ADVERSE DRUG EVENTS (ADEs) are estimated to injure or kill more than 770,000 people in hospitals annually.\(^1\) Prescribing errors are the most frequent source.\(^2\) Computerized physician order entry (CPOE) systems, however, are widely regarded as crucial for reducing prescribing errors\(^3\) and saving hundreds of billions of dollars each year.\(^4\)\(^5\)\(^6\)\(^7\)\(^8\)\(^9\)\(^10\)\(^11\)\(^12\)\(^13\)\(^14\)\(^15\)\(^16\)\(^17\)\(^18\)\(^19\)\(^20\)\(^21\)\(^22\)\(^23\) Computerized physician order entry system advocates include researchers, clinicians, hospital administrators, pharmacists, business councils, and the lay public.\(^2\)\(^3\)\(^6\)\(^12\)\(^14\)\(^17\)\(^20\)\(^22\) These systems are expected to become more prevalent in response to resident working-hour limits\(^2\) and will supposedly offset causes of nursing shortages.\(^24\)\(^25\)

**Context** Hospital computerized physician order entry (CPOE) systems are widely regarded as the technical solution to medication ordering errors, the largest identified source of preventable hospital medical error. Published studies report that CPOE reduces medication errors up to 81%. Few researchers, however, have focused on the existence or types of medication errors facilitated by CPOE.

**Objective** To identify and quantify the role of CPOE in facilitating prescription error risks.

**Design, Setting, and Participants** We performed a qualitative and quantitative study of house staff interaction with a CPOE system at a tertiary-care teaching hospital (2002-2004). We surveyed house staff (N=261; 88% of CPOE users); conducted 5 focus groups and 32 intensive one-on-one interviews with house staff, information technology leaders, pharmacy leaders, attending physicians, and nurses; shadowed house staff and nurses; and observed them using CPOE. Participants included house staff, nurses, and hospital leaders.

**Main Outcome Measure** Examples of medication errors caused or exacerbated by the CPOE system.

**Results** We found that a widely used CPOE system facilitated 22 types of medication error risks. Examples include fragmented CPOE displays that prevent a coherent view of patients’ medications, pharmacy inventory displays mistaken for dosage guidelines, ignored antibiotic renewal notices placed on paper charts rather than in the CPOE system, separation of functions that facilitate double dosing and incompatible orders, and inflexible ordering formats generating wrong orders. Three quarters of the house staff reported observing each of these error risks, indicating that they occur weekly or more often. Use of multiple qualitative and survey methods identified and quantified error risks not previously considered, offering many opportunities for error reduction.

**Conclusions** In this study, we found that a leading CPOE system often facilitated medication error risks, with many reported to occur frequently. As CPOE systems are implemented, clinicians and hospitals must attend to errors that these systems cause in addition to errors that they prevent.
Box. Advantages of CPOE Systems Compared With Paper-Based Systems1,2,6-9,11,13-15

Free of handwriting identification problems
Faster to reach the pharmacy
Less subject to error associated with similar drug names
More easily integrated into medical records and decision-support systems
Less subject to errors caused by use of apothecary measures
Easily linked to drug-drug interaction warnings
More likely to identify the prescribing physician
Able to link to ADE reporting systems
Able to avoid specification errors, such as trailing zeros
Available and appropriate for training and education
Available for immediate data analysis, including postmarketing reporting
Claimed to generate significant economic savings
With online prompts, CPOE systems can
Link to algorithms to emphasize cost-effective medications
Reduce underprescribing and overprescribing
Reduce incorrect drug choices
Abbreviations: ADE, adverse drug event; CPOE, computerized physician order entry.

