Partnership Update

DECEMBER 2019

Data Snapshot: Diagnostic Testing Results and Patient ID—Not Always a Perfect Match

BACKGROUND

The communication and tracking of diagnostic testing results continues to be a challenge across the continuum of care. Accurate tracking and monitoring of diagnostic results, including the transmission of the information, acknowledgement, documentation, and response to the information are essential to closed loops.

In a random sample of 330 recently reviewed events from January – June 2019, the diagnostic testing process was identified as an area of concern in 42% of reviewed events, with diagnostic testing results associated with the wrong patient or reported on the wrong patient identified in 33% of the selected events.

Examples of these events are seen in the case studies below.

EVENTS

A pathology test was ordered and the results were transmitted to the provider. However, the patient's name was entered incorrectly and the results were not posted to the electronic health record. Thirty days later, when the patient called to obtain the results, staff concluded that the results "never came over the interface." In investigating the missing results, staff looked at the error queue, found the patient's test results, and populated them into the patient's chart. The investigation of the missing results identified a gap in the office processes. The results for an incorrectly identified patient triggered an error in the
interface log, therefore the results remained in the error queue. The office had no consistent process in place for oversight of the interfaces or of the error queue, resulting in the results being missed. This caused a delay in diagnosis and treatment of the patient.

In another event:

The provider ordered a prostate biopsy and also a urine culture and sensitivity as part of the pre-op evaluation. The tests were performed and results were sent, but they were sent to the wrong provider. Following the biopsy the patient was subsequently admitted to the hospital with urosepsis. Upon review of the chart, the physician realized that the previously ordered test results were never posted to the patient’s record. It was identified that the wrong ordering physician was selected, therefore the physician was not notified of the abnormal results preprocedure. This patient ultimately died of sepsis.

CONTRIBUTING FACTORS

While technology plays a role in crafting solutions, it is also a contributing factor. How are providers matched to tests ordered? Are drop down lists used? Are there usability issues with those drop down lists? Here too, it is important to evaluate the contribution of interface issues. Patient identification issues are also a contributing element in errors related to failures to close the loop. Is the patient's information captured correctly? What attributes are used for patient matching? Communication and workflow are contributing factors in closing the loop. While technology is a useful communication tool, is the technology being used to monitor and track information to optimize the closing of the communication loop? How are workflow issues addressed? It is important to evaluate issues related to closing the loop by examining the applicable areas of the sociotechnical model—namely: software, workflow, communication, interface (usability), content, people, monitoring, and organizations and their policies and procedures.

LESSONS LEARNED

Closing the loop involves issues other than aligning clinical workflow with technology. While addressing these are important aspects in closing the loop, it is also important to consider the impact of patient identification when tracking diagnostic results. Knowing what to monitor, developing internal processes, and creating actionable reports is essential in making certain that the diagnostic testing loops are closed. Proper identification of patients, ordering
providers, covering providers and those providers that need to be informed of critical information is important. Closing the loop can be a time consuming burdensome task, but necessary to ensure safe care.

The Partnership’s publication Health IT Safe Practices for Closing the Loop recommends the following strategies to ensure that the loop is closed:

**Track Key Areas**

- Explore opportunities for tracking, determining where health IT can be used to correct deficiencies and improve tracking.
- Assign accountability for and ensure oversight of tracking.
- Improve tracking by implementing laboratory standards.
- Improve tracking by implementing bidirectional communication.

**CONCLUSION**

Accurate patient identification is imperative for timely tracking and communication of diagnostic test results. Equally important is ensuring that the results are sent to the correct provider. Technology can play a role in ensuring that this occurs and using technology to track results is one step in that process.

**Key Happenings**

*Partnership for Health IT Patient Safety Quarterly Conference Call*

Join us on Wednesday, January 22, 2019 3:00 - 4:00 p.m. ET

Join a robust discussion of Partnership activities for 2020. We are meeting together on January 22, 2020 from 3:00 to 4:00 PM ET for the Partnership’s Quarterly call.

The agenda includes:

- Review of upcoming white papers
- An InSight into the SAFER Guides
• Upcoming projects

Reminder: You must be registered to attend. Click here to register.

We look forward to your participation!

After registering, you will receive a confirmation email containing information about joining the meeting. If this is your first time using Zoom software, please sign in early to be certain that you are able to join the meeting without difficulty. Please send any comments or questions to: hit@ecri.org.

The meeting will be recorded.

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Assess your Health IT Safety with the SAFER Guides INsight On-line Assessment

We are looking for a limited number of organizations to beta test an on-line assessment tool using the SAFER Guides.

The SAFER Guides consist of nine guides that identify recommended practices to optimize the safety and safe use of EHRs. More information on the SAFER guides, can be found on The Office of the National Coordinator for Health Information Technology (ONC) website.

Please e-mail us at hit@ecri.org if you are interested in participating in the beta test.

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New Podcast

Access to accurate, up-to-date drug allergy information is a vital component to effective, safe, and timely patient care. This information comes directly from patients and from information contained in the electronic health record. Recommendations available to improve drug-allergy information to prevent adverse events have not been widely implemented. The safe practice recommendations are available from the Partnership for Health IT Patient Safety; additional information is available from the Institute for Safe Medication Practices.
In a special episode produced in conjunction with the Partnership, we look at how technology and clinical decision support could improve how drug and allergy information is handled.

2019 Publications

Our latest toolkit, Safe Practices for Drug Allergies—Using CDS and Health IT, is available. The toolkit addresses how the use of health IT can help implement existing recommendations to prevent potentially harmful medication interactions.

Implementation guides for Drug Allergies, Closing the Loop, Integrating a Health IT Safety Program, Patient Identification, and Copy and Paste are now available. Share them within your organization.

Advisory Panel

David W. Bates, MD, MSc
Kathleen Blake, MD, MPH
Pascale Carayon, PhD
Tejal Gandhi, MD, MPH
Chris Lehmann, MD
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Hardeep Singh, MD, MPH
Dean Sittig, PhD
Paul Tang, MD, MS

The Partnership for Health IT Patient Safety is sponsored through funding from the Gordon and Betty Moore Foundation.

Collaborating Organizations
Submit an Event?

Partnership participants can submit events through your membership portal. If you need assistance, please contact us at hit@ecri.org.

Get in Touch

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

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