

EXECUTIVE BRIEF

Top 10 Health Technology Hazards for 2026

Expert Insights from ECRI's Device Safety Team

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Top 10 Health Technology Hazards for 2026



Executive Brief

Each year, ECRI produces its Top 10 Health Technology Hazards report to highlight potential sources of danger involving the use of medical devices and systems. ECRI is providing this Executive Brief to inform the healthcare community about these key safety issues. The full report, available to members of ECRI programs, includes additional details about each hazard and offers practical recommendations for reducing the identified risks, all with the goal of preventing harm.

The List for 2026

1. The Misuse of AI Chatbots in Healthcare
2. Unpreparedness for a “Digital Darkness” Event
3. The Growing Challenge of Combating Substandard and Falsified Medical Products
4. Recall Communication Failures for Home Diabetes Management Technologies
5. Tubing Misconnections Remain a Threat Amid Slow ENFit and NRFit Adoption
6. Underutilizing Medication Safety Technologies in Perioperative Settings
7. Deficient Device Cleaning Instructions Continue to Endanger Patients
8. Cybersecurity Risks from Legacy Medical Devices
9. Technology Designs or Configurations That Prompt Unsafe Clinical Workflows
10. Water Quality Issues During Instrument Sterilization

ECRI MEMBERS: LOG IN TO ACCESS THE FULL REPORT

Detailed descriptions of the hazards outlined in this Executive Brief, along with ECRI's step-by-step recommendations for addressing them, are provided in the [2026 Top 10 Health Technology Hazards Solutions Kit](#). Members of ECRI programs can access the Solutions Kit through their membership web pages. For more information, contact clientservices@ecri.org; call +1 (610) 825-6000, ext. 5891; or visit www.ecri.org.

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The safe use of healthcare technology—from simple medical devices and supplies to complex information systems—requires identifying possible sources of danger or difficulty with those technologies and taking steps to minimize the risks and prevent harm. ECRI’s Top 10 Health Technology Hazards report, now in its 19th year, identifies the potential sources of technology-related danger that ECRI’s experts believe warrant the greatest attention for the coming year and offers practical solutions to safeguard patient care.

Improving Technology Safety, Reducing Preventable Harm

Building a safer healthcare system starts with acknowledging that healthcare is complex, that human beings are fallible, and that accidents happen. The challenge for healthcare organizations, then, is to find ways to manage that complexity, to reduce the likelihood of adverse events, and to prevent the missteps or accidents that do occur from causing significant harm.

For more than 50 years, ECRI has worked to create safer healthcare environments by providing the guidance and tools that stakeholders need to meet that challenge, with the goal of reducing the incidence of preventable harm during patient care. This report is one such tool. Here, we focus on how the design, selection, implementation, use, or maintenance of medical devices and other healthcare technologies can contribute to adverse events.

To create this report, ECRI’s various teams—Device Safety, Human Factors Engineering, Enterprise Safety Management, Medication Safety, Infection Prevention and Control, and others—work collaboratively to identify device-specific safety concerns that need attention, to probe the underlying system issues that may have contributed to the risks, and ultimately to recommend system-wide safety solutions.

Examining technology hazards through the lens of the total system, rather than in isolation, will help healthcare organizations create environments, tools, and workflows that help people do their best work, even under stress. Elements of the total system include the technologies and devices used to provide or support patient care, as well as the people involved in the patient care experience, the tasks and processes that are used to deliver care, organization-specific factors that can impact care delivery (including the organizational culture, which can influence whether organizations learn about, and learn from, adverse events), and the physical environment in which team members provide care. Designing systems that reduce the incidence of device-related harm requires assessing all of these elements.

Hazard. A device or system fault, design feature, or method of use that might, under certain circumstances, place patients or users at risk.

Identifying the Top Hazards

The topics included in the report are not necessarily the most frequently reported problems or the ones associated with the most severe consequences—although we do consider such information in our analysis. Rather, the report reflects our judgment about which risks should be given attention *now* to help care providers, device manufacturers, and others prioritize their patient safety efforts. Further, this report focuses on what we call generic hazards: problems that result from the risks inherent to the use of certain types or combinations of medical technologies. It does not discuss risks or problems that pertain to specific models or suppliers.

