



Poor EHR Data Integrity Threatens Patient Safety



The second annual report by the ECRI Institute identifies EHR data integrity near the top of its list of patient safety hazards in hospitals. Although many hospitals have invested heavily in systems designed to detect mundane errors in electronic medical records, incorrect or missing data continue to jeopardise safe care delivery. The report advises training staff to understand how important it is to immediately address IT problems, since errors in EHR systems can lead to directly to medical mistakes.

According to the report, most of the EHR problems frequently faced by hospitals involve easy access by multiple users, technology complexity, and the dependence on that technology for patient care. Poor communication at the time of patient transfers to different departments is also a major contributor of errors in the EHR, which may be remedied by standardising processes for patient transport and handoffs.

Data can be erroneously entered into EHRs when one patient's information appears in the record of another patient, when there are clock synchronisation errors between medical devices and systems, when default values are used by mistake or fields are pre-populated with the wrong data, or when there are inconsistencies between paper and electronic records. Missing, delayed or outdated data represent another source of error that can impact patient safety.

Alarm hazards again topped the ECRI's list of patient safety hazards, although it is not alarm fatigue but faulty configuration policies and practices that put patients in danger. "Our accident investigations have found that hospitals have either not had consistent or not had any practices to determine how alarms are set by care area or by patient type," said James Keller, the ECRI Institute's vice president of health technology evaluation and safety. "It doesn't make sense to use the same default alarm settings in paediatric intensive care as in adult intensive care."

The ECRI report recognises the following as the 10 most prominent patient safety hazards:

1. Alarm hazards: inadequate alarm configuration policies and practices
2. Data integrity: incorrect or missing data in EHRs and other health IT systems;
3. Managing patient violence;
4. Mix-up of IV lines leading to misadministration of drugs and solutions;
5. Care coordination events related to medication reconciliation;

6. Failure to conduct independent double checks independently;
7. Opioid-related events;
8. Inadequate reprocessing of endoscopes and surgical instruments;
9. Inadequate patient handoffs related to patient transport;
10. Medication errors related to pounds and kilograms

The insights come from patient safety reports voluntarily sent to the ECRI Institute. The institute compiles and analyses its findings, and shares them in order to improve awareness of patient safety hazards and recommend solutions. From 2009 to 2014, it collected almost 500,000 reports.

Source: [ECRI Institute](#)

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