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Interorganizational health information exchange-related patient safety incidents: a descriptive register-based qualitative study.

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Insufficient or incorrect transfer of patient information, whether caused by human or organizational factors, can result in adverse events during transitions of care. This study used four years of incident reports to identify the types, causes, and consequences of health information exchange- (HIE) related patient safety incidents in emergency care, (ED) emergency medical services (EMS), or home care. The two main kinds of HIE-related incidents were (1) inadequate documentation and inadequate use of information (e.g., deficiencies in content), and (2) causes related to the health professional or organization; consequences were adverse events or additional actions to prevent, avoid, and correct adverse events.