

Summary of CPOE Improvement Meetings as of June 18th

What Was Discussed:

The CPOE Project Management team admitted to the severe flaws in their training and admitted to an oversight on their part (i.e. the egregious lack of training given to the nursing staff). They appear to understand the extent to which their mistakes have affected the lab and are doing their best to correct them. The process will take time as they create and distribute new training materials and troubleshoot the sources of system errors.

You might be interested to know that Lab Med IT devotes the equivalent of 5.5 staff members per day to the cancelation of duplicates and orders that have been pending for more than 24 hours. With this in mind, please wait for as long as possible to log orders manually without compromising specimen integrity (unless of course the order is a STAT).

SPS shared that we had more than 152 reported CPOE related incidents in a 56 hour period, 25 of which required multiple phone calls, and most of which caused significant delays(good job SPS!). With the data we collected, we were able to single out the worst offenders, and the PM team have already started re-training on those floors.

What Will Happen:

ORCA order IDs will be added to printed requisitions so that SPS can more easily match our requisitions with orders in the system.

The PM team will continue to educate the nurses on the ORCA workflow and especially on how their input on the ORCA affects the quality of work that we perform in the lab.

What **Might** Happen:

Patient Service Specialists may gain access to release orders for the nurses. Apparently there are some issues with this, so it may take some time before we hear back about it.