#### **Observation Research**







Mary Anne Sterling, CEA PRINCIPAL CONSULTANT

42950 Tara Court Ashburn, Virginia 20147

(571) 437-6167 msterling@sterlinghealthit.com www.sterlinghealthit.com Ross Koppel, Ph.D.
Sociology Dept. and
School of Medicine
University of Pennsylvania
<a href="mailto:rkoppel@sas.upenn.edu">rkoppel@sas.upenn.edu</a>
215 576 8221

## Acknowledgements

- AMIA Usability Task Force
- HIMSS Usability Task Force
- Janey Barnes, Jiajie Zhang original learning module creators

## Purpose

- Observation research is used to learn about users, their goals, and their environments in the user's natural setting.
- Also known as ethnographic research, naturalistic observation, contextual observation, field observation, field research, observation and interview.

### Goals of the Method

- Learn about users, their goals, and their environments in the user's natural setting.
- Identify user's unmet needs i.e., opportunities.
- Identify workarounds, and more important, the causes of the workarounds.
- Implement solutions to avoid workarounds and/or incorporate good workarounds into workflow/technology processes

# Best Timing in the Software Development Lifecycle

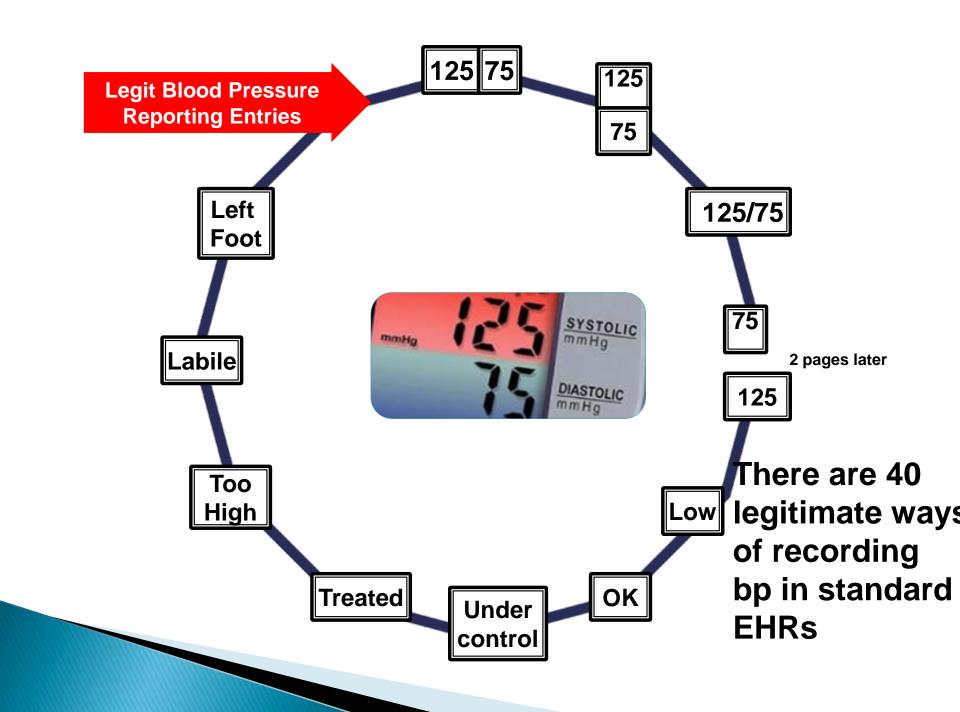
- Takes place early in the process long before any screens are built and likely before features and functions are identified.
- No. Can't observe interactions that don't exist. Must observe early, middle, constant, always.

