The cases are nonidentifiable and are drawn from events, helpdesk logs, RCAs and other data submitted to the Partnership.

Watch for proceedings from the *Partnering for Success* meeting, coming in December 2014. The report, along with video commentary from the Expert Advisory Panel, will be distributed to all collaborating organizations and participants and will be posted publically on ECRI Institute's website.

As always, we welcome your input. Please provide any updates that you have by submitting them with the subject line "Partnership Update" to hit@ecri.org.

Data Snapshot: Patients with Similar Names

Background

One form of data that the *Partnership* collects is the root cause analysis (RCA). Typically, an RCA is initiated when an organization experiences a sentinel event or identifies a particular trigger or issue requiring further investigation. Here, the trigger was an increase in wrong patient chart entries after changing to a new integrated EHR system.

The organization previously reported fewer misidentified patients than they were seeing since the implementation of the new system. The number of misidentified patients was also increased compared with earlier paper charting. Here is what happened.

Expert Advisory Panel

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Terhilda Garrido, MPH, ELP
Omar Hasan, MBBS, MPH, MS
Chris Lehmann, MD
Peter J. Pronovost, MD, PhD
Jeanie Scott, 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)
• American Health Information Management Association (AHIMA)
• American Medical Association (AMA)
• Association of Medical Directors of Information Systems (AMDIS)
• American Medical Informatics Association (AMIA)
• American Organization of Nurse Executives (AONE)
• American Society of Anesthesiologists (ASA)
• California Hospital PSO
• College of Healthcare Information Management Executives (CHIME)
• Council of Medical Specialty Societies (CMSS)
• Healthcare Information and Management Systems Society (HIMSS)
• Institute

Facts

The patient arrived unaccompanied in the ED. The patient provided her name and middle initial, and the nurse used these identifiers to enter information into the EHR. The nurse identified an already existing record for this patient.

When the patient's family arrived at registration, they noticed the date of birth was incorrect on the patient's armband. This was corrected, and a new medical record number was assigned. Registration personnel communicated the error to the nurse, the ED manager, and the medical records department. However, charting continued during the course of admission, often using the chart associated with the wrong medical record number.

Contributing Factors

The facility identified several causal factors: not following protocol by asking for the identifiers set forth in the facility's policy, not being familiar with the data entry points in the EHR to enter those identifiers, working in the chaotic environment of the ED and rapidly entering demographics, readily selecting the first item in the drop-down menu (here, another patient with the same first name and middle initial), incorrect assumptions regarding those responsible for correcting errors, the inability to tag charts for further action, and no alerts for patients with similar names.

Health IT-Related Factors

Analysis of the issue focuses on such categories as (1) data entry or selection issues, (2) a possible system configuration issue, and (3) the storage of data that does not match the patient. RCAs look at causes, evidence, solutions, and the implementation, tracking, and effectiveness of solutions. Identifying new ways to examine these issues through the eyes of the various stakeholders is valuable to the Partnership.

Lessons Learned

While the facility is still working on their own solutions to this issue, there are several initial lessons to be learned: (1) determine if there is a benefit to alerts for similar names, (2) identify ways to flag a record with a known error, (3) understand how to correct entries, (4) make certain that the correct fields are readily available for charting (with minimal clicks) so that workflow is not disrupted, and (5) when errors occur, ensure that no orders are entered into those incorrect records. We welcome your input. Please send your comments and

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Upcoming Partnership Events:

Expert Advisory Panel:
December 9, 2014 at 3 PM ET.

Proceedings: Watch for the published proceedings from *Partnering for Success* coming December 2014, including video interviews. Stay tuned!

Quarterly Meeting:
January 2015 (by phone)

HIMSS: Meet us at HIMSS in April 2015

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

Workgroup Topics Being Identified

Plans are currently under way to set forth ideas for workgroup topics. Workgroup topics should be identified beginning in January 2015. Watch for invitations to sign up for a particular topic-driven workgroup. Partners have suggested that workgroup topics should focus on items that will lead to improvements in health IT safety now and in the future. Topics must also be feasible and cost-effective for providers and vendors alike.

The Expert Advisory Panel guides this effort by identifying and fleshing out candidate topics (using topics identified at the *Partnering for Success* meeting as well as issues that providers have suggested), which have been presented to the full *Partnership* for review and comment. Stay tuned!

Call to Action: Request for Data Submission

In preparation for workgroups focused on areas to make health IT safer now, we asked all of you to increase your data submissions by **five new events/issues!** Please enter these events using the AHRQ Common Formats for Health IT and the HIT Hazard Manager. Submit these reports ASAP to provide as much input as possible into the workgroups. Thank you for all of your hard work!

New Web Design:



The Partnership's landing page will soon have a new look as changes are made to the ECRI Institute website. Keep your eyes open for these exciting changes. You will have the same functionalities, only better.

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!