ORIGINAL ARTICLES

Information Technology

371  Copy-Forward in Electronic Health Records: Lipstick on a Pig
L. Harrington

Copy-forward and other electronic health record (EHR) data-entry aids, the author contends, are “symptoms of much larger, more significant problems related to the challenges of using EHRs.”

375  Safe Practice Recommendations for the Use of Copy-Forward with Nursing Flow Sheets in Hospital Settings
E.S. Patterson, D.M. Sillars, N. Staggers, E. Chipps, L. Rinehart-Thompson, V. Moore, D. Simmons, S.D. Moffatt-Bruce

A multiple-methods approach, including stakeholder analysis and experts’ consensus opinion, was used to create four recommendations regarding nurses’ use of copy-forward to document patient assessments in flow sheet software in hospitals. These recommendations are intended to result in improvements in efficiency of documentation, work flow, and accuracy of information.

Performance Improvement

386  Power, Knowledge, and Transfusions: The Need to Refocus on Patient Blood Management
A. Shander, S. Ozawa, G. Lobel

In contrast to the “one size fits all” approach of red blood cell transfusions for anemia, the Jenkins et al. study, the authors state, shows how “the culture of transfusion” can be changed.

389  Transfusing Wisely: Clinical Decision Support Improves Blood Transfusion Practices

At an academic medical center, a revised computerized provider order entry, a transfusion protocol, and a BestPractices Advisory for transfusions above the hemoglobin threshold were associated with decreases in red blood cell transfusions. For example, the percentage of multiunit (≥ 2 units) transfusions decreased from 59.9% at baseline to 41.7% during the intervention period and to 19.7% post intervention. The estimated annual cost savings was $1,050,750.

Coordination of Care

396  Intraoperative Handoffs Among Anesthesia Providers Increase the Incidence of Documentation Errors for Controlled Drugs
R.H. Epstein, F. Dexter, D.M. Gratch, D.A. Lubarsky

Discrepancies between electronic anesthesia records and pharmacy transactions in terms of total doses of controlled drugs can affect patient safety and place hospitals at risk for regulatory action. Comparison of anesthesia drug documentation and pharmacy transaction data at an academic medical center revealed that handoffs were associated with higher discrepancy rates (p < 10−6; odds ≥ 1.38) and that discrepancy rates increased as a function of the case duration.

Methods, Tools, and Strategies

403  Pilot Testing Fall TIPS (Tailoring Interventions for Patient Safety): a Patient-Centered Fall Prevention Toolkit

The laminated paper Fall TIPS Toolkit, which provides clinical decision support at the bedside by linking each patient’s fall risk assessment with evidence-based interventions, was pilot-tested on high-risk units at two hospitals. Compliance with using Fall TIPS was very high, and the mean fall with injury rate decreased from 1.00 to 0.54 per 1,000 patient-days and from 0.47 to 0.31 per 1,000 patient-days at the two hospitals.

414  Evaluation of Sensor Technology to Detect Fall Risk and Prevent Falls in Acute Care

During Phase 1 of a performance improvement project, a depth sensor was evaluated, and in Phase 2, a combined depth and bed sensor system designed to assign patient fall probability, detect patient bed exits, and subsequently prevent falls was evaluated. During Phase 2, the designated evaluation unit had 14 falls, for a fall rate of 2.22 per 1,000 patient-days—a 54.1% reduction compared with the Phase 1 fall rate. The comparison medicine unit had 30 falls—a fall rate of 4.69 per 1,000 patient-days, representing a 57.9% increase as compared with Phase 1.

TOOL TUTORIAL

422  Use of Cascading A3s to Drive Systemwide Improvement

The cascading A3, an integral component of the Johns Hopkins Medicine (Baltimore) management system, is used to communicate vertically up and down the organization and horizontally across the organization among peer groups.

429  INFORMATION FOR AUTHORS