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Preventability of voluntarily reported or trigger tool–identified medication errors in a pediatric institution by information technology: a retrospective cohort study.

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Stultz JS, Nahata MC. Preventability of Voluntarily Reported or Trigger Tool-Identified Medication Errors in a Pediatric Institution by Information Technology: A Retrospective Cohort Study. Drug Saf. 2015;38(7):661-70. doi:10.1007/s40264-015-0303-y.
https://psnet.ahrq.gov/issue/preventability-voluntarily-reported-or-trigger-tool-identified-medication-errors-pediatric

Medication errors remain one of the most challenging problems in patient safety. Despite extensive investments in technological solutions such as computerized provider order entry and barcode medication administration systems, these errors still persist. This study examined all medication errors (detected by using trigger tools) over a 1-year period at an academic medical center. The investigators found that half of the errors could not have been prevented by the institution's health information technology (IT) system, and many of the avoidable errors occurred because clinicians used workarounds to bypass IT safety features. A case of a serious antibiotic overdose that took place at a fully computerized children's hospital is discussed in a recent book about the fundamental changes in health care resulting from widespread technology implementation.