tion error so distressing, circumstances of medication error so preventable, and studies of CPOE preliminary yet so positive.21,26-28 Studies of CPOE, however, are constrained by its comparative youth, continuing evolution, need to focus on potential rather than actual errors, and limited dissemination (in 5% to 9% of US hospitals).29-36 Two critical studies21,30 examined distinctions between reductions in possible ADEs vs actual reductions in ADEs; the former are well documented and often cited, but the latter are largely undocumented and unknown. Studies of CPOE efficacy (17% to 81% error reduction) usually focus on its advantages2,3,6-11,14-16 and are generally limited to single outcomes, potential error reduction, or physician satisfaction.28,30,34-40 Often studies combine CPOE and clinical support systems in their analyses.30,40,41

In the past 3 years, though, a few studies21,26-28,30,31,33,35-40 suggested some ways that CPOE might contribute to medication errors (eg, ignored false alarms, computer crashes, orders in the wrong medical records). Several decades of human-factors research, moreover, highlighted unintended consequences of technologic solutions, with recent discussions on hospitals.32,33,42-44,47-52

We undertook a comprehensive, multimethod study of CPOE-related factors that enhance risk of prescription errors.

METHODS

Design
We performed a quantitative and qualitative study incorporating structured interviews with house staff, pharmacists, nurses, nurse-managers, attending physicians, and information technology managers; real-time observations of house staff writing orders, nurses charting medications, and hospital pharmacists reviewing orders; focus groups with house staff; and written questionnaires administered to house staff. Qualitative research was iterative and interactive (ie, interview responses generated new focus group questions; focus group responses targeted issues for observations).

Setting
We studied a major urban tertiary-care teaching hospital with 750 beds, 39,000 annual discharges, and a widely used CPOE system (TDS) operational there from 1997 to 2004. Screens were usually monochromatic with pre-Windows interfaces (Eclipsys Corp, Boca Raton, Fla). The system was used on almost all services and integrated with the pharmacy’s and nurses’ medication lists.

This study was approved by the University of Pennsylvania institutional review board. The researchers were not involved in CPOE system design, installation, or operation.

Data Collection
Intensive One-on-One House Staff Interviews. To develop our initial questions, we conducted 14 one-on-one house staff interviews. An experienced sociologist (R.K.) conducted the open-ended interviews, focusing on stressors and other prescribing-error sources (mean interview time, 26 minutes; range, 14-66 minutes).

Focus Groups. We conducted 5 focus groups with house staff on sources of stress and prescribing errors, moderated by an experienced sociologist (R.K.) and audiorecorded. Participants were reimbursed $40 (average group size, 10; range, 7-18; and average length, 1.75 hours; range, 1.4-2 hours).

Expert Interviews. We interviewed the surgery chair, pharmacy and technology directors, clinical nursing director, 4 nurse-managers, 5 nurses, an infectious disease fellow, and 5 attending physicians. All interviews, except 1, were privately conducted by the same investigator (R.K.).

Shadowing and Observation. During a discontinuous 4-month period (2002-2003), we shadowed 4 house staff, 3 attending physicians, and 9 nurses engaged in patient care and CPOE use. We observed 3 pharmacists reviewing orders. The researcher (R.K.) wore a faculty identification badge. Observation notes were freehand but guided by the interview findings.

Survey. From 2002 to the present, we distributed structured, self-adminis-
tered questionnaires to house staff who order medications via CPOE. The 71-item questionnaire focused on working conditions and sources of error and stress. We report here on 10 CPOE-related questions. We constructed the survey after our interviews and focus groups, leading us to provide separate answer options about sources of error and sources of stress; add questions on CPOE as a possible source of error risk, an issue that emerged in our qualitative research; and quantify the frequency of these error risks. Not all CPOE-related error risks are amenable to survey questions. We have robust survey results on 10 of the 22 identified error risks; these findings are presented with the qualitative findings.

The sampled population (N=291) included house staff who typically enter more than 9 medication orders per month. The target study population excluded 648 residents in services that seldom use CPOE: pathology, podiatry, occupational medicine, anesthesia, radiology, radiation oncology, ophthalmology, and dermatology.

