# **Patient Safety Alert**

## Veterans Health Administration Warning System Published by VA Central Office

AL09-19 April 3, 2009

Item: CPRS – Changing Medication Schedule may Leave Incorrect

**Medication Administration Times** 

**Specific Incidents:** A medication had a defaulted schedule of QID (four times a day),

with administration times of 9am, 1pm, 5pm and 9pm (0900, 1300, 1700 and 2100). When the CPRS user typed BID (twice a day) to change the schedule and then pressed the <Enter> key, the four QID administration

times remained stored with the order, instead of only the two BID administration times of 9am and 5pm (0900 and 1700). (See

Attachment 1). This problem has existed in prior versions of CPRS and was reported at a VAMC. This problem may lead to underdosing or overdosing of medications. We are not aware of any patient harm at this

time.

**General Information:** Within VistA Inpatient Medications software, facilities may establish a

default schedule for particular medications. This provides the ability for CPRS to present the clinical user with a preselected medication schedule. If the CPRS user changes the medication schedule by **TYPING** a different schedule and presses the <Enter> key, the administration times associated with the schedule may be incorrectly

assigned to the medication order. (See Attachment 2).

Actions: 1. By close of business (COB) April 6, 2009, the Facility Director shall

ensure that all CPRS users and Pharmacy staff are aware of this

Patient Safety Alert.

2. By COB April 6, 2009, CPRS users that are changing the medication

schedule shall select the new schedule from the defined list. (See

Attachment 3)

3. By COB April 6, 2009, Pharmacy staff while finishing a medication order shall ensure the number of "Admin Times" correlate to the intended "Schedule" when the message "PLEASE NOTE: This order's admin times (xxxx) do not match the ward times (yy) for this administration askedule (777)" is displayed. Pharmacy at the

this administration schedule (zzz)" is displayed, Pharmacy staff shall use the "Shift 6" (i.e. "^") key to abort processing and edit the

order appropriately. (See Attachment 4)

4. By COB April 6, 2009, the Patient Safety Manager shall document the status of this Patient Safety Alert on the VHA Hazardous Recalls/Alerts website.

http://vaww.nbc.med.va.gov/visn/recalls/index.cfm

Additional Information: An updated CPRS version, expected release June 2009, will prevent

saving a medication order if the schedule has not been selected from the

defined list. An Inpatient Pharmacy Patch PSJ\*5\*113 will provide

additional medication schedule validation. The estimated release date for

PSJ\*5\*113 is not yet determined.

Source: Multiple VA medical facilities

**Attachments:** 1) Incorrect CPRS Inpatient Medication Administration Times Order

Schedule Selection

2) Detailed display illustrating incorrect administration times assigned to

a CPRS Inpatient Medication Order

3) Correct CPRS Inpatient Medication Schedule Selection

4) Inpatient Pharmacy Finishing Notification

Contacts: Nancy Smestad, MS RPH at VHA Office of Information Patient Safety

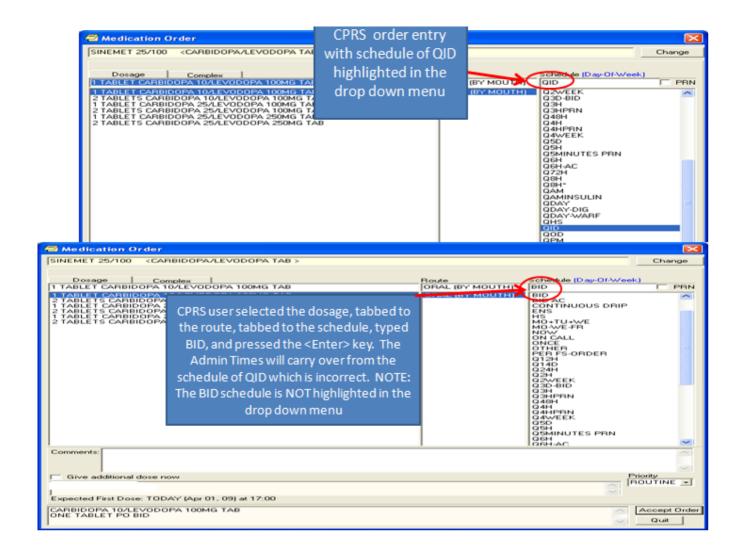
(701) 239-3700 ext 93802, or

Jeanie Scott at VHA Office of Information Patient Safety (518) 605-6543

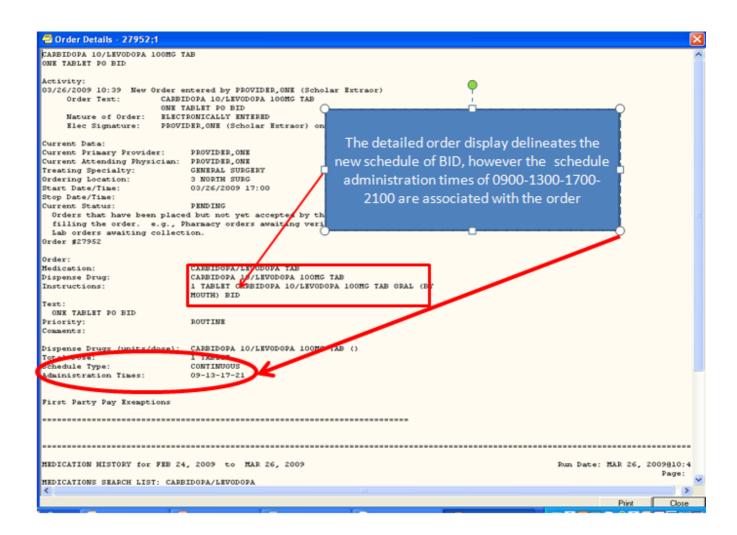
or

Tom Bauld at VA National Center for Patient Safety (734) 930-5861.

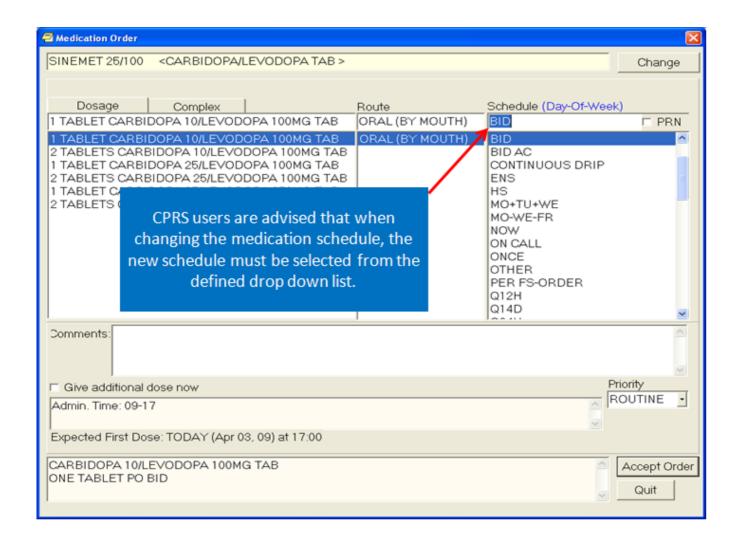
### ATTACHMENT 1: Incorrect CPRS Inpatient Medication Administration Times Order Schedule Selection



## ATTACHMENT 2: Detailed display illustrating incorrect administration times assigned to a CPRS Inpatient Medication Order



#### **ATTACHMENT 3: Correct CPRS Inpatient Medication Schedule Selection**



#### **ATTACHMENT 4: Inpatient Pharmacy Finishing Notification**

