Appendix F – “Other (specify)” Entries

Several questions in the beta Hazard Manager **Discovery¸ Causation, Impact, Corrective Action,** and **Vetting and Resolution** tabs permitted participants to select “Other” and write their response in a text field if they did not feel that any of the existing answer options were appropriate. The following tables summarize these “Other (specify)” entries.

Discovery		
Characteristic	**"Other (specify)" write ins**	**N**
"Who discovered the hazard?"	Vendor (name)	5
	Pharmacy	5
	Outside provider or 3rd party	2
	Nurse manager	1
	Anesthesia	1
	Risk management during RCA	1
	Patient report to dietician	1
"How was the hazard discovered?"	Vendor reported	25
	Routine use	2
	3rd party provider	2
	Unknown	1
	At the time of error	1
	Clinic report- facilities	1
	Pharmacy	1
	Known deficiency	1
	Grant reporting	1
	FDA MedWatch report	1
	Testing prior to upgrade	1
	During build	1

Causation		
Characteristic	**“Other (specify)” write ins**	**N**
“Usability”	Poor end user attention	1
	End user login process issues	1
	Hardware physical mounting issue	1
	Lab information system crashed	1
	Hard stop by design- need to call pharmacy	1
	A function stopped working after upgrade	1
	Paper/computer disconnect	1
“Data Quality”	Data coded incorrectly or confusingly	4
	Human error- faulty update of provider file	1
	Data linked to wrong user	1
	Information documented on wrong patient	1
	Data sent to wrong provider	1
	Incorrect documentation of provider on record	1
	Incorrect information displayed	1
	Wrong result for given test	1
	Incorrect display of patient information, data integrity maintained	1
	Data not in sync; test/production	1
“Clinical-Decision Support	Inadequate alerts or CDS	6
“Software Design”	Local programming	3
	Interfacing issues	3
“Implementation”	Inadequate testing before a change	4
	Inadequate workflow design	1
	Data lost during upgrade	1
	Technical limitations of migration tool	1
	Go-live cutover planning	1
“Hardware	Server issues	1
	Hardware issues in facilities	1
	Poor mounting technique	1
	Software not working for one patient	1
“Other Organizational Factors”	User bypassed alert or did not follow process	6
	Order review/handoff communication	1
	Physicians pressured to close encounters same day	1
	Multiple sources of patient data	1
	Using multiple vendors	1
	Paper/computer disconnect	1
	Poor coordination with house staff scheduling	1
	Poor connection to a wall	1
	Unclear feedback to user on what would happen	1

Impact		
Characteristic	**“Other (specify)” write ins**	**N**
“Type of potential care-process compromise from this hazard”	Question should be multi-select	13
	Data lost	2
	Miscommunication	1
	Patient may be non-compliant with medication	1
	Misinterpreted information	1
	Incorrect documentation of provider on record	1
	Not affected	1
	Risk to data servers and loss of power	1

Corrective Action		
Characteristic	**“Other (specify)” write ins**	**N**
“Initial Fix”	Manual chart/data correction	4
	User training	4
	Delay software installation or go-live	3
	Security	3
	Research cause of problem	1
	New batteries	1
	Equipment fixed	1
	Lab information system came back up	1
	Inter-team communication	1
	Will have to move in a fix	1
	Initiated downtime procedures	1
“Definitive Fix”	No action needed	5
	Workaround	3
	Manual chart/data correction	2
	Security	2
	TBD	2
	Department training/communication	2
	Order vendor configuration change	1
	Order new plate hardware for system, clean existing heat exchange	1
	HIM approved workflow to correct	1
	Reboot of server	1
	Facilities repair	1
	New batteries	1

Vetting & Resolution		
Characteristic	**“Other (specify)” write ins**	**N**
“Responsible for Vetting”	Security	2
	Prescription transmission vendor	1
	Content expert	1
	Vendor (name)	1
	Dietary	1
“Responsible for Hazard Mitigation”	Security	2
	Prescription transmission vendor	1
	Content expert	1
	Vendor (name)	1
	Dietary	1
	User education	1