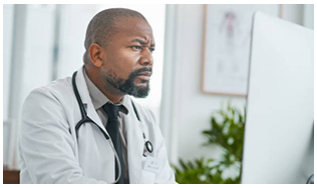

After deadly drop-down case: Fail-safe your EHR medication orders

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Health IT

A recent drop-down error that, authorities suggest, contributed to a patient's death is a reminder to keep up with electronic health record (EHR) safety improvements from your vendor, and to make sure everyone at your practice is empowered to speak up when something seems amiss.

On June 9, the Florida Department of Health (DOH) brought a complaint against John Ellis Agens Jr., M.D. It is alleged that while treating a 94-year-old patient at an assisted living facility in Tallahassee, Agens tried to put in an order for the laxative Bisacodyl but, fumbling the drop-down menu, instead ordered Bisoprolol Fumarate, a heart medicine that appeared next to Bisacodyl on the menu.

The patient allegedly was given the wrong medicine for two days, at the end of which she was hospitalized with septic shock and pneumonia and died shortly thereafter.

Florida DOH holds that Agens "failed to practice medicine with that level of care, skill and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable." Agens could lose his license.

EHR errors remain uncommon

Worries about the misuse of EHRs and resulting patient harm were much discussed in the early days of meaningful use and other CMS efforts to make use of electronic records ubiquitous (*PBN 11/16/15*). In 2012, the U.S. Institute of Medicine issued a report, "Health IT and Patient Safety: Building Safer Systems for Better Care," warning that "health IT carries benefits and risks of new and greater harms."

Since then, studies on the subject have occasionally emerged, such as "EHR-related medication errors in two ICUs" in the Jan. 2017 Journal of Healthcare Risk Management, which found that "34% percent of [adverse] medication events were found to be EHR related." But the topic of EHR safety is no longer quite so top-of-mind as it once was.

Robert Murry, M.D., chief medical officer at health IT company and EHR maker NextGen Healthcare as well as a practicing physician in New Jersey, agrees that "we're hearing about EHR errors less frequently than in the past for a couple of different reasons."

In Murry's view that's a good thing. "The concerns commonly expressed 10 or 12 years ago led to significantly more attention in the industry to the process of designing and testing these systems to try to avoid patient safety problems," Murry says. "In fact, part of the certification for EHR systems requires user testing on their most sensitive and risky functions. So the systems themselves have gotten better."

Murry says he and others in the health IT industry have learned from the approaches of other industry watchdogs, such as the National Transportation Safety Board (NTSB), which investigates air crashes and near-misses with an emphasis "less on blaming individuals and more on examining the system [that produced the error]," he says. This approach, he says, leads to very thorough investigative processes that can be used to tweak systems and reduce the chance of user error.

3 paths to fewer errors

Nonetheless, the risk is never zero. "Frequent users of [EHR] systems become very good at data entry shortcuts," says Doreen DeGroff, senior director at Nashville health IT company CereCore. But these can lead to peril: For example, "our printer is always #3 on the list," DeGroff says, "but then they add a new printer and it's not #3 anymore and what we printed isn't on our printer." The implication for drop-down safety is obvious.

Murry mentions three factors that may help keep your providers out of trouble:

- **Tall man lettering**. This is specifically for medication issues, such as is alleged in the Agens case. "It takes the names of medications and capitalizes, not the first letter, but letters in the middle of the name to help distinguish it from similarly-spelled medications," Murry says. This small enhancement in visual identification can help providers distinguish between similar-looking drugs.

- **Optimize your system**. Think about EHR preferences that may not be turned on for your system but could help stave off errors if they were. “If the ordering prescriber has diagnosed the patient with, for example, diabetes, the best kinds of systems will present them with choices for medications that treat that condition — what are called order sets or standard orders — that wouldn’t include a similarly-spelled medication that doesn’t treat that condition,” Murry says.
- **Empower colleagues to watch your back**. Murry is a fan of the High Reliability Organization (HRO) management model. As described by HHS’ Agency for Healthcare Research and Quality (AHRQ), HROs “operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures,” which results when the organization “cultivate[s] resilience by relentlessly prioritizing safety over other performance pressures.”

In such organizations, Murry says, “there’s an emphasis on reliable communication among the various parties involved because miscommunication is often the ultimate cause of the error.” In his practice, a community hospital with outpatient clinics, “we look very closely at outcomes — clinical standards like getting needed medications to stroke patients within X hours, central line infections, etc.”

To keep the safety screws tight, Murry works with “representatives from various disciplines at the hospital — physicians, nurses, pharmacists, outpatient and inpatient, front desk folks” in meetings and on incident reports and root cause analyses whenever potential problems emerge. But these colleagues also help keep safety standards up in the day-to-day by keeping an eye on one another’s work and not letting things slide.

“Let’s say I ordered a tetanus shot [verbally but] not in the computer,” Murry says. “That’s already a red flag for the nurse or the medical assistant. Then they’ll go in and double-check and make sure that that patient really is due for that. The concept is, they don’t just do what they’re told — they are expected and empowered to speak up and make sure that they understand and agree with what is about to happen.”

In fact, Murry says, “We love it when the pharmacy calls and says, ‘Did you really mean to prescribe it this way?’”

Resources

- Journal ofHealthcare Risk Management study, “EHR-related medication errors in two ICUs,” Jan. 2017: www.ncbi.nlm.nih.gov/pmc/articles/PMC8311113/
- Agency for Healthcare Research and Quality (AHRQ), “High Reliability,” Sept. 7, 2019: https://psnet.ahrq.gov/primer/high-reliability

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