

Patient Safety Tip of the Week

January 30, 2018 Texting Errors Revealed

When Joint Commission considered allowing texting of orders we took an immediate stance against the practice (see our May 24, 2016 Patient Safety Tip of the Week “[Texting Orders – Is It Really Safe?](#)”), citing numerous opportunities for error and misinterpretation with texted orders.

Joint Commission reconsidered (see our January 2017 What’s New in the Patient Safety World column “[Joint Commission Thinks Twice About Texting Orders](#)”) and, thankfully, reimposed its ban on texted orders.

Then in our June 27, 2017 Patient Safety Tip of the Week “[Texting – We Told You So!](#)” we began to show examples of the pitfalls of texted orders.

Now ISMP ([ISMP 2017a](#)) has accumulated many more examples of patient safety issues created by texting. ISMP did an extensive survey of its readership and identified some interesting findings. First, while 33% of the total healthcare professionals surveyed felt that texted orders should not be allowed under any circumstance, 55% of medication/patient safety officers and risk/quality managers felt they should not be allowed under any circumstance. Not surprisingly, physicians were the group least concerned about the safety of texted orders.

Particularly bothersome was the finding that, despite most hospitals having policies banning texted orders, the practice continues. And many, if not most, texted orders are being sent without encryption.

Another interesting wrinkle is that pharmacists and nurses often communicate with prescribers via text messages for clarification of orders. And the person entering the order into the electronic medical record or ordering system often does not indicate the source of the order was a text message.

Some of the problems associated with texting are ones we noted in our original May 24, 2016 Patient Safety Tip of the Week “[Texting Orders – Is It Really Safe?](#)”. For example, we speculated that the **autocorrect** feature on most smartphones might change the intended word(s) to something else. Most respondents to the ISMP survey felt that the autocorrect feature should be disabled on any smartphone used for texting orders.

Common texting **abbreviations** are a threat. We’ve spoken before about the example of a texted “2day” (meaning “today”) getting misinterpreted as “two daily” ([ISMP 2009](#)). ISMP provided some other examples of errors related to texted abbreviations last summer ([ISMP 2017b](#)) and the latest ISMP survey ([ISMP 2017a](#)) uncovered a new one: the text

abbreviation “BTW” (meaning “by the way”) was misinterpreted as meaning “twice daily”.

The potential for **patient misidentification** is serious, not only because the sender may not be seeing the patient medical record, but because the sender may not have access to the second identifier (eg. date of birth) that would be used in verification of patient identity. One example given was a texted order to “discharge patient in Room xxx” when the intended patient had previously been transferred to a different room.

Misspellings and **incomplete orders** were also cited in the survey as special concerns. Misspellings are a particular concern for patient names and drug names (particularly for those drugs that sound alike). ISMP notes that, unlike selecting drugs and doses from a drop-down menu in CPOE, most texted orders must be entered as free-text or via a voice-recognition feature that may be misheard and, thus, misspell words, including drug names. Similarly, orders entered via free text are more likely to omit all the required elements of a complete order.

Texting orders or any health information to the wrong person is a serious issue. Remember when we told a story about patient orders being faxed to the local supermarket? Well the ISMP survey revealed a case of an order being texted to someone outside the hospital. We all laugh about “butt dialing” the wrong person and we’ve all probably done that a few times on our cell phones. What if we mistakenly enter orders (or any PHI) in a message that we send to the wrong phone number?

We all like the convenience of texting and the fact that such a form of asynchronous communication helps us avoid playing telephone tag and save time. But that very **asynchronous nature of texting** can give rise to problems when **urgency** is an issue. In our February 9, 2016 Patient Safety Tip of the Week [“It was just a matter of time...”](#) we discussed a case where an alarm alert message went to the wrong person (a person who was not the responsible party to respond to that alarm alert). When you text a message that requires an urgent response you need some way of verifying that the responsible party has received and acknowledged the message and is responding appropriately.

