



PATIENT SAFETY

Bulletin No.1

IT problems, especially new systems, new upgrades and links

Missing text

Interpretive comments are key to the clinical message. There have been events where comments were stripped off during transmission, especially into primary care systems.

Historical data

Import of historical data can be problematic, and issues have occurred with blood transfusion records. Records may be complex and many systems are not designed with transfusion in mind. Not having antibody or irradiated component status records properly migrated can be very serious. Pay particular attention to transfusion!

Decimal points

Implementation of an electronic patient record system stripped out numbers after decimal points when importing data...not great to have a lab report of potassium of 3... watch with care.

Missing supplementary reports

Additional results or amended reports are often issued as supplementary reports...in some centres these have not appeared when viewed by clinical teams, especially where the lab system sends to a system other than the primary electronic health care record. Histopathology is a good place to look for this. Faults can be dangerous, especially if an amended report has been issued!

Training

Don't think that training a busy person once on a complex system will work. Clinicians and scientists are experts in pathology, not in lab systems that are seldom intuitive. Make sure there is simple access to 'how to do it' materials for help (and do check!).



'Minor' issues

There is a tendency to regard IT hiccups as 'glitches', but minor issues, such as a missing supplementary report or text, may be symptoms of a serious problem. Encourage staff to let you know, and alert key users to report problems. e.g nephrologists are high volume pathology consumers and good at spotting errors.

Sorry we forgot to mention

We changed our system...Labs have been caught out by users changing systems but not thinking about pathology IT links. A major network had serious problems with messaging following implementation of an electronic health record system in one of their hospitals. Key to stopping unwanted surprises is communication.

Key learning

Make sure to test end to end systems for all report types and secondary systems. Don't forget users across all different primary care systems, and get a good spread of 'index reports' with comments etc, validated from end to end. And don't ever imagine the really bizarre couldn't possibly occur...