NSW GOVERNMENT | eHealth

Digital Health Safety & Quality Bulletin

A joint communique from eHealth NSW & the Clinical Excellence Commission

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Issue # 1 – December 2021

Background

Welcome to the first edition of the Digital Health Safety & Quality (S&Q) Bulletin. This is a joint communique from the eHealth NSW Safety & Quality team and the Clinical Excellence Commission (CEC).

Every patient deserves the safest possible care, and continuous improvement is the path to safer healthcare.

This bulletin is to provide a systematic communication of digital health clinical safety and quality issues and risks to the relevant NSW Health staff and communities. The intention is to share lessons learnt in order to improve the reliability, safety and quality of care to our patients.

The target audience are clinicians, digital health solutions technical staff and system governance team members who use or have oversight of the electronic medical record (eMR), electronic medication management (eMM) system and other digital health systems.

We encourage you to make use of this bulletin as a way to learn, share and contribute to NSW Health's efforts in providing world-class clinical care where patient safety is the first priority.

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Distribution: Please forward this bulletin to all relevant individuals, distribution lists and committees in your organisation. If you would like to be added to this bulletins distribution list, please send the eHealth S&Q team an email EHNSW-SafetyandQuality@health.nsw.gov.au.

Contact: If you wish to communicate directly with the eHealth NSW S&Q team or the CEC, please do so via their generic emails (see below).

- eHealth NSW Safety & Quality team generic email: EHNSW-SafetyandQuality@health.nsw.gov.au
- CEC Patient Safety inbox: CEC-PatientSafety@health.nsw.gov.au

Topics

Medication History Modification:

Documenting a medication history is a fundamental component of the medication review workflow in Cerner eMR. Clinicians rely on the '*Medication History Snapshot*' view in the Medication List tab to determine when the last history was documented, by whom and whether a subsequent history is required.

A defect has been reported which affects the date associated with an entry on the *Medication History Snapshot* view which may result in perception that the medication history has been reviewed and found to be accurate. This may impact the medication history and reconciliation workflows. The defect has been raised with the vendor (Cerner) and a resolution has been provided: see Solution Change: 1-000000275220 for a full list of affected and resolved packages. The fix has been tested and implemented in one Local Health District (LHD). A clinical risk remains until testing and implementation are complete across all districts and networks that use the Cerner eMR.

The recommendations are:

- Clinicians are advised that until the fix has been tested and implemented within your Local Health District or Specialty Health Network, they should only update and finalise information in the 'Document Medication by Hx' screen when a complete medication history or best possible medication history, current to the episode of care, has been obtained.
- Clinicians should refer to the '*Document Medication by Hx*' screen (rather than the *Medication History Snapshot* view) to confirm when the last medication history was documented and signed.

A factsheet with further information and actions for Local Health Districts (LHDs)/Specialty Health Networks (SHNs) can be accessed here.

For more information on Medication History documentation and reconciliation:

- Clinical Excellence Commission Continuity of Medication Management Program
- Australian Commission on Safety and Quality in Healthcare Medication Safety Program

Inpatient Medication Prescribing and Dispensing Workflow Requirements

Medication prescribing and dispensing requirements for sites using electronic Medication Management (eMeds) systems to prescribe and administer inpatient medication orders have been developed. These requirements have been developed in response to two medication dispensing workflow issues involving reliance on the 'treatment note' and changing of the 'Ordered as' field within the Cerner eMeds system.

The requirements further clarify and expand on recommendations made in 2018, published in response to a near miss incident. They have been developed based on additional policy and legislative advice from the NSW Chief Pharmacist, a review of professional requirements, and extensive consultation with clinical and technical LHD/SHN representatives.

The requirements are:

- When a pharmacist is dispensing a medication from an eMeds

system, the pharmacist must dispense from an authorised prescriber's order
- All clinicians must be able to view the original prescriber's order in the eMeds system and readily identify any modifications to the order

A factsheet with further information can be accessed here

Coming in the next Bulletin - eHealth NSW strategies to address the National Accreditation Standards

eHealth NSW has developed a gap analysis tool to assist health service organisations in reviewing their implementation of the National Safety and Quality Health Service Standards (second edition) published by The Australian Commission on Safety and Quality in Healthcare. This tool looks at evidence required from a digital health perspective, providing information on eHealth NSW products and solutions mapped to actions within each of the eight standards, allowing health service organisations to review their electronic medical record (eMR) and any associated electronic medical record solutions and products, and track them against progress of implementing each standard. The tool is going through a final review process, before being released to all Local Health Districts and Specialty Health Networks across NSW in late 2021.

