

# 1 Problem

What When	Problem(s)	Missing alert; potential for missed testing
	Date	November 2009 to February 2013
	Time	N/A
Where	Different, unusual, unique	Internal code for drug changed
	Facility, site	Hospital
	Unit, area, equipment	Clinical decision support system (CDSS)
	Task being performed	Evaluation of patients treated with amiodarone

## Impact to the Goals

<b>Patient Safety</b>	Potential for untreated thyroid issues
<b>Patient Services</b>	Potential for missed thyroid testing

Frequency	93% of surveyed Medical Information Officers experienced at least 1 CDSS malfunction
-----------	--

# CDSS CHANGE IMPACTS PATIENT SAFETY

## Programming Error Leads to Missed Alert

Cause Map

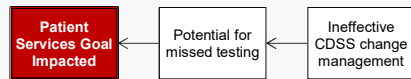
Clinical decision support systems (CDSS) aim to improve health care quality, safety and effectiveness by providing alerts to providers based on criteria (such as identifying drug interactions). However, a malfunctioning CDSS can actually reduce patient safety when physicians rely on these alerts.

"CDSS malfunctions are widespread and often persist for long periods. The failure of alerts to fire is particularly difficult to detect. A range of causes, including changes in codes and fields, software upgrades, inadvertent disabling or editing of rules, and malfunctions of external systems commonly contribute to CDSS malfunctions, and current approaches for preventing and detecting such malfunctions are inadequate."

- Analysis of clinical decision support system malfunctions: a case series and survey  
 Adam Wright, Thu-Trang T. Hickman, Dustin McEvoy, Skye Aaron, Angela Ai, Jan Marie Andersen, Salman Hussain, Rachel Ramoni, Julie Fiskio, Dean F. Sittig, David W. Bates  
 Journal of the American Medical Informatics Association Mar 2016, DOI:10.1093/jamia/ocw005

# 2 Analysis

**Basic Level Cause Map** - Start with simple Why questions.



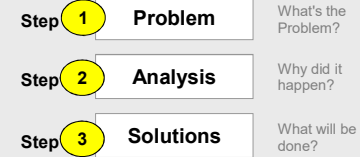
**Basic Cause-and-Effect**

The CDSS malfunction in this case study involved a stopped alert for annual thyroid testing in patients prescribed amiodarone. When the issue was noticed and resolved in February 2013, it was determined that the alert had been stopped since November 2009, when the internal code for the drug amiodarone was changed.

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

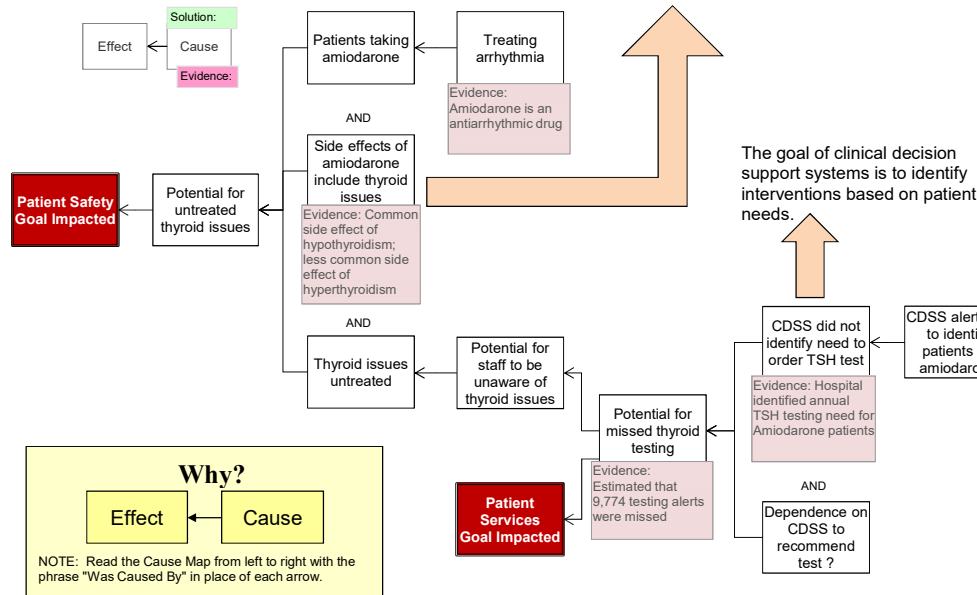
## CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis



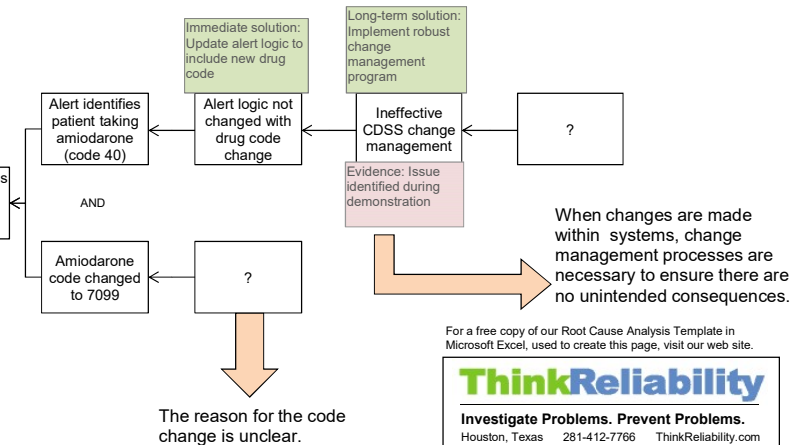
**More Detailed Cause Map** - Add detail as information becomes available.

Many medications have side effects that require ongoing



# 3 Solutions

The issue was identified during a demonstration of this particular feature of the CDSS and fixed the next day. While the details aren't known, this issue identifies an ineffective change management program. When changes are made within systems, change management processes are necessary to ensure there are no unintended consequences. While updating the amiodarone code in the alert logic fixed this particular problem, a robust change management program is necessary to ensure that there are no other unintended consequences that could affect patient safety.



For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

**ThinkReliability**  
 Investigate Problems. Prevent Problems.  
 Houston, Texas 281-412-7766 ThinkReliability.com