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The Joint Commission Issues Health IT-Related Patient Safety Alert

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The Joint Commission, an independent, non-profit organization that accredits and certifies health care organizations, recently issued a Sentinel Event Alert to identify patient safety risks related to the use of health information technology and to recommend actions that hospitals and other accredited organizations should consider.

The Joint Commission describes a sentinel event as "a Patient Safety Event that reaches a patient and results in . . . death, permanent harm, [or] severe temporary harm and intervention required to sustain life." From 2010 through mid-2013, The Joint Commission received 120 health IT-related sentinel event reports. Such events may occur for many reasons, including the ordering of drugs, tests, or procedures for the wrong patient by entering an incorrect room number into the system, clicking the wrong option on a drop-down menu, or entering information into the wrong patient record.

The Commission's analysis of health IT-related sentinel events suggests that the most frequent contributing factors are: "human-computer interface" issues, such as usability issues that result in data errors (33 percent); workflow and communication issues (24 percent); and design or data issues relating to the clinic content or decision support feature of health IT (23 percent).

To reduce the risk of future health IT-related safety or sentinel events, The Joint Commission suggests that organizations take actions in three areas:

1. Develop and maintain a culture of safety that includes internal (and in appropriate cases external) identification, reporting, and analysis of health IT-related "hazardous conditions, close calls or errors." This should include analysis of all patient safety events to determine if the use of health IT contributed to the event in any way.

2. "Develop a proactive, methodological approach to health IT process improvement." The Joint Commission recommends that organizations use the "Safety Assurance Factors for EHR Resilience (SAFER) Guides" (self-assessment checklists available at HealthIT.gov) to identify an organization's level of safe health IT implementation. The Commission also recommends that organizations back up data and have redundant systems in place; use standardized elements to record allergies, problem lists, and test results; and have safeguards such as the prominent display of patient identifying information on each screen and limiting the number of

patient records that can be edited at any one time.

3. Ensure multidisciplinary leadership and oversight of health IT planning, implementation, and evaluation. This may include examining workflow processes for risks, involving clinicians who use health IT in system selection, design, and other decisions, and continually improving the organization’s ability to exchange information with external systems.

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