For more information on The National Safety and Quality Health Service Standards (NSQHS) (second edition): Australian Commission on Safety and Quality in Healthcare

Residual Risks

Each Bulletin will examine a residual risk from the eHealth NSW Clinical Risk Register. In this issue we will discuss selection errors.

Selection Errors

Selection errors are more common with the introduction of electronic medical record systems of all types. It is similar in nature to ticking the wrong box in a paper record checklist. The risk of a selection error rises as the number of options appearing in drop-down lists and selection windows increases. Whilst these errors may not be eliminated completely, they can be minimised using strategies such as Tall Man lettering, arranging order sets/sentences by frequency of use and using smart filters which search the drop-downs for your identified value.

Tall Man lettering is one of a few strategies used to reduce error by warning clinicians about the risk of confusing medicine names. It highlights differences in names which look or sound similar, and thereby helping clinicians select the right product in electronic systems (or from shelves). Tall Man lettering is designed to draw the eye to the differences rather than the similarities between *look-alike, sound-alike* medications (known as LASA errors) as illustrated here:

Examples where Tall Man lettering is used to minimise LASA errors	
amiODARONe	**amLODIPIne**
ciprAMIL	**ciprOXIN**
HYDROmorphone	**morphine**

Drop-down lists require regular review and updating. Redundant or out-of-date options should be removed, and order sets or sentences may require updating so they continue to reflect current evidence-based practice and clinical guidelines. If you see out-of-date or redundant options, or if your selection lists need to be updated, you can notify your local Information Communication Technology (ICT) Department to help improve the safe use of your electronic Medical Record or electronic Medication Management systems.

The recommendations are:

Users can minimise the chance of selection error by remaining alert to mouse drift, using a search function (if available) and always making a habit of double checking selections after having made a choice.
- Drop-down lists require regular review and updating.

1. Tall Man lettering
2. CEC resources on Tall Man lettering
3. Australian Commission on Safety and Quality in Health Care (ACSQHC) Safe selection and storage of medicines

Please email the eHealth Clinical Engagement and Patient Safety (CEPS), Safety & Quality team via EHNSW-SafetyandQuality@health.nsw.gov.au if you would like to share any successful strategies your organisation has used to address any of the issues presented in this bulletin.

eHealth Safety & Quality Advisory Group (SQAG) and Safety & Quality Oversight Committee (SQOC) updates

There are two key safety and quality governance committees in eHealth NSW:
- Safety and Quality Oversight Committee (SQOC)
- Safety and Quality Advisory Group (SQAG)

These committees provide safety and quality advice, governance and support to eHealth NSW in identifying and managing clinical and patient safety issues related to the design, implementation or use of digital health tools across NSW Health. The committees actively monitor these processes using the risk register developed for SQOC. The SQAG escalates issues to SQOC.

The following issues were discussed at SQAG and SQOC:

SQAG: Safety and Quality Advisory Group October 28th 2021:
- Data Lake Update
- Victorian Coronial Report – dual anticoagulation
- Bulletin Review
- Overbed Cameras

SQOC: Safety and Quality Oversight Committee: October 14th 2021:

- Downtime Survey Results
- Forms in eMR
- eHealth NSW Clinical Risk Register

If you would like further information about these discussions, please contact EHNSW-SafetyandQuality@health.nsw.gov.au