To develop this report, ECRI engineers, scientists, clinicians, and other patient safety analysts nominate topics for consideration based on their own expertise and insight gained through:

- Investigating incidents
- Testing medical devices in the ECRI lab
- Observing and assessing hospital operations and practices
- Reviewing the literature
- Speaking with clinicians, clinical engineers, technology managers, purchasing staff, health systems administrators, and device suppliers

Staff also consider the thousands of technology-related problem reports that we receive through our medical device Problem Reporting Network and through data that participating facilities share with our patient safety organization, ECRI and the Institute for Safe Medication Practices PSO.

After the topic nomination phase, professionals from ECRI's many program areas and affiliate organizations, as well as external advisors, review these topics and select their top 10. We use this feedback to produce the final report, weighing factors such as the following:

- **Severity.** What is the likelihood that the hazard could cause serious injury or death?
- **Frequency.** How likely is the hazard? Does it occur often?
- **Breadth.** Is the hazard likely to be experienced in many facilities or care environments? Or, if the hazard occurs, are the consequences likely to spread to affect a great number of people?
- **Insidiousness.** Is the problem difficult to recognize? Could the problem lead to a cascade of downstream errors before it is identified or corrected?
- **Public Profile.** Is the hazard likely to receive significant publicity? Has it been reported in the media, and is an affected healthcare organization likely to receive negative attention? Has the hazard become a focus of regulatory bodies or accrediting agencies?
- **Preventability.** Can practical actions be taken now to prevent the problem or at least minimize the risks? Would raising awareness of the hazard help reduce future occurrences?

All the hazards we select for the report must, to some degree, be preventable. But any one of the other criteria can, on its own, warrant including a topic on the list. We encourage readers to examine these same factors when judging the criticality of these and other hazards within their own care environments.

Not all of the hazards discussed will apply to all healthcare facilities. Nor is every possible hazard included; the omission of a topic that was included in a previous year's report should not be interpreted to mean that the topic no longer deserves attention. Most of those hazards persist, and healthcare organizations should continue working toward minimizing them. Rather, our experts determined that the topics listed here should receive greater attention in 2026.

THE IMPORTANCE OF PROBLEM REPORTING

The topics included in our Top 10 Health Technology Hazards report often derive from user-submitted reports of medical-device-related events and near misses. Effective reporting of such events by frontline healthcare workers and others who use or manage healthcare technologies can help identify areas of risk, pinpoint causes, and prevent recurrence that could lead to patient harm.

ECRI encourages all care providers and device users to [send us reports](#) of medical-device-related adverse events and near misses so we can share the findings with the rest of the healthcare community, whether through our [Alerts service](#) or through annual reports like this one.

All healthcare organizations should establish processes for learning about, and learning from, device-related failures and near misses. Key to this effort is fostering and sustaining a “just culture,” where staff are empowered to speak up so that any incident that does occur becomes a building block toward safer patient care, rather than an obstacle that invites future incidents.

Putting the Recommendations into Action

The topics we include in this report represent problems that can be avoided or risks that can be minimized through the careful management of technologies. However, reducing preventable harm requires more than just vigilance on the part of technology managers and device users. The medical device industry also has a role to play.

Several of the hazards outlined in this report could be mitigated—and possibly even eliminated—by improved device designs or manufacturing practices. As a rule, an engineering solution that eliminates a hazard will always be preferable to a training solution that can only warn of a hazard. In such instances, we challenge our industry colleagues to make those improvements.

With the additional content provided in the full report (see the inset on page 2), ECRI's Top 10 Health Technology Hazards report serves as a tool to help all stakeholders—from technology managers and device users to manufacturers and policymakers—to prioritize patient safety efforts and manage risk efficiently and effectively.



The Misuse of AI Chatbots in Healthcare

1

AI is rapidly transforming healthcare, and not just at the organizational level. Patients, clinicians, technology managers, and others working in healthcare are embracing AI tools—namely AI chatbots and other large language models (LLMs)—for quick responses to healthcare-related questions. LLMs are generative AI models that produce coherent, contextually relevant responses to a user’s questions. These responses appear authoritative, but on occasion can be incorrect. Sometimes dangerously so.

Commonly available LLMs—tools like ChatGPT, Claude, Copilot, Gemini, and Grok—are not designed or regulated for healthcare purposes. Yet users may turn to these tools for quick answers to questions about medical conditions, treatments, or less clinical concerns, such as how to use a medical device or what supplies to buy. Such applications often seem innocuous, but can have critical implications for patient safety.