More than 70% of the questionnaires were administered at routine house staff meetings. Other house staff were located via departmental coordinators or pagers. Participants received $5 coupons for local coffee shops. Two hundred sixty-one house staff (88% of the target population) completed the questionnaire.

**RESULTS**

Characteristics of the house staff were as follows. Of 94 interns contacted, 85 (90.4%) participated; of 96 second-year residents, 84 (87.5%) participated; and of 107 third- through fifth-year residents, 92 (85.9%) participated. The participating sample was 44.8% female, 66.3% white, and 32.5% were interns. Participants’ mean age was 29.6 years. These data did not differ significantly from characteristics of nonparticipants.

Our qualitative and quantitative research identified 22 previously unexplored medication-error sources that users report to be facilitated by CPOE. We group these as (1) information errors generated by fragmentation of data and failure to integrate the hospital’s several computer and information systems and (2) human-machine interface flaws reflecting machine rules that do not correspond to work organization or usual behaviors.

### Information Errors: Fragmentation and Systems Integration Failure

**Assumed Dose Information.** House staff often rely on CPOE displays to determine minimal effective or usual doses. The dosages listed in the CPOE display, however, are based on the pharmacy’s warehousing and purchasing decisions, not clinical guidelines. For example, if usual dosages are 20 or 30 mg, the pharmacy might stock only 10-mg doses, so 10-mg units are displayed on the CPOE screen. Consequently, some house staff order 10-mg doses as the usual or “minimally effective” dose. Similarly, house staff often rely on CPOE displays for normal dosage ranges.

House staff regularly use CPOE to determine dosages (Table). In the last 3 months, 73% of house staff reported using CPOE displays to determine low doses for medications they did not usually prescribe; 82% used CPOE displays to determine range of doses (Table). Two fifths (38%-41%) used CPOE displays to determine dosages at least a few times weekly; 10% to 14% used CPOE displays in this misleading way daily.

**Medication Discontinuation Failures.** Ordering new or modifying existing medications is usually a separate process from canceling (“discontinuing”) medications is usually a separate process from canceling (“discontinuing”)

### Table. Frequencies of Reported Medication Ordering Errors and Error Risks Involving the CPOE System (n = 261 Respondents)

<table>
<thead>
<tr>
<th>Error Type</th>
<th>Error Frequency During Past 3 Months, %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Errors</strong></td>
<td></td>
</tr>
<tr>
<td>Used CPOE to determine low dose for infrequently used medications</td>
<td>27.3</td>
</tr>
<tr>
<td>Used CPOE to determine the range of doses for infrequently used medications</td>
<td>18.5</td>
</tr>
<tr>
<td>Delayed for several hours canceling medication because of fragmented CPOE display</td>
<td>48.6</td>
</tr>
<tr>
<td>Observed a gap in antibiotic therapy because of unintended delay in reapproval of antibiotic</td>
<td>16.9</td>
</tr>
<tr>
<td><strong>Human-Machine Interface Flaws</strong></td>
<td></td>
</tr>
<tr>
<td>Not able to quickly tell which patients ordering for because of poor CPOE display</td>
<td>45.4</td>
</tr>
<tr>
<td>Been uncertain about patients’ medications because of multiple CPOE displays</td>
<td>28.5</td>
</tr>
<tr>
<td>Delayed ordering because CPOE system down</td>
<td>16.3</td>
</tr>
<tr>
<td>Had difficulty specifying medications and problems ordering off-formulary medications</td>
<td>8.5</td>
</tr>
</tbody>
</table>

Abbreviation: CPOE, computerized physician order entry.

*Generated by fragmentation of data and failure to integrate the hospital’s several computer and information systems.
†A reflection of machine rules that do not correspond to work organization or usual behaviors.

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an existing medication. Without dis-
continuing the current dose, physi-
cians can increase or decrease medica-
tion (giving a “double” total dose, eg, 
every 6 hours and every 8 hours), add 
new but duplicative medication, and 
add conflicting medication. Medication-
canceling ambiguities are exacerbated 
by the computer interface and multiple-
screen displays of medications; as dis-
cussed below, viewing 1 patient’s medica-
tions may require 20 screens.

