Test Data for §170.314(a)(16) Inpatient setting only - Electronic medication administration record

Test data provided for public comment are samples and will be updated when the test procedures are finalized. Test data are provided to ensure that the functional and interoperability requirements identified in the criterion can be adequately evaluated for conformance, as well as to provide consistency in the testing process across multiple ATLs. The provided test data focus on evaluating the basic capabilities of required EHR technology, rather than exercising the full breadth/depth of capability that installed EHR technology might be expected to support. The test data are formatted for readability of use within the testing process. The format is not prescribing a particular end-user view or rendering. No additional requirements should be drawn from the format.

The Tester shall use and apply the provided test data during the test, without exception, unless one of the following conditions exists:

- The Tester determines that the Vendor product is sufficiently specialized that the provided test data needs to be modified in order to conduct an adequate test. Having made the determination that some modification to the provided test data is necessary, the Tester shall record the modifications made as part of the test documentation.
- The Tester determines that changes to the test data will improve the efficiency of the testing process; primarily through using consistent demographic data throughout the testing workflow. The Tester shall ensure that the functional and interoperable requirements identified in the criterion can be adequately evaluated for conformance and that the test data provides a comparable level of robustness.

Any departure from the provided test data shall strictly focus on meeting the basic capabilities required of EHR technology relative to the certification criterion rather than exercising the full breadth/depth of capability that installed EHR technology might be expected to support.

The Test Procedures require that the Tester enter the test data into the EHR technology being evaluated for conformance. The intent is that the Tester fully controls the process of entering the test data in order to ensure that the data are correctly entered as specified in the test procedure. If a situation arises where it is impractical for a Tester to directly enter the test data, the Tester, at the Tester's discretion, may instruct the Vendor to enter the test data, so long as the Tester remains in full control of the testing process, directly observes the test data being entered by the Vendor, and verifies that the test data are entered correctly as specified in the test procedure.

Ambulatory Setting Test Data

TD170.314.a.16 – 1: Electronically Verify the 5 Rights of Medication Administration

All test data are for adult patients; additional information may be supplied by the Vendor as needed.

Test Data – Set 1— Use this Test Data Set with the Test Data – Set 1 in TD170.314.a.16 – 2: Electronically Record the Right Documentation of Medication Administration

First Test Patient—to be used for showing the verification of 5 Rights when all of the Rights are correct

- First Test Patient Information:
  - Patient ID: Vendor-specified (for example, 12345678)
  - Patient Name: Jane Appleseed
  - Date of Birth: Vendor-specified (for example, 03/30/1977)

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (e.g., patient ID bar code)

- First Test Patient Medication Orders:
  These medications will be recorded as administered during this test
  - Name: Ativan
  - Dose: 2 mg
  - Route: Oral
  - Frequency: Now, and then every 8 hours

  - Name: warfarin
  - Dose: 3 mg tablet
  - Route: Oral
  - Frequency: Now, and then once per day

  Vendor inputs these medication orders in the EHR for this test patient and provides the materials needed by the assistive technology for identification of these medications (e.g., unit dose bar codes)

Second Test Patient—to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect

- Second Test Patient Information:
  - Patient ID: Vendor-specified (for example, 23456789)
  - Patient Name: Joan Bishop
  - Date of Birth: Vendor-specified (for example, 04/03/1977)

  Vendor creates a record in their EHR for this test patient and generates the materials needed by the assistive technology for identification of this patient (for example, patient ID bar code)

- Second Test Patient Medication Order:
  This medication will not be recorded as administered during this test, as none of the 5 Rights will be met for this medication
  - Name: cephalexin
  - Dose: 500 mg
  - Route: Oral
  - Frequency: Every 12 hours (start in 4 hours)

  Vendor inputs this medication order in the EHR for this test patient

- Patient/Medication Information to be used for showing the verification of 5 Rights when some or all of the Rights are incorrect:

  (A) Wrong Patient Verification
  Vendor provides materials needed by the assistive technology for identifying a patient who is NOT the Second Test Patient (for example, patient ID bar code for First Test Patient)
  For all other 5 Rights verifications listed below for Second Test Patient, the correct patient ID materials are used

  (B) Wrong Medication Verification
  - Name: Ativan (wrong medication)
  - Dose: 2 mg (right dose)
  - Route: Oral (right route)

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong medication (for example, unit dose bar code) for the Second Test Patient

  (C) Wrong Dose Verification
  - Name: cephalexin (right medication)
  - Dose: 250 mg (wrong dose)
  - Route: Oral (right route)

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong dose (for example, unit dose bar code) for the Second Test Patient

  (D) Wrong Route Verification
  - Name: cephalexin (right medication)
  - Dose: 500 mg (right dose)
  - Route: Intravenous (wrong route)

  Vendor provides the materials needed by the assistive technology for identifying this medication as a wrong route (e.g., unit dose bar code) for the Second Test Patient

  (E) Wrong Time Verification
  - Name: cephalexin (right medication)
  - Dose: 500 mg (right dose)

- Route: Oral (right route)
- Time: EHR system clock will indicate a time other than a time for which this medication is to be administered (wrong time) for the Second Test Patient

TD170.314.a.16 - 2: Electronically Record the Right Documentation of Medication Administration

Test Data – Set 1—Use this Test Data set with the Test Data – Set 1 in TD170.314.a.16 - 1: Electronically Verify the 5 Rights of Medication Administration

- Administration documentation for the following medications verified/submitted for First Test Patient:
  - Name: Ativan
  - Dose: 2 mg
  - Route: Oral
  - Frequency: Now, and then every 8 hours

  - Name: warfarin
  - Dose: 3 mg tablet
  - Route: Oral
  - Frequency: Now, and then once per day

- Administered by (User Name): Vendor-specified (for example, Robert Michaels, RN)
- Administered by (User ID): Vendor-specified (for example, 1234567890)
- Administration Date: Provided automatically by EHR synchronized clock
- Administration Time: Provided automatically by EHR synchronized clock