LLM responses derive from predictions based on large datasets, not from genuine comprehension of the information. This can lead to “hallucinations” (incorrect or misleading responses) or distortions from biases embedded in the dataset. These limitations, along with the models’ predisposition toward

pleasing the user (more so than providing an accurate response), can cause a model to provide incorrect medical advice.

Importantly, even questions that are not directly health related could lead to responses that can adversely affect patient care. For example, ECRI testing identified instances of LLMs recommending products, or methods of product use, that could lead to patient or staff harm.

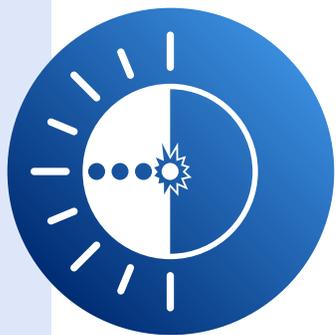
Users must recognize the limitations of these models and carefully scrutinize responses whenever using an LLM for an application that could influence patient care. LLM output should never be used as a substitute for qualified medical advice or professional judgment.

LLM responses can be incorrect—
sometimes dangerously so.
Caution is required whenever using
an LLM for an application that
could influence patient care.

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Unpreparedness for a “Digital Darkness” Event

2

Healthcare organizations face the growing risk of a “digital darkness” event—a sudden loss of access to electronic systems and patient information that can compromise care delivery, delay treatment, and jeopardize patient safety. Cyberattacks, natural disasters, vendor outages, and internal system failures all could lead to such events, potentially paralyzing a healthcare facility.

The types of outages associated with digital darkness events can have cascading effects that spread rapidly across clinical and operational workflows, putting patients, staff, and the organization itself at risk.

- For patients: A provider’s inability to access devices or systems needed for treatment or to retrieve medication histories, lab results, or other data pertinent to their care can lead to medical errors, inappropriate treatment decisions, or delayed care.
- For clinicians, IT personnel, and other staff: The strain of working under downtime procedures—involving long hours and the need to work under unfamiliar circumstances without the benefit of relied-upon tools—can increase the risk of errors and lead to burnout.

- For healthcare organizations: The loss of access to critical business systems or the need to postpone procedures, divert patients to other facilities, or increase staff workloads can translate into lost revenue, reduced productivity, regulatory sanctions, and higher labor costs.

To prevent a downtime event from escalating into a hospitalwide (or broader) safety crisis, organizations should: (1) strengthen disaster recovery planning, including establishing downtime procedures and implementing reliable data backup processes; (2) build robust recovery capabilities; and (3) ensure organizational readiness through training, tabletop exercises, and safety drills.

Cyberattacks, natural disasters, vendor outages, and internal system failures all could potentially paralyze a healthcare facility.

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The Growing Challenge of Combating Substandard and Falsified Medical Products

3

THREE

Product quality has become a persistent concern in healthcare. As highlighted in our 2025 report,* substandard and falsified (e.g., counterfeit) medical products are reaching the US market with alarming frequency. This development can have widespread implications: Medical devices or supplies that do not function as intended or medications that do not meet appropriate quality standards can cause harm. In addition, the presence of such products on the market can lead to recalls, shortages, or other supply chain disruptions that can cost organizations time and money to correct.

Healthcare organizations addressing this challenge in 2026 must consider the potential impacts that developments at the US federal level could have on their efforts. For example: The US withdrawal from the World Health Organization could impede international efforts to safeguard the global supply chain; and workforce reductions at the US Department of Health and Human Services could further limit its capacity to conduct device and drug manufacturer inspections or to make needed improvements

to the recall management process. Such developments could result in healthcare organizations having to shoulder more of the burden of preventing substandard or falsified products from reaching the patient.

ECRI encourages healthcare providers to strengthen supply chains, leverage purchasing power to demand high-quality products, and implement measures to protect patients and staff from the use of flawed products. (We offer recommendations to support these efforts.) Further, we challenge government agencies and manufacturers to strengthen efforts to prevent defective products from entering the market.

In 2026, healthcare organizations may have to shoulder more of the burden of preventing substandard or falsified products from reaching the patient.

* Available to ECRI members at <https://members.ecri.org/guidance/substandard-or-fraudulent-medical-devices-and-supplies>.