Discontinuation failures “for at least 
several hours” from not seeing pa-
tients’ complete medication records 
were reported by 51% (Table). Twenty-
two percent indicated that this failure 
occurs a few times weekly, daily, or more 
frequently.

Procedure-Linked Medication Dis-
continuation Failures. Procedures and 
certain tests are often accompanied by 
medications. If procedures are can-
celed or postponed, no software link au-
tomatically cancels medications.

Immediate Orders and Give-as-
Needed Medication Discontinuation 
Faults. NOW (immediate) and PRN 
give as needed) orders may not enter the 
usual medication schedule and are sel-
dom discussed at handoffs. Also, because 
mistakes in charting is so cumbersome 
and displays so fragmented, NOW and 
PRN orders are less certain to be charted 
or canceled as directed. Failure to chart 
or cancel can result in unintended med-
cations on subsequent days or reorder-
ing (duplications) on the same day.

Antibiotic Renewal Failure. To maxi-
mize appropriate antibiotic prescrib-
ing, house staff are required to obtain ap-
proval by infectious disease fellows or 
specialist pharmacists. Lack of coordi-
nation among information systems, how-
ever, can produce gaps in therapy be-
cause antibiotics are generally approved 
for 3 days. Before the third day, house staff 
should request continuation or modifi-
cation. To aid this process, reapproval 
scraps are placed on paper charts on the 
second day. However, when house staff 
order medications, they primarily use 
electronic charts, thus missing warning 
stickers. No warning is integrated into 
the CPOE system, and ordering gaps ex-
pand until noticed. Some unintentional 
“gaps” continue indefinitely because it 
is unknown whether antibiotics were in-
tentionally halted. In the last 3 months, 
83% of house staff observed gaps in anti-
biotic therapy because of unintended 
delays in reapproval. Twenty-seven per-
cent reported this occurrence a few times 
weekly; 13%, once daily or more fre-
quently (Table).

Diluent Options and Errors. A re-
cent CPOE innovation requires house 
staff to specify diluents (eg, saline so-
lution) for administering antibiotics. A 
few diluents interact with antibiotics, 
generating precipitates or other prob-
lems. Many house staff are unaware of 
impossible combinations. Pharma-
cists catch many such errors, but their 
terventions are time-consuming and not 
ensured.

Allergy Information Delay. CPOE 
provides feedback on drug allergies, but 
only after medications are ordered. Some house staff ignored allergy no-
tices because of rapid scrolling through 
screens, the need to order many medi-
cations, difficulties discontinuing and 
reordering medications, possibility of 
false allergy information, and, most im-
portant, post hoc timing of allergy in-
formation. House staff claimed post hoc 
alerts unintentionally encourage house 
staff to rely on pharmacists for drug-
allergy checks, implicitly shifting re-
sponsibility to pharmacists.

Conflicting or Duplicative Medi-
cations. The CPOE system does not 
display information available on other 
hospital systems. For example, only the 
pharmacists computer provides drug in-
teraction and lifetime limit warnings. Phar-
macists call house staff to clarify ques-
tionable orders, but this additional step 
costs time and increases error potential. 
House staff and pharmacists reported that 
this method generates tension.

Human-Machine Interface Flaws: 
Machine Rules That Do Not 
Correspond to Work Organization 
or Usual Behaviors

Patient Selection. It is easy to select the 
wrong patient file because names and 
drugs are close together, the font is small, 
and, most critical here, patients’ names 
do not appear on all screens. Different 
CPOE computer screens offer differ-
ing colors and typefaces for the same 
information, enhancing misinterpre-
tion as physicians switch among 
screens.

Patients’ names are grouped alpha-
betically rather than by house staff 
teams or rooms. Thus, similar names 
(combined with small fonts, hectic 
workstations, and interruptions) are 
easily confused.

