American Nursing Informatics Association

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POSITION STATEMENT

Addressing the Safety of Electronic Health Records

Effective Date	October 1, 2015
Adopted by	ANIA Board of Directors

Purpose: The purpose of this position statement is to affirm the American Nursing Informatics Association's (ANIA) support for development and implementation of evidence-based electronic health record (EHR) safety programs at the organizational level to foster clinical practices that improve patient safety.

Statement of ANIA Position: The American Nursing Informatics Association advocates the use of evidence-based practices to support safe use of EHRs. Therefore, in alignment with the Office of the National Coordinator for Health Information Technology (ONC) and The Joint Commission, the ANIA recommends that organizations:

1. Incorporate EHR-related patient safety initiatives into existing patient safety efforts. This will require a strong collaboration among personnel with expertise in nursing/clinical informatics, quality improvement, patient safety, and risk management.
2. Develop an EHR safety program that includes regular multi-disciplinary self-assessments, using the SAFER Guides from the ONC. (http://www.healthit.gov/safer/safer-guides).
3. Enhance incident-reporting systems to include identification and collection of patient safety events associated with the use of EHRs.
4. Use standardized terms to report EHR-related patient safety events and incorporate these terms into incident-reporting systems (For example, Agency for Healthcare Research and Quality's (AHRQ) Common Formats or Magrabi et.al.'s classification for health IT reporting).
5. Make the reporting process easy for nurses and other care providers to submit EHR-related patient safety events.
6. Ensure that a risk management response protocol is in place to review and investigate EHR-related patient safety events. Include personnel with informatics expertise in these incident reviews.
7. Ensure follow-up and communication to the original submitter of an EHR-related patient safety event.

Background

Patient safety has been in the spotlight of healthcare since the publication of the Institute of Medicine's *To Err is Human* in 1999. Since then, the quest for a safer healthcare system has focused on various forms of information technology, including the EHR; yet unintended consequences and new types of errors have emerged with health information technology (IT) use. Nurse specific areas of patient safety in relation to the EHR are articulated in the literature and are focused on the need to address usability, support of workflow, medication administration, timely access to information (lab results, vital signs, therapies, diagnostic/radiologic results, and other pertinent data), copying data forward, and over reliance on the technology.

Federal and regulatory agency sponsored publications have addressed the issue of EHR-related patient safety and have provided recommendations to help improve health IT safety and safe use. These include:

- *Health IT and Patient Safety: Building Safer Systems for Better Care* (IOM, 2012)
- *Health Information Technology Patient Safety Action & Surveillance Plan* (ONC, 2013)
- *Sentinel Event Alert #54 Safe use of health information technology (*The Joint Commission, March 31, 2015)

The Joint Commission Sentinel Event Alert recommends that organizations incorporate health IT safety into existing patient safety programs – based on safety culture, process improvement, and leadership. It also recommends use of the SAFER (Safety Assurance Factors for EHR Resilience) Guides as self-assessment tools.

The SAFER Guides were developed by health IT safety researchers, with ONC sponsorship, and aim to enable healthcare organizations to optimize the safety and safe use of EHRs. They are tools to proactively self-assess an organization's practices to mitigate selected areas of risks associated with EHRs. The guides are based on the best available evidence and are intended to be useful for all EHR users, developers, patient safety organizations (PSOs), and others who are concerned with safe use of clinical information systems.

Incorporating use of standardized or structured terms for EHR-related events into an incident-reporting system will allow organizations to more effectively analyze the data and look for trends. These analyses can lead to significant improvements in patient safety. AHRQ hopes that organizations will adopt the standard terms found in the Common Formats as they collect, analyze, and report health IT-related errors at both the organizational and PSO levels. Magrabi and colleagues offer another classification for health IT issues that includes information on contributing factors related to human actions. Incorporation of either set of terms or a combination of both can provide the ability to more effectively aggregate and analyze incident data for continued improvement.

The foundation of a successful EHR safety improvement program will be the ability for clinicians to quickly and easily submit issues. Achieving this ability means the configuration of links within EHRs or other systems to incident-reporting systems to support workflow and ease of data entry.

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