Recall Communication Failures for Home Diabetes Management Technologies

4

Improvements in home diabetes management technologies have revolutionized the treatment of diabetes outside of direct clinical supervision. Advances such as the integration of insulin pumps with continuous glucose monitors (CGMs)—allowing closed-loop control of insulin delivery—have significantly improved the quality of life for millions of people. However, the use of these technologies is not without risk.

Harm can result if product recalls and updates do not reach patients and caregivers in a timely manner or if recipients do not respond to those notices appropriately. Following are just a few recent examples of recalls that could have serious consequences if patients do not receive or understand the warnings*:

- An integrated [insulin pump](#) could overdeliver insulin.
- [Sensors on a CGM](#) could yield incorrectly high glucose readings, which may lead to users being unaware of their actual glucose level.
- A [CGM receiver](#) may not communicate alarms or alerts to the user, or the alarms or alerts may be delayed.
- A change in air pressure could cause unintended insulin delivery from an [insulin pump](#).

Incidents such as these can lead to hypoglycemia or hyperglycemia, which in turn can cause seizures, coma, diabetic ketoacidosis, and even death.

Given the seriousness of the consequences, home users of these technologies need to be proactive in identifying and responding to safety notices related to their diabetes management devices and smartphone apps. To support users in this effort, product manufacturers, medical equipment suppliers, and healthcare providers should institute processes to provide users with product safety information in a clear, easy-to-understand form.

Harm can result if product recalls and updates do not reach users in a timely manner or if recipients do not respond to those notices appropriately.

* Refer to the ECRI Resources section on page 16 for details about these recalls.

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FOUR



Tubing Misconnections Remain a Threat Amid Slow ENFit and NRFit Adoption

5

The inappropriate connection of a syringe, tubing, or other device to a patient line that was intended for a different use can lead to medications, solutions, nutrition, or gas being introduced into the wrong line. The consequences of such misconnections can be severe. For example, patient deaths have resulted from enteral feeding solution mistakenly being delivered into the patient's vasculature through an intravenous line.

This hazard arises from the prevalence of the Luer-lock design for making connections in a variety of healthcare applications. The physical compatibility between Luer-lock connectors on devices and lines intended for different purposes creates an environment in which misconnections can—and do—occur.

Safer connector designs, which mate only with corresponding connectors used for that specific application, are available and recommended for use. Yet the adoption of these connectors—namely, application-specific connectors that conform to specifications outlined in the International Organization for Standardization's ISO 80369 series of standards—has been slow in some parts of the world, notably in the United States.

ENFit connectors for enteral/oral applications (e.g., delivering enteral nutrition through a feeding tube) and NRFit connectors for neuraxial applications (e.g., administering an epidural) are two examples. The slow adoption of ENFit and NRFit connectors warrants particular attention because of the reported incidence of misconnections for those applications, the potential for severe consequences, and the availability of products that can eliminate the hazard.

For organizations that have not yet made the transition to ENFit and NRFit products, ECRI recommends that they develop and institute plans to do so.

The adoption of application-specific connector designs has been slow in some parts of the world, notably in the United States.

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FIVE



Underutilizing Medication Safety Technologies in Perioperative Settings

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Failure to implement medication safety technologies in perioperative settings puts patients at risk for serious medication errors. Perioperative settings encompass the locations in hospitals or ambulatory surgery centers where surgical patients receive care before, during, and after a procedure. Medication errors can occur at several points in the perioperative workflow, including the ordering, selection, dosing, preparation, and administration of medications.

The following safety technologies are commonly used in other critical care areas, yet remain underutilized in perioperative settings:

- Barcode medication administration systems, which help clinicians verify the patient’s identity and confirm that the medications to be administered match the provider’s intention
- Smart infusion pumps, which incorporate dose error reduction system software that can prevent pump programming errors
- Automated dispensing cabinets, which can provide a mechanism to safely control medication stock

Medication safety is of particular concern in perioperative care areas because of the risks and routine practices in these settings. Drugs administered to surgical patients often are “high alert” medications (e.g., opioids, vasopressors), which have a heightened risk of causing significant harm if used in error. Also, medications in intraoperative settings are typically prescribed, prepared, and administered by a single practitioner (e.g., anesthesia provider), without additional clinicians providing a safety check in this high-stress, fast-paced environment.

While cost considerations can make implementing safety technologies in perioperative settings a challenge, healthcare organizations nevertheless should work toward incorporating tools that can reduce the risk of medication errors.

