



## SAVE THE DATES:

- I. **Virtual Quarterly Meeting, July 25, 2017, 3 p.m. ET**
- II. **Partnership In-Person Meeting, November 15, 2017**

- Where: ECRI Institute headquarters, Plymouth Meeting, PA
- Topics: Wrap-up of 2017 workgroups; implementations—where we are now and where we are going; 2018 and beyond—transforming and growing the *Partnership*.

## Partnership Workgroup Update:

**Partnership Workgroup 3, on Developing, Integrating, and Maintaining a Health IT Safety Program, continues to meet.** The next workgroup meetings are May 25, June 14, and July 19 at 12 p.m. ET.

**Participate in Partnership Workgroup 4, Closing the Loop – using health information technology to close the loop and mitigate delayed, missed, and incorrect diagnoses.** Meetings are June 13, July 11, August 15, September 19, and October 17 at 10 a.m. ET. For more information, contact the *Partnership* at [hit@ecri.org](mailto:hit@ecri.org).

## ECRI Institute PSO Webinar:

The PSO webinar, Safe Use of Health IT for Patient Identification, was held on April 20. A [recording of this presentation](#) is available.

## ONC Updates SAFER Guides with Best Practices for Patient Safety in EHRs

The Office of the National Coordinator for Health Information Technology (ONC) updated its SAFER Guides, which healthcare providers and organizations can use to identify potential patient safety vulnerabilities in their electronic health record (EHR) systems and reduce potential harm associated with EHRs. Two key updates to the guides include new recommendations in the [Test Results and Follow-up Reporting Guide](#) and the [Contingency Planning Guide](#).

According to Dean Sittig, PhD (The University of Texas Health Science Center

## Expert Advisory Panel

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The *Partnership for Health IT Patient Safety* is sponsored in part through a grant from the Jayne Koskinas Ted Giovanis Foundation (JKTG) and in part through funding from the Gordon and Betty Moore Foundation.



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**Virtual Quarterly Meeting**  
Tuesday, July 25, 2017  
3:00 - 4:00 PM ET

**Partnership for Health IT Patient Safety In-Person Meeting**  
November 15, 2017

at Houston, School of Biomedical Informatics) a member of our *Partnership* expert advisory panel (EAP), "The 2017 update to the guides takes into account comments from the EHR Association on the 2014 version, experience of those who used the guides, new health IT-related safety research, and emerging risks. For example, we made changes to the Contingency Planning Guide to reflect best practices for prevention and mitigation for the epidemic of ransomware attacks on hospitals around the world."

Another member of the *Partnership* EAP, Hardeep Singh, MD, MPH (Michael E. DeBakey VA Medical Center and Baylor College of Medicine) says, "The updates also reflect emerging patient safety issues in context of rapidly evolving health IT applications. For example, in the Clinical Process Guide for Test Results Reporting and Follow-up, we added a new recommendation aimed to reduce diagnostic errors that occur when the patient is not informed of abnormal diagnostic test results. Our recommendation builds on the 2015 "[Improving Diagnosis in Health Care](#)" report from the NAM [National Academy of Medicine], and promotes patient engagement as part of the diagnostic testing process."

The updates reflect feedback that ONC received from the American Medical Informatics Association, the EHR Association, the National Quality Forum, NAM, and others.

## Data Snapshot: Downtime not an "if" but a "when" event; be prepared.

### Background

Downtime is the time during which a medical device or computer system is malfunctioning or is otherwise unavailable to users. Unscheduled downtimes can be attributed to power outages, hardware malfunction, software malfunction, inadequate bandwidth, incompatible systems, updates and upgrades, viruses, worm attacks, ransomware, and human error. Problems can stem from internal hardware sources or external sources. Downtime can be system wide or affect a single application. Regardless of the cause, a disruption in patient care occurs, which can lead to patient harm. In the event of either unplanned or scheduled downtime, staff needs to be prepared to work without technology to continue to treat patients.

### Events Reviewed

ECRI PSO has received and reviewed several events related to downtime of technology that have impacted patient safety and patient care. The downtimes caused issues in radiology reporting, in visualization of images, in the EHR, in the nurse call system, and in the house paging system. The following examples emphasize the need for organizational downtime preparedness.

Suspecting a resolving brainstem stroke, a physician ordered a computerized axial tomography (CAT) scan. When the physician attempted to access the images on the picture archiving and communication system (PACS), the system was down, but a verbal report indicated the CAT scan was normal. Not confident of these findings, the physician admitted the patient to the intensive care unit (ICU). This admission allowed for appropriate treatment of the individual.

In another event, a nurse call system and the overhead paging system went down at the same time a code blue was called. A code is activated by pressing the code blue button on the nurse call system. In this case, multiple systems failed. If not for the quick thinking of the operator, who notified the house supervisor by phone, no one would have been aware of the need for the code team. However, this set of circumstances resulted in a slower response time for the code team and a delay in patient care.

## Contributing Factors – Health IT-Related

Downtimes are inevitable as systems are upgraded or maintained or because of unanticipated power outages, cyberattacks, and interoperability issues that freeze systems. As healthcare providers become ever more dependent on technology, the inability to access complete clinical information in a timely manner paralyzes care. During a downtime, users realize how much they have come to rely on technology to treat their patients.

## Lessons Learned

Unplanned downtimes are not an “if” but a “when” event. Be prepared. Downtimes should be given the same attention as any other disaster an organization may face. Organizations should have a downtime response team in place. There should be built-in redundancy and adequate backups for all systems. In the event of a downtime, communication is key to providing an effective option to continue to provide safe patient care. Consider the following questions when formulating your downtime procedures.

- How do we prepare for this event (e.g., staff training, staff testing, backup system testing)?
- What steps are necessary to continue to provide safe care during a downtime?
- How do we handle downtimes lasting longer than expected?
- What systems are unavailable?
- Can labels, documents, and other materials be printed?
- What are the potential issues to consider and address; how do you obtain that information?
- What other options are available?
- How do you handle reentering all data after a downtime?
- How do you reconcile data into the EHR?
- How is downtime tracked and measured (e.g., system use time, downtime)?
- Are downtime drills conducted?
- Is there built-in redundancy?

The Partnership's [Self-Assessment Questionnaire: Unplanned Downtimes of Health IT](#) provides further questions.

## In the News

The National Patient Safety Foundation's Lucian Leape Institute announced the creation of a new award program, the NPSF Lucian Leape Institute Medtronic **Safety Culture & Technology Innovator Awards**. Details about the award, including how to submit a nomination online, are available at [www.npsf.org/liiaward](http://www.npsf.org/liiaward).

The ONC has announced the **Oh the Places Data Goes: Health Data Provenance** challenge. For details and instructions visit <https://www.cccinnovationcenter.com/challenges/provenance-challenge/>.

The ONC also launched the Patient Matching Algorithm challenge. For information and details, visit the challenge site at <https://www.patientmatchingchallenge.com/>.

**Partnership collaborators join forces.** The Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF) will begin to work as one organization after their merger, effective May 1, 2017.

## Collaborating Organizations



## Working Together:



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### Need to Submit an Event?

Partnership participants can submit events through your [membership portal](#).

If you need assistance, please contact us at [hit@ecri.org](mailto:hit@ecri.org).

### Get in Touch with the Partnership

Do you have questions about any of these articles? Get in touch with us today by e-mailing [hit@ecri.org](mailto:hit@ecri.org). If you wish to submit information for this publication, please submit items for the Update using the subject line "Partnership Update" to [hit@ecri.org](mailto:hit@ecri.org).

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