“Range of urgency” was one of the themes identified in the study by Luxenberg and colleagues ([Luxenberg 2017](#)) that we discussed in our June 27, 2017 Patient Safety Tip of the Week [“Texting – We Told You So!”](#). You’ll recall they looked at a sample of text messages on an internal medicine service at UCSF. The vast majority (93%) of text messages were non-urgent. But most did not indicate the **degree of urgency** or the **expected response**. For example, some text messages had a tag “FYI” (for your information) but actually asked a question in the body of the text message for which a response was expected.

And here’s another problem. You’ve heard us say that, when we ask nurses how they identify a person calling in verbal orders, the usual response is “we recognize their voice”. Well, the problem is even worse with texted orders. **How do you really know who is on the sending end of a texted order?** So **any texted communication** (not just

orders) must be done over a secure system where you can verify the identity of the text sender. Regrettably, that does not protect against the owner of the device sending the text from giving his/her password to someone else. But, of course, the same problem (sharing passwords) exists with CPOE or any EMR system.

And, while we all assume that texting reduces telephone tag and saves us time, we know of no studies in healthcare that confirm that. It is possible that the terse nature of text messages might actually lead to **telephone tag** since clarification of some questions and responses may require such phone communication.

ISMP disagreed with comments from some survey respondents who thought that texting might be safer than verbal or telephone orders. ISMP noted that at least with verbal or telephone orders the person receiving the communication must **read back** the order for clarification, accuracy and understanding. (See also our January 10, 2012 Patient Safety Tip of the Week “[Verbal Orders](#)”.)

See our May 24, 2016 Patient Safety Tip of the Week “[Texting Orders – Is It Really Safe?](#)” and our January 2017 What's New in the Patient Safety World column “[Joint Commission Thinks Twice About Texting Orders](#)” for all the areas of concern we had regarding texted orders:

- Bypassing clinical decision support tools
- Taking the easy way and avoiding CPOE as a shortcut
- Ordering in a vacuum (without important clinical information in the chart that might impact orders)
- Promoting telephone tag
- Failure to allow the recipient to ask appropriate questions
- AutoText/AutoCorrect issues
- Security issues
- HIPAA issues

We applaud the strong stance against texting orders that ISMP ([ISMP 2017a](#)) has clearly taken: “The texting of medication-specific orders should not be allowed until the safety issues have been identified and resolved through advanced technology along with the development of vetted, industry-wide clinical guidelines that can be employed in organizations to ensure standardized, safe, and secure texting processes. Leadership must establish and communicate policies on the texting of orders and take a strong stance on avoiding texted medication-specific orders at this time until they can be safely introduced into healthcare through careful pilot testing and implementation plans.”

And CMS (Centers for Medicare & Medicaid Services) also recently issued a clarification about its stance on texting ([CMS 2017](#)). “**CMS does not permit the texting of orders** by physicians or other health care providers. The practice of texting orders from a provider to a member of the care team is not in compliance with the Conditions of Participation (CoPs) or Conditions for Coverage (CfCs).“

CMS recognizes CPOE (Computerized Provider Order Entry) as the preferred method of order entry and reaffirms that a physician or Licensed Independent Practitioner (LIP) should enter orders into the medical record via a hand written order or via CPOE.

CMS does recognize that the use of texting as a means of communication with other members of the healthcare team has become a reality. So for communications other than orders it allows texting but specifies that “all providers must utilize and maintain systems/platforms that are secure, encrypted, and minimize the risks to patient privacy and confidentiality as per HIPAA regulations”. CMS also expects that providers/organizations “will implement procedures/processes that routinely assess the security and integrity of the texting systems/platforms that are being utilized, in order to avoid negative outcomes that could compromise the care of patients.”

We all like the convenience of texting and the fact that such a form of asynchronous communication may help us save time in certain circumstances. But in healthcare we need to take every precaution to avoid allowing texting to contribute to medical errors and adverse patient outcomes. Every healthcare organization needs to comply with The Joint Commission and CMS bans on texting orders. Moreover, doing in your organizations the sort of in-depth review of texting practices that UCSF did ([Luxenberg 2017](#)) or addressing the issues raised in the ISMP studies and our prior columns may prove eye-opening.