Medication safety is of particular concern in perioperative care areas because of the risks and routine practices in these settings.

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Deficient Device Cleaning Instructions Continue to Endanger Patients

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SEVEN

Failure to properly clean and disinfect or sterilize reusable medical devices between uses can lead to the spread of infection, device damage, and other forms of harm. Successful reprocessing is made more challenging, however, by the wide variation in the content, quality, and feasibility of the reprocessing instructions provided by product manufacturers.

ECRI addressed this topic in our 2024 report,* noting that we were aware of numerous reusable medical devices and healthcare items that have incomplete, impractical, or onerous reprocessing instructions. That remains the case, and healthcare facilities inform us that they are continuing to struggle with this challenge. Thus renewed attention is warranted.

Without adequate reprocessing instructions, healthcare workers may find it difficult or impossible to complete the task effectively. Consequences can include:

- Harm to patients through exposure to infection-causing pathogens
- Injury to healthcare workers from repeatedly performing onerous reprocessing procedures
- Costs to the organization in the form of financial penalties and reputational damage

The best time for healthcare organizations to address this issue is *before* purchasing reusable medical devices or healthcare items. That is, reprocessing considerations should be evaluated during the prepurchase risk assessment of a product. If the product supplier cannot provide validated reprocessing instructions that are practical to complete in your environment, ECRI recommends considering alternative vendors and products.

Manufacturers, for their part, must provide reprocessing instructions that are complete (e.g., that adhere to relevant guidance from the US Food and Drug Administration) and that have been validated as practical and effective (e.g., through human factors testing).

Without adequate reprocessing instructions, healthcare workers may find it difficult or impossible to complete the task effectively.

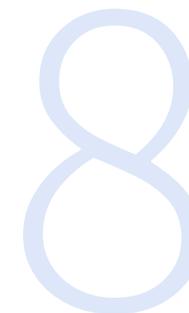
* Available to ECRI members at <https://members.ecri.org/guidance/inadequate-or-onerous-device-cleaning-instructions-endanger-patients>.

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Cybersecurity Risks from Legacy Medical Devices



Cyber threats are a constant source of concern for healthcare organizations. Malicious actors are continually seeking to infiltrate IT networks to access valuable patient data or extract ransom payments by impeding an organization's activities. In addition to disrupting business operations, a successful attack could block access to patient data, force staff to alter workflows, or render devices or systems unavailable—all of which could lead to delayed or inappropriate care, and thus patient harm.

Legacy medical devices are a particular concern when it comes to guarding against cyberattacks because they provide an opening that malicious actors can exploit. The term “legacy devices” in this context includes software-based devices and systems that are no longer being updated with sufficient cybersecurity protections, as well as those that are not practical to secure within the environment or with available controls.

The consequences of a security incident involving a legacy device can be direct, whereby the performance of the compromised device is altered, or indirect, whereby the compromised device provides an entry point that the attacker exploits to access other

networked devices or systems. In either case, attacks can have a significant impact on an organization's ability to provide timely, safe, and effective patient care.

Virtually every healthcare organization has legacy devices and software systems; and few have room in their budgets to replace all affected devices or applications. Thus, mitigating actions are needed. Depending on the circumstances, this might include segmenting devices on (or disconnecting them from) the network, deploying security tools to manage vulnerabilities, or planning for device replacement.

Legacy medical devices are a particular concern because they provide an opening that malicious actors can exploit.

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Technology Designs or Configurations That Prompt Unsafe Clinical Workflows

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Implementing healthcare technologies without fully understanding the workflow of frontline users can lead to device usability problems that contribute to patient harm. The safe and effective use of integrated interoperable systems, software as a medical device (SaMD), and other modern medical devices and systems requires that they be designed, configured, and incorporated into patient care processes with an understanding of current clinical practice, the environment of use, and the needs of the intended patient population.

Device usability problems can result when manufacturers, IT personnel, or healthcare technology management (HTM) staff implement devices without sufficient knowledge of (or attention to) these factors. Scenarios that can lead to harm include, for example:

- The use of default settings or software configurations that are inappropriate for the intended patient population
- Training programs that are misaligned with clinical practice
- Interoperability failures that prevent data exchange between systems or that create duplicate documentation burdens

Usability barriers such as these can compromise device effectiveness and contribute to adverse events. That is: When devices or device configurations fail to support appropriate processes, device users may be forced to adapt their workflow to the technology. That, in turn, may compel staff to resort to unsafe workarounds.