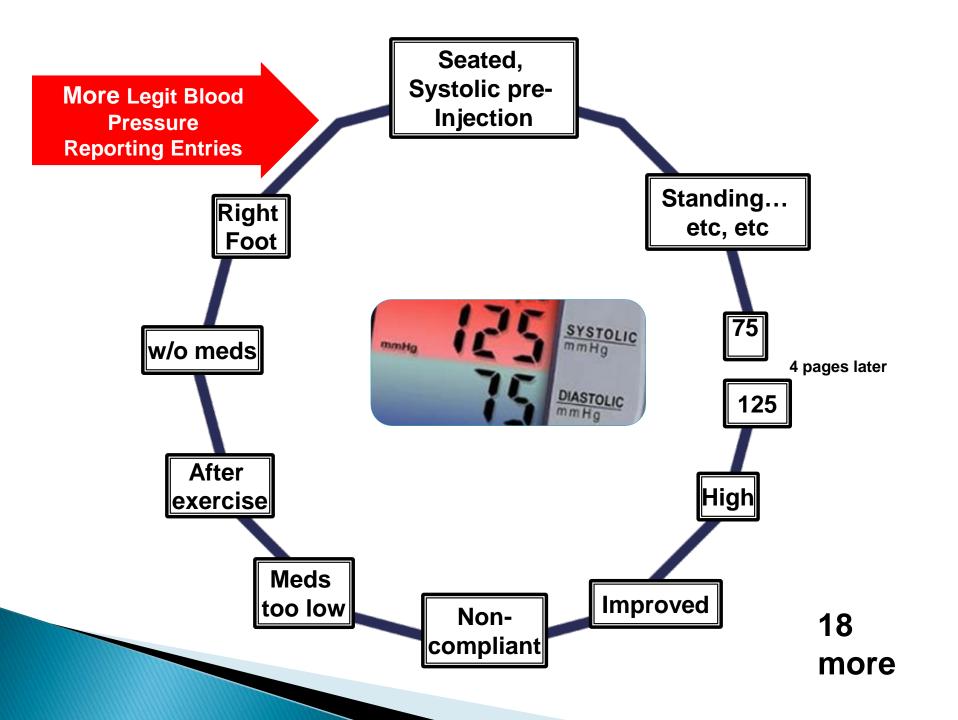
### Exercise:

Hands, Heels, Ceiling

# Example 1: A seemingly straightforward measure in an EHR







WORKAROUNDS TO BARCODE MEDICATION ADMINISTRATION SYSTEMS: THEIR OCCURRENCES, CAUSES, AND THREATS TO PATIENT SAFETY

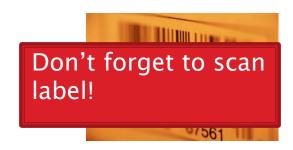
Koppel, Wetterneck, Telles, Karsh (JAMIA)



### 31 Causes of workarounds e.g.,

Unreadable medication-barcodes (crinkled, smudged, torn, missing, covered by another label)

malfunctioning scanners



#### Causes:

- unreadable or missing patient-ID-wristbands (chewed, soaked, wrong, missing)
  - Elderly
  - Children
  - Moving (unit or floor or nursing home)
- And: \*Covered and \*Contact isolation
- New: \*Intentional (not in paper)

### Causes

Uncertain wireless connectivity

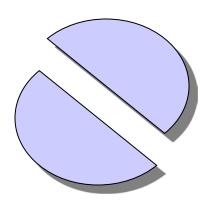
Dumb programming(2 X 10 = 20?)



## Many other causes...







### Now, The fun stuff:

### 15 identified Workarounds

Barcodes affixed to:

RN clipboard
Scanner itself
In nurses' pockets,
Belt-rings,
Worn as bangles





### More places we found extra copies of pt. barcodes (1st workaround, continued)

Nurses' desk

- Medication cart
- Supply room





- Baby crib
- Other places





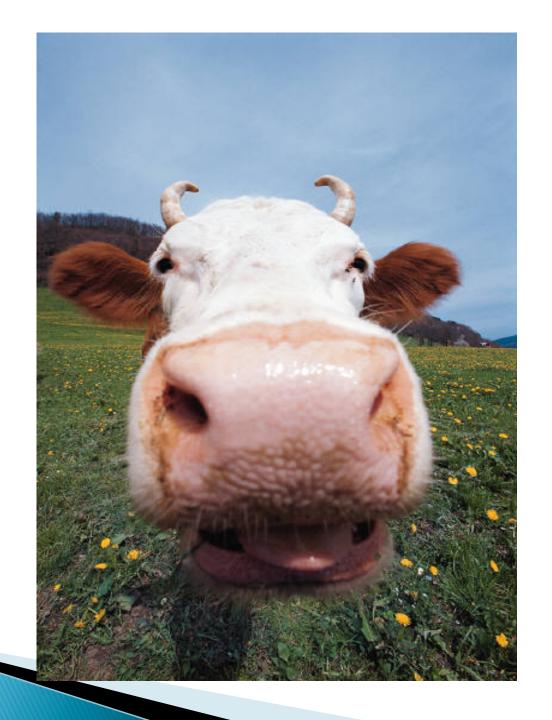












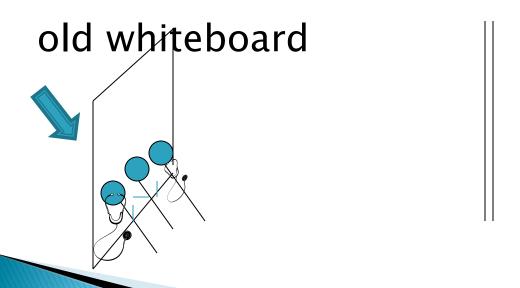
#### The ED e-Whiteboard

Robert Wears' example of new electronic ED whiteboard: Displayed all: pt name, team, stage of movement through ED, pending data, additional information, etc.

But, <u>new</u> e-whiteboard's computer console inconveniently located. Staff could not all look at e-whiteboard and make immediate changes or notes. Loss of flexibility: Staff can't physically interacted with board, i.e., *Move names, add notes, participate.* 

#### ED e-Whiteboard (2)

- Wears' photo: The ED staff all leaning against the new e-whiteboard looking at the old whiteboard
- New whiteboard (a head board?)



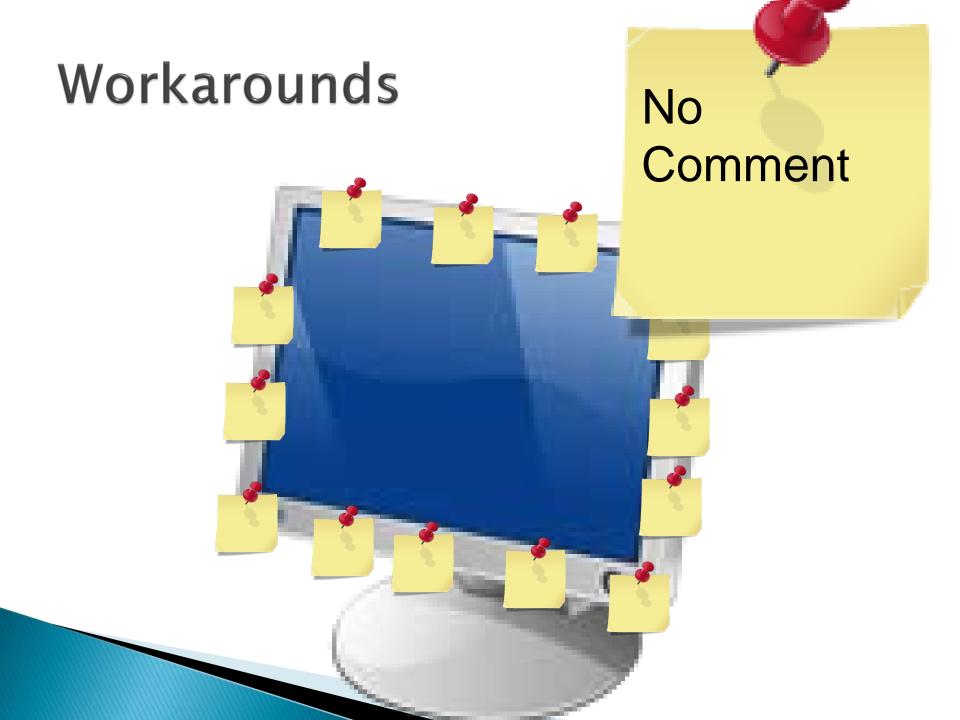
## ED Whiteboard: Allows freedom on the right: Smart Workaround? Approved Workaround?

Name	Bay	Tea m	DX	Test s	Admit?	Notes
						Waiting for CT Scan
						Mom looking for parking space
						Where's Harry with that lab report?
						Call his dad xxxxxxx
						Michigan   American (CC "Recording of " I was assemble. The state of t

### ED e-Whiteboard (3)

Also, the e-whiteboard couldn't put up a little magnetic teddy bear to denote infant patients











### Workarounds in tightly coupled systems: Outsmarting smart pumps and physicians



The 85% solution

### Application Analysis (NISTIR 7804)

- Application Analysis:
  - description of the application's basic functions
  - analysis of the user characteristics
  - task analysis describing the interactions between users and the application
  - analysis of the anticipated environment of use related to interactions with the application
  - identification of critical user tasks related to aspects of patient safety

# Details for Planning & Executing the Method

- Determine research questions/issues that need to be addressed
- Identify who and where to observe
- Create Observation Guide
- Conduct observations
- Compile data
- Draw Conclusions and Report to team

#### Exercise

- Identify issue to address.
- Make observations in public space regarding identified issue.
- ▶ Take notes on observations.