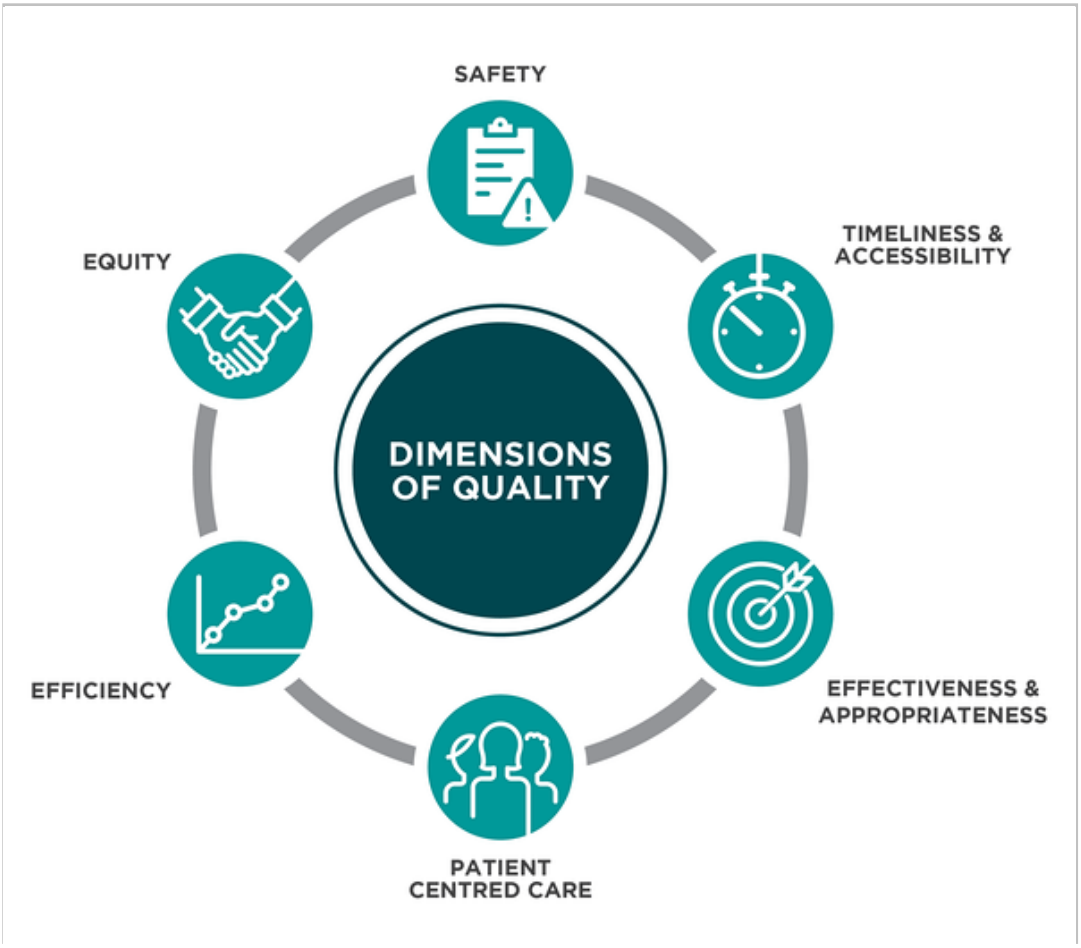
Safety & Quality Education offerings via the CEC Academy and My Health Learning (MHL)

The Safety & Quality Essentials Pathway: Building safety and improvement capability for everyone in NSW Health.
The CEC is partnering with NSW Health Districts and Entities to transition to a new learning pathway of locally delivered programs. Programs along the pathway builds NSW Health staff capability in safety and quality improvement from foundational to adept level. Resources at each level are mapped to the Healthcare Safety and Quality Capabilities.

Foundational level programs
Safety and quality is everyone's business. Foundational programs are for all NSW Health, ensuring we are all aware of our role and responsibilities in patient safety and quality improvement.

Foundational level programs include:

The 6 Dimensions of Healthcare Safety and Quality video* here (My Health Learning Code *340129036)
This six minute video defines healthcare quality as having 6 dimensions. While safety is the over-arching aim of healthcare, we need to continuously improve in all 6 dimensions in order to reliably achieve positive healthcare outcomes.



Foundations of Healthcare Safety and Quality **eLearning here (My Health Learning Code *335318052)***

This eLearning guides staff to apply each dimension of healthcare quality to their local health service. Areas of strength and opportunities for improvement are highlighted. This program builds awareness of the safety & quality processes and tools used in health to measure and assure healthcare safety and quality. Content from the eLearning is also available as a one-hour PowerPoint presentation for optional face to face workshops. Both programs are available now on My Health Learning.

eHealth NSW	Clinical Excellence Commission	Agency for Clinical Information
(NSQHS) Standards V2.0	Institute for Healthcare Improvement	Australian Digital Health Agency
Australian Commission on Safety and Quality in Healthcare	Safety Alert Broadcast System – NSW Health	NSW Therapeutic Advisory Group Inc

Bulletin Evaluation Survey

We value your feedback regarding the usefulness of this bulletin and ideas for future topics. Please complete the short questionnaire here

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