ECRI Institute
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PARTNERSHIP for
HEALTH IT PATIENT SAFETY
Making healthcare safer together

Partnership for Health IT Patient Safety

Partnership Update
Fall 2015

New Workgroup Announced. On the July 28 quarterly call, patient identification was announced as the next workgroup topic. Details regarding the *Partnership* patient identification workgroup will be discussed at the October 16 Partnering for Success: Applying What We've Learned meeting. We look forward to your participation.

REMINDER:

Full-Day Annual *Partnership* Meeting on October 16, 2015: Action Agenda

Partnering for Action: Applying What We've Learned

When: Friday, October 16, 2015
Time: 8:00 - 3:00 ET
Where: ECRI Institute Headquarters, 5200 Butler Pike, Plymouth Meeting, PA (suburban Philadelphia)

- Continental Breakfast
- Welcome and *Partnership* Progress Overview
- Safe Practices Forum: Reporting and Best Practices from the *Partnership* Copy and Paste Initiative
- Safe Practices Forum: Partnering on New Solutions for Patient Identification
- Networking Lunch
- Interactive Shared Learning Forum: Hot Topics in Health IT Safety
- Mapping Out Next Steps

If you have not yet registered and would like to attend, please e-mail us at hit@ecri.org.

Data Snapshot:

Data Snapshots provide lessons learned from patient safety reports submitted to the *Partnership*.

Background

"Discharge instructions" and visit summaries are an

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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 Organization of Nurse Executives (AONE) • American Society of Anesthesiologists (ASA) • California Hospital PSO • College of Healthcare Information Management Executives (CHIME) • Constellation • Council of Medical Specialty Societies (CMSS) • Health Care Improvement Foundation (HCIF) • Healthcare Information and Management Systems Society (HIMSS) • Institute for Safe Medication Practices (ISMP) • Kentucky

important aspect of patient care and follow-up across all care settings. These instructions are provided at the end of an admission (hospital or emergency department) and at the conclusion of a visit. Discharge instructions facilitate care coordination, inform and educate patients, and expedite interventions. However, when instructions or summaries are unclear or incorrect, patient safety is placed in jeopardy.

Event Review
The patient received hospital discharge instructions that the patient should begin taking ("start") a particular medication. However, during the admission, the patient's provider ordered that the patient *stop* taking that very medication. In this instance, the patient's family member recognized that the medication was stopped and questioned the discharge summary; no harm occurred.

In another event, the provider was able to access the record and write orders after the patient had been discharged. Thus, it was impossible to carry out the orders.

In a third event, a patient received discharge instructions that included a new medication. The milligrams of the medication and the total number of pills to be dispensed were indicated on the instructions; however, the number of pills the patient was supposed to take per day was not included in the discharge instructions.

Contributing Factors

Understanding how discharge and visit summaries are created and used is helpful in anticipating possible errors. Where is the information drawn from that populates the summary? What form is the information in—for example, is the information provided to a patient about a weight-based dose in kilograms (kg) instead of appearing in pounds (lb.)? How is information recorded? Does crossing out information indicate that the patient has or does not have that condition? It is important to review the information that is being handed to the patient to ensure it is accurate, complete, and easily understood.

Health IT–Related Risk Factors
Errors in discharge instructions or visit summaries are possible if there is inadequate or incorrect information transfer, if the information populating the report is not updated, or if the method of input varies across applications. Determine if systems transferring the information are doing so in a manner that allows it to be transferred correctly and consistently across all applications. If crossing out an option indicates a positive finding in one setting, does it mean something different in another application (crossing out interpreted as a negative finding)? Be certain that once patients are discharged, orders cannot still be entered. Lack of standardization across

Upcoming *Partnership* Events:

In-Person Meeting Date:
See you on Friday, October 16, 2015, for the full-day, in-person *Partnership* meeting at ECRI Institute's headquarters in Plymouth Meeting, PA.

applications can lead to misinterpretation and incorrect information, thus jeopardizing patient safety.

Lessons Learned
Timely receipt of accurate discharge instructions and visit summaries enables patients to understand the care provided and to complete the course of treatment that is recommended. Moreover, accurate summaries of these events enhance care coordination and prevent duplication of testing, prescribing, and follow-up. These documents provided to patients on a regular basis facilitate patient safety, but only if they are accurate and timely.

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

ONC Provides Health IT Complaint Form

The Office of the National Coordinator for Health Information Technology (ONC) recently made available a Health IT Complaint Form to capture issues that are arising with health IT. The form is not intended to address HIPAA-related issues but rather focuses on certification, safety, usability, information blocking, privacy and security, and clinical quality measures. A link to the form is provided here.

Your Submissions are Always Welcome

The *Partnership* welcomes all of your continued contributions, including items for this publication. Please submit any Update items with the subject line "Partnership Update" to hit@ecri.org and continue to submit data, RCAs, and help desk logs 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!

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