To avoid the safety risks that arise from technology-driven workflows, organizations must establish collaborative, clinically informed technology selection, configuration, and implementation processes. Recommended practices include establishing multidisciplinary healthcare technology governance teams, conducting comprehensive workflow analysis before technology deployment, instituting training programs that are sufficiently comprehensive and that are extended to all clinical staff, and implementing structured postimplementation surveillance.

When devices or device configurations fail to support appropriate processes, users may resort to unsafe workarounds.

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Water Quality Issues During Instrument Sterilization

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Failure to maintain sufficient water quality during instrument disinfection or sterilization risks exposing patients to potentially infectious pathogens or causing treatment delays that prevent access to timely care. When water that is not sufficiently pure is used during high-level disinfection or sterilization, devices and instruments may retain bioburden, become spotted with minerals or residues, or become corroded, rendering them unsuitable for use. Use of such instruments puts patients at risk of infection or other adverse reactions.

Healthcare facilities that experience water quality challenges may be forced to delay surgeries and other medical procedures until concerns about device cleanliness can be resolved. ECRI is aware of instances in which operating-suite procedure volumes had to be significantly curtailed, delaying treatments for many patients

and causing a significant loss of revenue. Further, poor-quality water can damage pipes and water treatment equipment in the facility, compounding the costs and challenges of remediation.

To prevent water quality issues from adversely affecting patient care, ECRI recommends that healthcare organizations work toward the goals outlined in ANSI/AAMI ST108:2023—a standard introduced by the American National Standards Institute and the Association for the Advancement of Medical Instrumentation. Additional recommendations include routinely assessing the cleanliness of processed devices and instruments, periodically sampling water quality, and developing a contingency plan for maintaining appropriate patient care in the event that water quality issues arise.

Poor water quality can lead to spotting, corrosion, and residues on reprocessed instruments and devices.



Water quality challenges could delay surgeries and other medical procedures until concerns about device cleanliness can be resolved.

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ECRI Resources for Addressing the Hazards

Members of certain ECRI programs can access resources such as the following to learn more about the topics included in this year's report:

1. The Misuse of AI Chatbots in Healthcare

Refer to [AI-Enabled Technologies: The Essentials](#) for dozens of ECRI articles and other resources related to the use of AI in healthcare.

The general public can access a collection of ECRI resources through our resource hub: [Artificial Intelligence Insights for Healthcare and Government Leaders](#).

2. Unpreparedness for a “Digital Darkness” Event

[2025 HIPAA security rule notice of proposed rulemaking to strengthen security of ePHI](#) [ECRI exclusive hazard report]. Alert Accession No. H1018. Updated July 25, 2025.

[Sustaining life during a “digital darkness” event](#). Webcast. September 24, 2025.

[Technology investments to support growth and survive a hurricane: Prisma Health’s award-winning IT infrastructure improvement project](#). June 18, 2025.

Risk management resources:

- [Emergency preparedness for ambulatory surgery](#). July 8, 2024.
- [Preparing for medical emergencies in physician practices](#). March 25, 2024.
- [Unplanned downtime of health information technology systems](#). Self-Assessment Questionnaire. February 27, 2017.
- Additional resources are available from the [Emergency Preparedness and Response](#) page.

Additional resource available from the Institute for Safe Medication Practices (ISMP)*:

- [Emergency preparedness: be ready for unanticipated electronic health record \(EHR\) downtime](#). *ISMP Medication Safety Alert! Acute Care*. 2022;27(17):1-5.

3. The Growing Challenge of Combating Substandard and Falsified Medical Products

[The growing threat of substandard and falsified drugs](#). #6 Concern—Top 10 patient safety concerns 2025. ECRI. March 10, 2025.

[How staffing changes may affect FDA recall efficiency—and what healthcare organizations can do now](#). ECRI blog. May 20, 2025.

