

The challenges of electronic health records and diabetes electronic prescribing: implications for safety net care for diverse populations.

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<https://psnet.ahrq.gov/issue/challenges-electronic-health-records-and-diabetes-electronic-prescribing-implications-safety>

[Diabetes](#) medications are known to be high risk for [adverse drug events](#). This case study reviews several patient safety measures for electronic prescribing for diabetes in outpatient care. Researchers describe an adverse drug event involving electronic prescribing of insulin and detail how the incident could have been prevented. Electronic prescribing is not currently standardized and may require using a trade name for medications, which may lead to prescribing errors. Adoption of the medication naming conventions put forth by the National Library of Medicine's [RxNorm](#) would prevent this vulnerability. Similarly, standardizing electronic prescribing orders for high-risk medications like insulin may reduce the risk of erroneously choosing a long-acting instead of short-acting insulin formulation, which can have life-threatening consequences. The authors advocate for using [Universal Medication Schedule](#) instructions and providing language-concordant labels to patients to support safe medication self-administration. They suggest that real-time, bidirectional communication between prescribers and pharmacists may improve safe prescribing. The authors conclude that recommended safety practices are not uniformly implemented in clinical practice and advocate for [implementation research](#) to ensure medication safety for outpatients with diabetes.