

Are we heeding the warning signs? Examining providers' overrides of computerized drug–drug interaction alerts in primary care.

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[Computerized provider order entry](#) with clinical decision support can be a powerful tool for alerting clinicians to potential [prescribing errors](#). This study investigated how often and why providers overrode [drug–drug interaction](#) (DDI) warnings in an outpatient system that had already been extensively modified to show only the most important alerts. Clinicians frequently [overrode](#) critical DDI warnings. More than 30% of alert overrides were considered inappropriate and put patients at significant risks for adverse events. In some of the appropriate alert overrides, clinicians indicated that they would "monitor as recommended" for possible DDI effects, but according to a detailed chart review only about one-third actually did so. This study suggests that medication alert overrides will likely remain an important source of patient harm despite significant efforts to reduce [alert fatigue](#).