## Impact of the Observation Research Methods

- Share learning from observations.
- Share sample outcomes from previous observation studies e.g., unmet needs, workflow.

## So... The secret to identifying usability (and many interoperability) issues



### Finding and Fixing



### Finding and Fixing



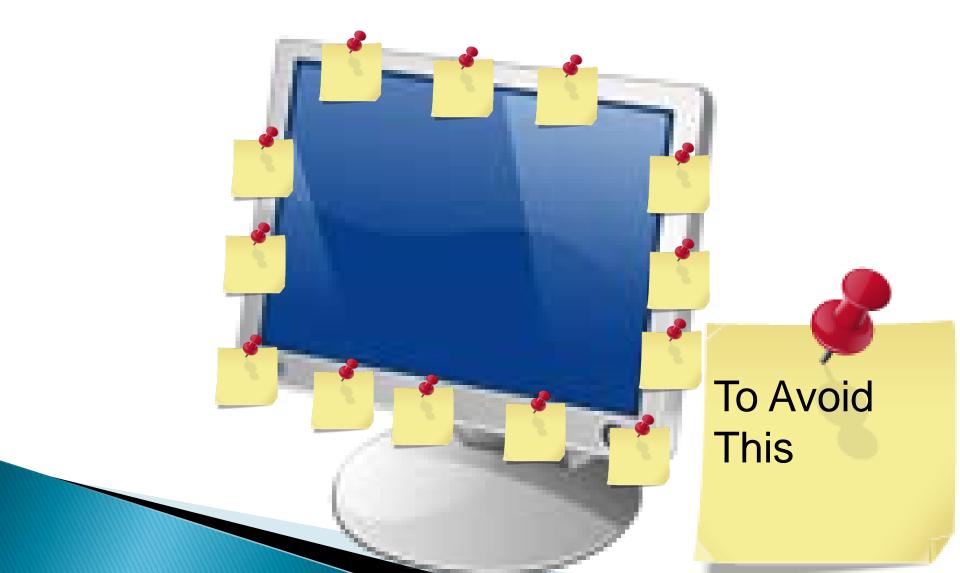
Question selfreports

#### Workflow Analysis





## Why Document Workflow?



## Goals of Workflow Analysis

- Measure workflow efficiency as part of a process improvement strategy
- Evaluate productivity, improve utilization, and reduce human effort
- Measure return on investment of "newly" implemented health IT product
- Inform the design of "next generation" health IT product

