

Computerized prescriber order entry–related patient safety reports: analysis of 2522 medication errors.

October 13, 2018

Amato MG, Salazar A, Hickman T-TT, et al. Computerized prescriber order entry-related patient safety reports: analysis of 2522 medication errors. *J Am Med Inform Assoc.* 2017;24(2):316-322.

doi:10.1093/jamia/ocw125.

<https://psnet.ahrq.gov/issue/computerized-prescriber-order-entry-related-patient-safety-reports-analysis-2522-medication>

[Computerized provider order entry](#) (CPOE) systems can effectively prevent many prescribing errors, but their overall safety benefit has not yet been fully realized. More widespread implementation of these systems has revealed new safety concerns. A [prior study](#) funded by the US Food and Drug Administration found that many of the safety issues associated with CPOE could be ascribed to poor usability of the systems, the lack of interoperability, and failure to track and learn from concerns identified by users. This follow-up study analyzed more than 1300 CPOE error reports to further classify the types of errors and their impact on patient care. Investigators determined that patients experienced delays in receiving medications due to these errors and were at risk of receiving duplicate medications or incorrect doses of medications. Similar to previous studies, the most common types of CPOE errors included problems with transmitting orders to the correct site of care, incorrect dose, or duplicate orders that were not detected by the system. A [WebM&M commentary](#) discussed an error that led to patient harm due to an incorrect default CPOE order.