

Appendix 2. **BRIGHAM and WOMENS NSPF MEDMARX CPOE ERRORS PROJECT - CPOE ERRORS TAXONOMY**

WHAT Happened

Patient

- Meds ordered for wrong patient
 - Meds ordered on wrong patient account
- Meds labeled for wrong patient
- Meds administered to wrong patient
 - Same or similar patient names

Drug

- Omitted drug
- Drug not available in TPN template
- Missing drug form
- Ordered wrong drug
 - Look alike sound alike drug
- Correct drug ordered/wrong drug processed
- Ordered wrong formulation/dosage form
 - Ordered wrong PO formulation (ER, XR, etc.)
 - NDC Mismatch/wrong package size
- Ordered wrong diluents (IV)
- Allergy
 - Prescribed drug to white patient was allergic
 - No Allergy Assessment
- Contraindicated
- Duplicate Order
 - Same exact drug
 - Same drug different routes
- Duplicate Therapy
 - Different drug same class
- Ordered a drug that was non-formulary
- Ordered a drug that was restricted
- Ordered a drug that was out of stock/drug shortage
- Ordered for a home medication
- Non-existent medication

Dose

- Ordered wrong dose or strength
 - Incorrect units used
- Correct dose ordered/incorrect dose processed
- Dose range order
- Wrong concentration/volume
- Unavailable dose ordered
 - Combinatory issues
 - Dose modification issue
- Missing number/quantity or wrong number ordered

- Missing dose on Rx
- Under dose or potential under dose
- Patient missed dose
- Potential for missed dose(s)
- Dose lower than ordered
- Overdose or potential overdose
- Patient given extra dose
- Patient potential for extra dose
- Dose higher than recommended
- Prolonged infusion (e.g. extra dose for IV infusion)

Route

- Missing route
- Ordered wrong route for patient
- Route-formulation mismatch
- IV/PO issue

Time

- Missing time/schedule information
- No start date entered
- No stop date entered
- Wrong time selected
- Wrong schedule entered
- Correct schedule entered/incorrect schedule processed
- Wrong order date
- AM/PM Mix-up
- Date/time mismatch
- Frequency range order
- Patient received delayed dose
- Drug product expires before infusion finished
- Drug product expires before prescribed amount finished
- Confusion related to initial start time and continuation
- ED order issues – scheduled vs. once or future
- Wrong administration rate
- No administration rate
- Refill information missing or erroneous

Miscellaneous

- Unable to enter desired order
- Staff workload increase and/or order not processed or delayed
 - Order missed
 - Data loss
 - Order entered prior to admission
 - Order wasn't renewed
 - Order not verified
 - Order was held
 - Hold order mismatched
 - Order was confusing: Order needed to be clarified
 - Order was confusion: Missing info/incomplete order

Order was confusing: Comments field has conflicting information
Routing issue
Missing or incorrect SIG/patient instructions
Nursing process/administration issues
Erroneous alert
Ordered wrong template /order set
Discontinuation issues
Verbal/Telephonic issues
Corollary order issues
IV flush issues
Controlled substance issues
No valid order
Administration/order label mismatch
Monitoring
 Order mismatch
 Failure to act on critical lab
 Inadequate monitoring
Order entered under incorrect MD
Ordered wrong non-drug product
Electronic order correct; hard copy ordered incorrectly

WHY it Happened

CPOE – Order Entry Issues

- System interface/usability/visual display issues
 - Pull-down menu issues
 - SALA/LASA issues
 - Instructions/meds in comment field were not seen
 - Comments field or free text confusing/confusion
 - Use of system or SIG abbreviations
 - Computer dosing calculation issues
 - Weight information not available/inaccurate
 - Initial vs. continuing order issues
 - Discontinuation order issues
 - Hold orders
 - Order/reorder modification issues
 - Lack of transparency in duration/renewal status
 - CDS failure/problem
 - Order set/template/protocol issues
 - Issues with favorites
 - Patient information on screen after order was filed
 - Visual display confusing or inadequate
 - Transcription (copy/paste)

- System limitations/inadequacy
 - Drug formulary issues
 - Build issues—route/drug not in CPOE
 - Drug dictionary miscode/out-of-date drug information
 - Inadequate field length
 - Inability/problems in titrating/tapering
 - Inability to enter alternate day dosing
 - Error in default dose or schedule
 - Default SIG or other default issues
 - Scheduled drug routing issue
 - Pharmacy routing issue
 - Corollary orders: timing to properly linked
 - Routing/mapping issue