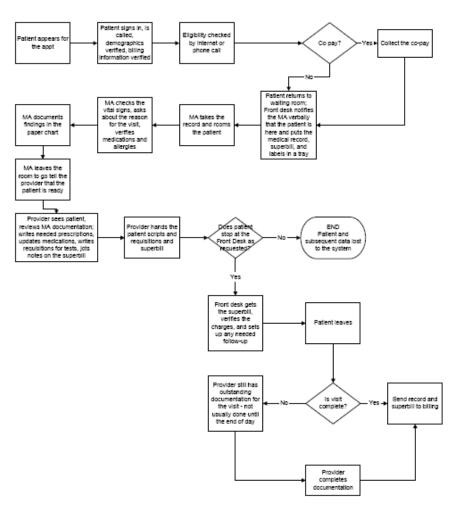


### How is Workflow Documented?

#### Analysis of the Provider Visit

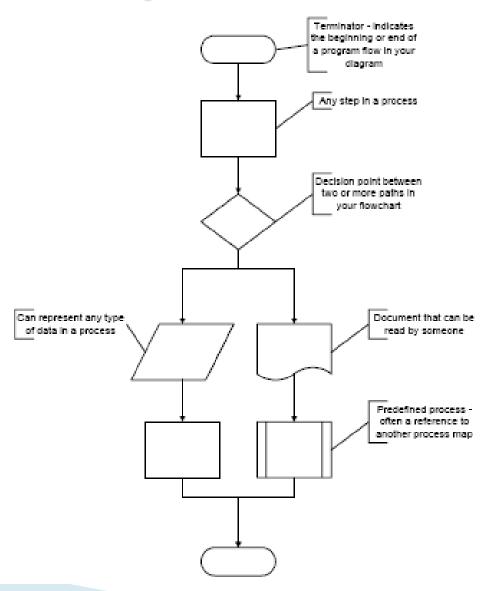
#### Check-In What type of information is gathered by the front desk at check-in? Verification of name and address □ Copy of insurance card HIPAA forms □ Other: If you are using a PMS, what information must be entered or checked at each visit? Address, insurance information List any information that goes forward with the chart after check-in. A Extra labels A Patient Hx/ROS Forms if new patient ☐ Other: Do you collect co-pays at check-in? □ No How does the clinical staff know that the patient has arrived? Chart is in the rack. If patients back up in waiting room, front desk staff go find the MA Rooming the Patient Who takes the patient to the exam room? MA MA MD Nurse Other: Is the chart reviewed for outstanding tasks by the rooming staff? 🔎 Yes 🗖 No How is this information communicated to the provider for action? MA creates list on sticky-posted on outside of chart What information is gathered before the provider sees the patient? Reason for visit ✓ Vital signs ✓ Medications reviewed ■ Allergies reviewed Other: Are any tests done before the provider sees the patient? Yes □ No If yes, please list: Glucose, A10 for diabetics Is the information gathered written on a specific type of form? ☐ Yes 🥦 No If yes, is the form specific to a type of visit? ☐Yes 🎾 No How does the provider know that the patient is ready to be seen? Chart on the outside of the door

#### Current State Process Flowsheet: Provider Visit



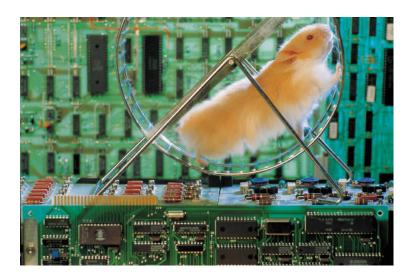
## What is that Funny Notation?

- Basic Flowchart
- Standards: BPMN (Object Management Group)



## When should I Document Workflow?

- When you are evaluating the impact of health information technology on your organization
- When you are looking at overall process improvement in your organization
- When you are looking for the cause of workflow "bottlenecks"



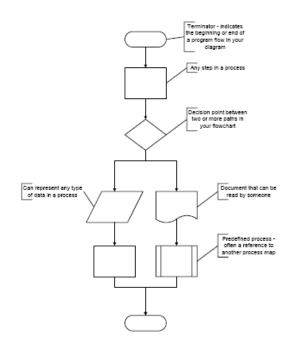
- Identify areas of interest that are related to or contribute to variation in the process to be observed
  - e.g., different roles, physical location, environmental, cognitive, social, organization characteristics
- Identify key tasks performed in the current workflow
- Identify tasks and task categories to observe and time during data collection

Determine the number of observations that are needed to account for variation in the process

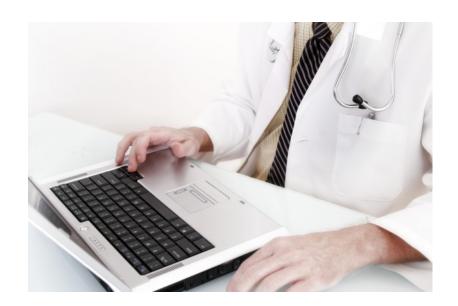
✓ Identify who and where observations will take

place

Select data entry tool



- Conduct Observer Training/Pilot Testing
- Perform Observation and Timing activities
- Complete Data Analysis



For Software Pre-implementation/Post-implementation Study:

- ✓Implement new/changed system
- ✓ Allow time for familiarization
- ✓ Repeat Observation and Timing
- √Complete Data Analysis



## Acknowledgements:

HRSA Health IT Adoption Toolbox

Guide to Remediating the Unintended Consequences of EHRs' Implementation and Use. Now on the ONC website: http://www.healthit.gov/ucguide

#### **Contact Info**



Mary Anne Sterling, CEA PRINCIPAL CONSULTANT

42950 Tara Court Ashburn, Virginia 20147

(571) 437-6167 msterling@sterlinghealthit.com www.sterlinghealthit.com Ross Koppel, Ph.D.
Sociology Dept. and
School of Medicine
University of Pennsylvania
<a href="mailto:rkoppel@sas.upenn.edu">rkoppel@sas.upenn.edu</a>
215 576 8221