Fifty-five percent of house staff re-
ported difficulty identifying the pa-
tient they were ordering for because of 
fragmented CPOE displays; 23% re-
ported that this happened a few times 
weekly or more frequently (Table).

Wrong Medication Selection. A pa-
tient’s medication information is sel-
dom synthesized on 1 screen. Up to 20 
screens might be needed to see all of a 
patient’s medications, increasing the like-
lihood of selecting a wrong medication.

Seventy-two percent of house staff re-
ported that they were often uncertain 
about medications and dosages be-
cause of “difficulty in viewing all the 
medications on 1 screen.”

Unclear Log On/Log Off. Physi-
cians can order medications at com-
puter terminals not yet “logged out” by 
the previous physician, which can re-
sult in either unintended patients re-
cieving medication or patients not re-
cieving the intended medication.

Failure to Provide Medications 
After Surgery. When patients un-
dergo surgery, CPOE cancels their pre-
vious medications. When surgeons or-
der new or renewed medications, 
however, the orders are “suspended” 
(not sent to the pharmacy) until “acti-
vated” by postanesthesia-care nurses. 
But these “activations” still do not dis-
perse medications. Physicians must re-
enter CPOE and reactivate each previ-
ously ordered medication. Surgery 
residents reported that they some-
times overlooked this extra process.

Postsurgery “Suspended” Medi-
cations. Physicians ordering medica-
tions for postoperative patients whom 
they actually observe on hospital floors
can be deceived by patients' real location vs patients' computer-listed location. If patients were not logged out of postanesthesia care, the CPOE will not process medication orders, labeling them “suspended.” Physicians must negotiate the CPOE and resubmit orders for patients to receive postsurgical medications.

Loss of Data, Time, and Focus When CPOE Is Nonfunctional. CPOE is shut down for periodic maintenance, and crashes are common. Backup systems prevent loss of data previously entered. However, orders being entered when the system crashes are lost and cannot be reentered until the system is restarted. House staff reported that the need to wait for the system's revival and order reentry increases error risks.

Eighty-four percent reported delayed medication orders because of system shutdowns. Forty-seven percent reported that shutdowns occur a few times weekly to more than once daily (Table). The CPOE manager confirmed house staff downtime estimates; 2 or 3 weekly crashes of at least 15 minutes are common.

Sending Medications to Wrong Rooms When the Computer System Has Shut Down. If the computer system is down when a patient is moved within the hospital, CPOE does not alert the pharmacy, and medications are sent to the “old” room, thus being lost or delayed. Also, wrong medications might be administered to “new” patients in “old” rooms.

Late-in-Day Orders Lost for 24 Hours. When patients leave surgery or are admitted late in the day, medications and laboratory orders might be requested for “tomorrow” at, for example, 7 AM. By the time the intern enters the orders, however, it might already be “tomorrow” (ie, after midnight). Therefore, patients do not receive medications or tests for an extra day.

Role of Charting Difficulties in Inaccurate and Delayed Medication Administration. Nurses are required to record (chart) administration of medications contemporaneously. However, contemporaneous charting requires time when there is little time available. Computerized physician order entry systems compound this challenge considerably. To chart drug administrations, nurses must stop administering medications, find a terminal, log on, locate that patient’s record, and individually enter each medication’s administration time. If medications are not administered (eg, patient was out of the room), nurses must scroll through several additional screens to record the reason(s) for nonadministration.

Nurses reported that up to 60% of their medications are not recorded contemporaneously but are charted at shift end or post hoc by the nurse manager via global computer commands.

Many house staff, aware of recording inaccuracies, seek nurses to determine real administration times of time-sensitive drugs (eg, aminoglycosides). House staff reported that these additional steps are distracting and time-consuming. Interrupted ordering or medication reviews can increase error risks.

Moreover, because of cumbersome charting, some medications, especially insulin, are recorded on parallel systems (ie, paper chart, separate paper sheets, or directly in CPOE). Multiple systems cause confusion, and off-system information is sometimes lost.