Coverage of related topics in past editions of the Top 10 Health Technology Hazards report:

- 2025 (Hazard No. 4): [Substandard or Fraudulent Medical Devices and Supplies](#)
- 2024 (Hazard No. 9): [Poor QC of Implantable Orthopedic Products Can Lead to Surgical Delays and Patient Harm](#)
- 2023 (Hazard No. 2): [Growing Number of Defective Single-Use Medical Devices Puts Patients at Risk](#)
- 2022 (Hazard No. 2): [Supply Chain Shortfalls Pose Risks to Patient Care](#)

4. Recall Communication Failures for Home Diabetes Management Technologies

Alerts—Home Diabetes Management Technologies

Following is a list of alerts related to home diabetes management technologies that ECRI has published in the past three years (2023 through 2025):

- [Abbott Diabetes Care—FreeStyle Libre 3 glucose monitoring system sensors: may produce erroneously high glucose readings \[MHRA FSN 5044080\]](#). ECRI. Alert Accession No. A40205. February 17, 2023.
- [Abbott—FreeStyle Libre 2 readers: may be unable to start new sensor and display “incompatible sensor” message](#). ECRI. Alert Accession No. A41162. September 27, 2023.

* ISMP is an ECRI affiliate organization.

- [Abbott—FreeStyle Libre 3 glucose monitor android apps: may not receive alarms \[MHRA FSN 5056305\]](#). ECRI. Alert Accession No. A40345. March 3, 2023.
- [Abbott—FreeStyle Libre 3 sensors: may yield incorrect high glucose readings](#). ECRI. Alert Accession No. A42792. Updated September 5, 2024.
- [Abbott—FreeStyle Libre 3 and FreeStyle Libre 3 Plus continuous glucose monitoring system sensors: may yield incorrectly low glucose readings](#). ECRI. Alert Accession No. A45134. Updated December 9, 2025.
- [Abbott—FreeStyle Libre Flash, FreeStyle Libre 14 Day Flash, and FreeStyle Libre 2 Flash glucose monitoring systems: use of charging cable or power adapter not included with reader may increase risk of fire hazard \[FDA Class I\]](#). ECRI. Alert Accession No. A40540. Updated April 14, 2023.
- [Abbott: FreeStyle LibreLink iOS apps: may not function because of unsuccessful software update \[MHRA FSN 5410313\]](#). ECRI. Alert Accession No. A41026. August 3, 2023.
- [AmerisourceBerg—Dexcom G6 and G7 continuous glucose monitoring receivers: alarms/alerts may not function](#). ECRI. Alert Accession No. A44029. May 15, 2025.
- [CamDiab—CamAPS FX app: entering incorrect daily dose estimates could lead to overdosing of insulin while in auto mode \[MHRA FSN 8915163\]](#). ECRI. Alert Accession No. A41138. September 7, 2023.
- [Dexcom—G6 CGM system receivers: alarms/alerts may not function as designed and may be missed or delayed](#). ECRI. Alert Accession No. A43618. February 19, 2025.
- [Dexcom—G6 continuous glucose monitoring system iOS apps: may experience delay before updating latest glucose value reading](#). ECRI. Alert Accession No. A44644. September 3, 2025.
- [Dexcom—G6 and G6 Pro continuous glucose monitoring system android apps: may terminate unexpectedly](#). ECRI. Alert Accession No. A45029. November 4, 2025.
- [Dexcom—G7 continuous glucose monitoring apps: may not provide “sensor failed” alert](#). ECRI. Alert Accession No. A44311. July 29, 2025.
- [Dexcom—G7 iOS continuous glucose monitoring apps: may stop updating glucose values](#). ECRI. Alert Accession No. A44003. May 14, 2025.
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- 2024 (Hazard No. 10): [Third-Party Web Analytics Software Can Compromise Patient Confidentiality](#)
- 2023 (Hazard No. 5): [Failure to Manage Cybersecurity Risks Associated with Cloud-Based Clinical Systems Can Result in Care Disruptions](#)
- 2022 (Hazard No. 1): [Cybersecurity Attacks Can Disrupt Healthcare Delivery, Impacting Patient Safety](#)
- 2021 (Hazard No. 7): [Vulnerabilities in Third-Party Software Components Present Cybersecurity Challenges](#)
- 2020 (Hazard No. 7): [Cybersecurity Risks in the Connected Home Healthcare Environment](#)
- 2019 (Hazard No. 1): [Hackers Can Exploit Remote Access to Systems, Disrupting Healthcare Operations](#)
- 2018 (Hazard No. 1): [Ransomware and Other Cybersecurity Threats to Healthcare Delivery Can Endanger Patients](#)
- 2017 (Hazard No. 6): [Software Management Gaps Put Patients, and Patient Data, at Risk](#)

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