TRANSPLANT: IMPROVING PATIENT SAFETY BY REDUCING DUPLICATE LAB MEDICAL RECORDS

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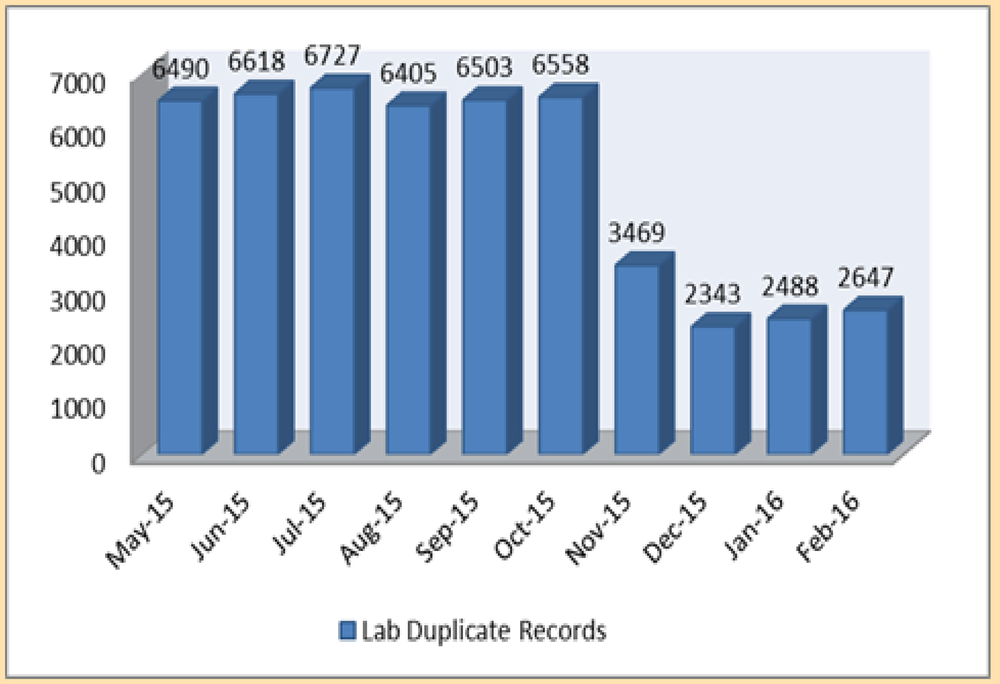
Rationale:
Transplant program patient outcomes are closely monitored every six months by the Centers for Medicare and Medicaid Services (CMS) and the United Network for Organ Sharing (UNOS). In addition to exceeding expected graft and patient survival outcomes, transplant programs, in order to assure continued eligibility to provide services, must demonstrate an effective process for ensuring patient safety through the identification, analysis and prevention of adverse events.

Problem:
Missed lab results place transplant patients at increased risk for rejection, graft loss and even death. In April 2015, the renal transplant program reported a safety event involving a missed lab test result. Later that month, two additional events involving transplant/Advanced Heart Failure patients occurred. The transplant staff quickly recognized results were not present in the existing medical record with use of their detailed work list for lab follow-up. The oversight was related to the lab result being entered into a newly-created duplicate medical record. The transplant staff linked the error to creation of duplicate records for external labs sent to Sentara, particularly involving home care.

Method:
The Transplant/Advanced Heart Failure Program gathered a cross-departmental team tasking them with eliminating duplicate lab medical records. This Performance Improvement Team included representatives from transplant, safety, lab, home care and information technology leadership. The team reviewed current workflows detailing lab test ordering, collection and processing. The team identified middle initial variances between home care and existing EPIC medical records. Strategies developed for patient safety improvement included standardizing home care electronic medical record documentation and implementation of an "alias" in the Beaker-EPIC lab system for patients with middle initial variances, as an exception to other "like" demographics.

Results:
The new strategies were applied to all external lab specimens processed through the Sentara laboratories. Sentara experienced a system-wide reduction in duplicate records for external labs. In May 2015, system-wide lab duplicate records were 6,490. First quarter 2016 data demonstrates duplicate records reduction to 2,647, which is a 60% reduction from baseline.



Conclusion:
Although the Transplant/Advanced Heart Failure Program initiated scrutiny of duplicate medical records as the result of a focused review of patient safety events, the end result is a 60% error reduction throughout Sentara. When members of the team collaborate across lines of care, processes and outcomes are improved.

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