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PARTNERSHIP for HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update January 2017

SAVE THE DATE: Partnership Quarterly Conference Call
The next *Partnership* quarterly conference call will be held on Tuesday, January 24, 2017, from 3:00 to 4:00 pm ET.

The agenda includes:

- Obtaining *Partnership* support for Safe Practice Recommendations for the use of health IT in patient identification
- Upcoming events and ways for you to participate

Please register here.

After registering, you will receive a confirmation e-mail containing information about joining the meeting. Additional materials will be provided before the meeting.

To prepare for our next workgroups, we ask you to respond to a brief survey.

Proceedings Coming Soon: Partnering for Transformation: Making a Positive Impact

The *Partnership* for Health IT Patient Safety will soon issue the proceedings from the third face-to-face meeting, held on September 16, 2016 at ECRI Institute. This year's meeting included a packed agenda and a stellar group of *Partnership* participants. This year's theme was Partnering for Transformation: Making a Positive Impact. The proceedings reflect an action orientation: we present discussion points but also provide tools and best practices. By providing actual tools to support systems safety, we aim to accelerate uptake and spread improvements. That's what Partnering for Transformation is all about.

As part of the agenda, we covered the *Partnership's* safe practice recommendations on copy and paste and patient identification, heard lessons from the field on medication reconciliation, and set the stage for future topics of focus. Our *Partnership* workgroup examining the issue of patient identification presented their investigation and resultant recommendations and implementation toolkit, which was built upon the review of safety-related events and hazards as well as a targeted evidence scan.

A very big thank you to all of the participants and to our funders, The Jayne Koskinas Ted Giovanis Foundation for Health and Policy and the Gordon and Betty Moore

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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

Foundation. Together, as a multi-stakeholder collaborative, we make health IT safer.

Data Snapshot: Automatic Stop Orders — Medications

Patient was receiving multiple intravenous [IV] antibiotics. An automatic stop order (ASO) was in place to discontinue the all of the IV antibiotics after 5 days of therapy. A notice of the [ASO] for each medication was available in the system to notify the physician. The physician did not see the note. The dosing pharmacist also missed the ASO because the order-entry pharmacists completed the ASO notices that day. The dosing pharmacist caught the incident and had to restart all medications as per the MD. Peaks and troughs were ordered as needed to rectify dosing.

Background:

"Automatic stop orders on medications are intended to safeguard patients against unnecessary or prolonged drug therapy, yet they also have been shown to cause medication errors when critical therapy is inadvertently and arbitrarily discontinued." (American Society of Health-System Pharmacists)

Events Reviewed:

Events submitted to the ECRI Institute Patient Safety Organization (PSO) revealed 28 events involving ASOs reported between October 2011 and January 2016. These medication events revealed that ASOs resulted in both medication dose omissions (68%) and extra dosing of medications (32%). The medication classifications identified in these events included antibiotics (46%, 13); opioids (21.4%, 6); and other medications (32.1%, 9), including anticoagulants, anticonvulsants, chemotherapy, corticosteroids, IV fluids, and other medications.

Contributing Factors:

Considering where and when ASOs should be implemented to provide safe patient care requires clinical end-user input and appropriate technological planning. Contributing factors identified through the event analysis included implementation and communication of policies and procedures were less than adequate; communication of information was either not done, was untimely, or the ASO was misunderstood; responsibility for acting upon a notification was not clearly defined; and the need for training on the handling process of ASOs was not identified.

Health IT-Related Risk Factors:

Health IT-related risk factors identified in the analysis include Usability: mismatch with user expectations,

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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) for Health and Policy and in part through funding from the Gordon and Betty Moore Foundation.

Upcoming *Partnership* Events:

***Partnership* Quarterly Meeting**

January 24, 2017
3:00–4:00 pm

inadequate user feedback; Data Quality: discrepancy in displayed, printed or exported data; Decision Support: missing safeguard; Local Implementation: faulty local configuration, inadequate testing; and Other Factors: inadequate training, compromised communication, unclear policies.

Lessons Learned:

The risks and benefits of implementation need to be considered when determining whether ASOs for medications are an appropriate intervention. Organizations should assign an interdisciplinary group to establish criteria for ongoing review and approval of ASOs. When implementation is necessary, communication to providers should be timely, apparent, and actionable. It is important to evaluate and monitor ASOs to determine appropriateness and effectiveness of use. Organizations also need to consider alternative orders, such as orders for therapies and equipment such as physiological monitoring, restraints, and respiratory treatments.

As part of the *Partnership* meeting, Partnering for Transformation: Making a Positive Impact, a self-assessment questionnaire on automated end times was developed and will be disseminated when the proceedings are distributed.

We invite you to send your events, suggestions, and strategies for safe use of ASOs 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*.

NIST – Usability Testing of the Copy and Paste Recommendations

The National Institute of Standards and Technology (NIST) assessed the copy and paste recommendations by developing test cases for which users were observed performing various tasks in electronic health record (EHR) systems. The formal evaluation and discussion of these results will be available upon release of the report issued by NIST early this year.

21st Century Cures Act Update

The 21st Century Cures Act was approved by the Senate and became law on December 13, 2016. Section 4005 (c) Leveraging Electronic Health Records to Improve Patient Care allows health information technology developers to be treated as providers for reporting and conducting patient safety activities. This allows developers to work with PSOs concerning improving clinical care through the use of health

information technology that could result in improved patient safety, healthcare quality, or healthcare outcomes.

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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