See our other Patient Safety Tip of the Week columns dealing with texting:

- February 9, 2016 “[It was just a matter of time...](#)”
- May 24, 2016 “[Texting Orders – Is It Really Safe?](#)”
- January 2017 “[Joint Commission Thinks Twice About Texting Orders](#)”
- June 27, 2017 “[Texting – We Told You So!](#)”

See some of our other Patient Safety Tip of the Week columns dealing with unintended consequences of technology and other healthcare IT issues:

- June 19, 2007 “[Unintended Consequences of Technological Solutions](#)”
- May 20, 2008 “[CPOE Unintended Consequences – Are Wrong Patient Errors More Common?](#)”
- June 17, 2008 “[Technology Workarounds Defeat Safety Intent](#)”
- August 26, 2008 “[Pattern Recognition and CPOE](#)”
- September 9, 2008 “[Less is More....and Do You Really Need that Decimal?](#)”
- December 16, 2008 “[Joint Commission Sentinel Event Alert on Hazards of Healthcare IT](#)”
- February 2009 “[Healthcare IT The Good and The Bad](#)”
- March 3, 2009 “[Overriding Alerts...Like Surfin’ the Web](#)”

- October 2009 “[A Cautious View on CPOE](#)”
- November 24, 2009 “[Another Rough Month for Healthcare IT](#)”
- April 20, 2010 “[HIT’s Limited Impact on Quality To Date](#)”
- March 22, 2011 “[An EMR Feature Detrimental to Teamwork and Patient Safety](#)”
- January 24, 2012 “[Patient Safety in Ambulatory Care](#)”
- June 26, 2012 “[Using Patient Photos to Reduce CPOE Errors](#)”
- June 2012 “[Leapfrog CPOE Simulation: Improvement But Still Shortfalls](#)”
- July 17, 2012 “[More on Wrong-Patient CPOE](#)”
- January 2013 “[More IT Unintended Consequences](#)”
- April 30, 2013 “[Photographic Identification to Prevent Errors](#)”
- October 8, 2013 “[EMR Problems in the ED](#)”
- March 11, 2014 “[We Miss the Graphic Flowchart!](#)”
- October 2014 “[Ebola Exposes Fundamental Flaw](#)”
- January 2015 “[Beneficial Effect of EMR on Patient Safety](#)”
- March 2015 “[CPOE Fails to Catch Prescribing Errors](#)”
- March 31, 2015 “[Clinical Decision Support for Pneumonia](#)”
- August 2015 “[Newborn Name Confusion](#)”
- December 2015 “[Opioid Alert Fatigue](#)”
- January 12, 2016 “[New Resources on Improving Safety of Healthcare IT](#)”
- January 19, 2016 “[Patient Identification in the Spotlight](#)”
- February 9, 2016 “[It was just a matter of time...](#)”
- April 5, 2016 “[Workarounds Overriding Safety](#)”
- May 2016 “[Name Confusion in the Pharmacy](#)”
- May 3, 2016 “[Clinical Decision Support Malfunction](#)”
- May 24, 2016 “[Texting Orders – Is It Really Safe?](#)”
- August 23, 2016 “[ISMP Canada: Automation Bias and Automation Complacency](#)”
- November 22, 2016 “[Leapfrog, Picklists, and Healthcare IT Vulnerabilities](#)”
- January 2017 “[Joint Commission Thinks Twice About Texting Orders](#)”
- February 28, 2017 “[The Copy and Paste ETTO](#)”
- March 2017 “[Yes! Another Voice for Medication e-Discontinuation!](#)”
- April 2017 “[How Much Time Do We Actually Spend on the EMR?](#)”
- June 27, 2017 “[Texting – We Told You So!](#)”
- August 1, 2017 “[Progress on Wrong Patient Orders](#)”

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