Summary of CPOE Improvement Meeting, September 7th 2012

In attendance were the members of the CPOE Project Management (PM) team, representatives from Lab Med IT, myself, and 6 or 8 representatives from the clinical staff (nurses and providers).

The PM Team thanked the lab for our efforts and continued hard work.

The PM team presented the clinical staff with an accurate representation of our current situation, and did a good job of emphasizing the amount of extra work required of the lab since the start of CPOE. They then demonstrated that the majority of these problems were due to order entry errors on the clinical side.

The group discussed the origins of these errors and began brainstorming solutions. It was clear that the vast majority of the lab's additional work is caused by poor communication on the floor and continued confusion about how to use the system. The group agreed that it is not in our best interest for the lab to work around these errors, and that correcting the problems where they occur (at the provider's end) will be the best solution to the problem. The clinical representatives took responsibility for their role in preventing confusion for the lab and were enthusiastic about changing their protocols to reduce our workload. More information was needed before we could agree upon the best course of action, so a task force has been charged with a more intense investigation.

Because some of these problems are complicated and because solving them will require significant preliminary work and communication, it may take a few months before a drastic improvement is seen. However, the group is already acting upon as many immediate solutions as possible, and you should continue to see a gradual reduction in the total number of ordering issues as the months progress.

Thank you again for your hard work and continuing feedback! We will bring you updates as they are available.

Best,
Christine