**Institute for Safe Medication Practices**

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**Partnership for Health IT Patient Safety Releases New**

**Recommendations to Avoid Testing and Medication Mix-Ups**

**Horsham, Pa.** — The Partnership for Health IT Patient Safety, a multi-stakeholder collaborative in which the Institute for Safe Medication Practices (ISMP) is a participant, has released a new report that identifies ways that technology can reduce and eliminate errors from diagnostic testing and medication mix-ups.

The Partnership leverages the work of multiple Patient Safety Organizations (PSOs), along with providers, vendors, an expert advisory panel, and collaborating organizations to create a learning environment that mitigates risk and facilitates improvement. This new report is the fourth in a series of safe practices toolkits published by the private-sector Partnership since 2014.

*Health IT Safe Practices for Closing the Loop* is based on reported events in ECRI Institute PSO’s database of more than 2 million adverse events, an evidence-based literature review, and methodical analysis by a Partnership workgroup. The toolkit is available for use by healthcare systems worldwide.

In keeping with the goal of collaboration to make health IT safer, the Partnership convened a workgroup, chaired by Dr. Christoph U. Lehmann of Vanderbilt University, to address safety issues related to tracking diagnostic test results and medication changes. This issue, often referred to as “closing the loop,” has long been a challenge in all practice settings.

“The problem of not closing the loop has a significant impact on patients and care givers, and can lead to devastating effects on the outcome of patients,” states Lehmann, Partnership expert advisory panel member and workgroup chair.

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Specifically, the workgroup focused on identifying ways for health IT to mitigate missed, delayed, and incorrect diagnoses on diagnostic testing results and medication changes. The report includes detailed implementation strategies based on the following three key safe practice recommendations:

1. Develop and apply IT solutions to communicate the right information (including data needed for interpretation) to the right people, at the right time, in the right format.

2. Implement health IT solutions to track key areas.

3. Use health IT to link and acknowledge the review of information and the documentation of the action taken.

The Partnership is sponsored in part through funding from the Gordon and Betty Moore Foundation. To learn more about the Partnership, visit [www.ecri.org/HITpartnership](http://www.ecri.org/HITpartnership).

**About ISMP:** The Institute for Safe Medication Practices (ISMP) is an independent, nonprofit charitable organization that works closely with healthcare practitioners and institutions, regulatory agencies, consumers, and professional organizations to provide education about medication errors and their prevention. ISMP represents more than 30 years of experience in helping healthcare practitioners keep patients safe, and continues to lead efforts to improve the medication use process. For more information on ISMP, or its medication safety alert newsletters and other tools for healthcare professionals and consumers, visit [www.ismp.org](http://www.ismp.org).

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