



## **New Study Will Evaluate Order Entry Errors**



A team of patient safety experts at Montefiore Medical Center and Albert Einstein College of Medicine is embarking on a study to see if there are ways in which patient safety can be improved and risks minimised through the reduction of computer provider order entry (CPOE) errors.

Entering orders into the wrong patient's computer record can result in dire consequences for the patients involved. For example, entering an order for a paralytic and sedative originally meant for a car accident patient in the record of a cancer patient could result in the nurse administering this particular drug to the cancer patient. The patient could go into respiratory arrest and die as a result of the error.

According to a 2011 brief from the Institute for Safe Medication Practices, reducing CPOE errors is one of the most important challenges in healthcare administration. It is imperative that a systematic approach is implemented to reduce errors.

This does not mean that wrong patient orders are administered and cause harm all the time. Most errors are caught well before they are acted upon and corrections are generally made. However, there is always a risk and measures should be taken to avoid such near misses and actual errors.

This is the second time such a study has been conducted. Similar research was conducted two years ago which showed that forcing clinicians to verify and re-enter orders resulted in improved behaviour. Nine million electronic records placed by 6,147 providers were examined. It was found that 1,388 providers retracted and reordered 6,885 electronic orders, usually within one minute. Now, it has again been announced that with the help of a \$300,000 AHRQ grant, another study will be conducted to evaluate how clinicians behave in a system that only permits one patient record to be opened at a time as compared to a system that allows four open patient records.

"Not much is known about exactly how big of a problem this is," says Jason Adelman, MD, patient safety

officer at Montefiore, assistant professor of medicine at Einstein, and principal investigator on the grant. “The data we have is sporadic and some of it is unreliable. If you speak to CMIOs and patient safety officers, though, you will hear that it is a common problem. People don’t want to report it, because it is an embarrassing mistake.”

This study is part of a broader effort by AHRQ to assess the impact that health IT could have on patient safety. It is believed that health IT has the potential to prevent numerous errors. The benefits of computers should be maximised and the risks of using them should be minimised in order to improve patient safety.

Source: Hospital & Health Networks

Image Credit: Daily Mail

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