Inflexible Ordering Screens, Incorrect Medications. House staff reported that because of CPOE inflexibility, nonstandard specifications (eg, test modifications or specific scan angles) are often impossible to enter. Medications accompanying procedures must be stopped and reordered, with dangers linked to uncertain canceling and reordering.

Similarly, nonformulary medications can be lost because they must be entered on separate screen sections, might not be sent to the pharmacy, and might escape nurses’ notice (eg, nonformulary medication to prevent organ rejection was not listed among medications in CPOE, was not sent to the pharmacy, and was ignored for 6 days).

Ninety-two percent reported that CPOE is inflexible, generating difficulties in specifying medications or ordering off-formulary medications. Thirty-one percent reported that this occurred a few times weekly; 24% said daily or more frequently (Table).

COMMENT

Our qualitative research identified 22 situations in which CPOE increased the probability of prescribing errors. Our quantitative data reveal that several CPOE-enhanced error risks appear common (ie, observed by 50% to 90% of house staff) and frequent (ie, repeatedly observed to occur weekly or more often). We broadly grouped the error risks as information errors generated by fragmentation of data and failure to integrate the hospital’s several computer and information systems (10 error types) and human-machine interface flaws reflecting machine rules that do not correspond to work organization or usual behaviors (12 error types). Although this schema is not exhaustive, it informs both administrative and programming solutions.

Perhaps CPOE-facilitated error risks received limited attention because the methodologies and loci of previous studies addressed CPOE’s role in error reduction and seldom its role in error facilitation. One key study examined errors but was entirely qualitative, with no frequency estimates. Other reasons CPOE’s problems may have escaped larger examination include the orientation of medical personnel to solve or work around problems, beliefs that problems are due to insufficient training or noncompliance, erratic error-reporting mechanisms, and focus on technology rather than on work organization. Our multimethod, triangulated approach explored wider ranges of CPOE’s effects.

That CPOE use might increase the likelihood of medication errors was an unanticipated finding, which would not have surfaced without open-ended qualitative research. Survey data provided a different type of validation and strengthened our confidence in the findings. Our error risk frequency es-

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advantages of CPOE systems, researchers are looking at only one edge of the sword. This limitation is especially noteworthy because many problems we identified are easily corrected.

Our recommendations concentrate on organizational factors. (1) Focus primarily on the organization of work, not on technology; CPOE must determine clinical actions only if they improve, or at least do not deteriorate, patient care. (2) Aggressively examine the technology in use; problems are obscured by workarounds, the medical problem-solving ethos, and low house staff status. (3) Aggressively fix technology when it is shown to be counterproductive because failure to do so engenders alienation and dangerous workarounds in addition to persistent errors; substitution of technology for people is a misunderstanding of both. (4) Pursue errors’ “second stories” and multiple causations to surmount the barriers caused by episodic and incomplete error reporting, which is standard, and management belief in these error reports, which obscures and compounds problems. (5) Plan for continuous revisions and quality improvement, recognizing that all changes generate new error risks.

In our work, use of multiple qualitative and survey methods identified and quantified error risks not previously considered, offering many opportunities for error reduction. As CPOE systems are implemented, clinicians and hospitals must attend to the errors they cause, in addition to the errors they prevent.

Author Contributions: Dr Koppel had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Koppel, Metlay, Localio, Kimmel, Strom. Acquisition of data: Koppel, Cohen, Abulack, Localio. Analysis and interpretation of data: Koppel, Cohen, Abulack, Localio. Drafting of the manuscript: Koppel, Cohen. Critical revision of the manuscript for important intellectual content: Koppel, Metlay, Cohen, Abulack, Localio, Kimmel, Strom. Statistical analysis: Koppel, Cohen. Obtained funding: Koppel, Metlay, Localio, Kimmel, Strom. Administrative, technical, or material support: Koppel, Cohen, Localio, Strom. Study supervision: Koppel, Cohen, Strom.

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