- Drug allergy issues
 - Drug ordered as text, unable to check for allergy in text
 - Failure to alert
 - Drug allergy field limit
 - Drug allergy incomplete/unclear/conflicting

Computer System Issues

- Computer down/outage
- Hybrid system (electronic & paper)
- eMAR/MAR issues
- Multiple systems (2 or more electronic systems)
- Pharmacy order entry problems/issues

Profiling issues—failure to perform or do correctly
TPN issues

Transition Issues

Medication reconciliation issue
Home medication issue
Patient transferred (within hospital)
Patient discharged (out of hospital)
Transferred from outside hospital

User Issues

Communication issues
2 different clinicians entered
Misinterpretation of order(s)
Lack of computer training/system knowledge
Inexperienced end user
Failure to verify patient identification
Failure to follow established procedures or protocol
Lack of protocol knowledge
Calculation error
Lack of clinical knowledge
Alert ignored/overridden
Typing error
Nursing administration

Miscellaneous/Patient Issues

Insurance Issues

Patient Access Issues

Inaccurate/Inadequate Patient Drug Knowledge

Administrative Issue/Delay

Possible PREVENTION Strategies**Clinical Decision Support (CDS) Enhancements**

Ordering facilitators/alerts

ALLERGY

- Drug allergy checking (including class)
- Standardized SIGs

DUPLICATE

- Duplicate order checking/support
- Duplicate therapy checking/support

DOSING SUPPORT

- Dose availability checking
- Default dosing selections
- Dose range checking
 - Individual dosing calculations
- Auto-calculations for combinatory and other complex dosing regimens
- Dose conversion support
- Titration/dose change – better system for entering/conveying
- Scheduling feedback

DURATION SUPPORT

- Drug duration support
 - Drug expiration support
 - Reminders about automatic stop dates/need for re-order drug

route/mix/diluent

DDI

- Drug-drug interaction checking

COMPATIBILITY

- Route formulation checking (eye drops, ear)
- Patient access route guidance
- IV mix support (IV compatibility, how to mix)
- Enhanced ability to modify orders and regimens (tapers)
- Auto calculation for prescription quantities
- System for reconciling new/now with continuing dosing

FORMULARY

- Formulary status and restrictions warnings
- Alerts for non-formulary medications
- Generic substitution

DRUG LAB

- Drug-laboratory linking checking
- Automatic corollary lab orders

DRUG DISEASE STATE

- Drug-disease alerting

Pregnancy alerting

MISCELLANEOUS WORK FLOW DESIGN FACILITATORS

Order set support

Protocol support

Automatic corollary products/supplies

Blank field checking

Alert Tiering Enhancements

Hard stops

Tiered alerts with hard stops when necessary

Management Support (Policies/Infrastructure/Standards)

Order set QA testing/updates

Standardize product formulation naming

Standardized constructs for dosing regimens

Standardized constructs for dose form-route

Comment field display

Communication related to hold orders

Systems integration

Electronic transmission of Rx

Remove option to e-scribe federally controlled substances

Staff authorization issues

Improved downtime procedures

Improved patient registration workflow/logistics

Operationalize TPN and IV queues

Tie into internal scheduling

Direct order entry: Verbal/Telephonic issues

Medication handoff/transfer standardization

Enhanced Education/Training

Standardized SIGs

Standardized weights (only in kilograms)

Enhanced allergy entry for drugs not included in allergy list

Improved Design/Functionality

Reminders for Staff

Facilitation of products selection by pharmacists instead of MD

Unlimited number of medication allergies

Include a picture of the patient on the ordering screen

Indication on prescription

Include time in pick list (actual time)

Patient location support

Patient route access availability: IV access NPO

Provide links to clinical references

Tallman lettering

Order set/sentences for complex tapers

Order set/sentences for range orders

Weight-based dosing

Medication reconciliation support

[Other CPOE & System Enhancements](#)

Indication on prescription (standardized SIG)

Mapping standards

Direct order entry: Verbal/Telephonic issues

Direct order entry and transmission of controlled substances

DEA direct order entry

[Drug Database Improvements/Enhancements](#)

[Other Pharmacist Interventions](#)