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Examining Causes, Consequences, and Interventions to Address E-Prescribing Errors in Community Pharmacies

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Objectives	
1) Characterize e-prescribing errors, contributing factors and their potential consequences	
2) Examin	e the process of addressing e-prescribing errors in community pharmacies and work system factors
facilitate or hinder this process	
3) Identify	v interventions to reduce e-prescribing errors encountered in community pharmacies
Methods	
Design	• The project was conducted in two phases. The first phase consisted of using observations and interviews to identify common e-prescribing errors, contributing factors, and their potential consequences on patients and pharmacies.
	 The second phase involved two focus separate focus groups with pharmacists and pharmacy technicians to explore work system factors that influence prevention of e-prescribing errors and potential interventions to improve e-prescribing safety.
	• Field notes and transcripts from interviews and focus groups were subjected to content and thematic analysis to arrive at study findings.
Study	Common e-prescribing errors detected in community pharmacies
endpoints	Strategies used by pharmacies to prevent e-prescribing errors
	Interventions to improve e-prescribing safety
Results • Four main types of e-prescribing errors detected in community pharmacies includde: wrong drug quantity,	
 Four main types of e-presenting errors detected in community pharmacies mendade, wrong duig quantity, wrong dosing directions, wrong duration of therapy, and wrong dosage formulation. Factors that contributed to e-prescribing errors included technological incompatibility between the pharmacy and clinic systems, and usability issues that could lead to incorrect drug or patient information, such as, autopopulate features and dropdown menus. E-prescribing errors could have negative consequences for patients, such as, poor disease management or failed drug therapy. Most e-prescribing errors were detected by pharmacy personnel during the inputting of e-prescription information into the pharmacy system by using strategies such as printing to paper and verifying information on the computer screen with information on the printed e-prescription. Pharmacy personnel addressed detected e-prescribing errors by carefully reviewing patients' medication history, making educated guesses of prescribers' intent, or contacting prescriber offices via telephone or fax. Work system factors related to people, tasks, environment, tools/technologies, and the organization play a significant role in making prevention of e-prescribing errors either easier or harder. 	
Conclusion	
This research sheds light on the important role that community pharmacy personnel play in preventing and mitigating e-prescription errors. Findings suggest that implementation of health information technology like e-prescribing does not always yield improved patient safety but instead can introduce new kinds of safety hazards that need to be studied and addressed.	