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PHARMACY ERROR PROBABLE CAUSE OF PCEHR PROBLEM

WRITTEN BY KATE MCDONALD ON 27 MAY 2013.

Further investigations into how two incorrect prescriptions were added to the PBS section of a *Pulse+IT* journalist's PCEHR have shown that it was most probably an error at a local pharmacy, one that has since been compounded when repeat scripts were dispensed from a different pharmacy a month later.

As we reported recently, I discovered that two prescriptions had been added to my PCEHR in February. The prescriptions were for drugs that had never been prescribed for me, and were for medical conditions I do not have.

The prescriptions were written on March 12, 2012, and came with a number of repeats for each drug. Two of those repeat scripts were dispensed from my local pharmacy on January 4, 2013, and the details then found their way onto the PBS section of my PCEHR in February, although there were no corresponding MBS items on my record ...ing that a consultation had taken place.

After publishing the story, I was contacted by the eHealth team from the Department of Human Services (DHS), who told me they were investigating the problem as a matter of urgency. I had also reported that I had been unable to rectify the problem through the PCEHR help desk, which could not verify my identity over the phone.

The DHS representatives told me that the two prescriptions had been dispensed from my regular pharmacy, and encouraged me to approach it to investigate further. I did so, and the pharmacist in question cancelled those prescriptions on my patient file.

The cancellation flowed quickly to the PBS, and the erroneous scripts were deleted from my PCHER within a day. However, on Wednesday last week, I received another call from the eHealth team, who informed me that the same two prescriptions had been dispensed again on February 13, this time from a different pharmacy.

The second pharmacy was one I had never attended and was in a suburb I had not been to for several years. That raised the possibility that the error may not have arisen at the first pharmacy but perhaps from the prescribing doctor or were a far more serious matter of potential identity theft.

DHS recommended that I approach the second pharmacy to investigate further, which I agreed to do. First, however, I dropped in on my local GP, the only medical practice of any kind that I have attended in the last decade.

The very helpful practice manager checked my file and found no record of my having attended since September 2010, as correctly shown on my PCEHR, or having had those drugs prescribed for me. He also checked other patients with a similar name to mine, searched the database to rule out the potential my Medicare number had been duplicated, and even checked all people with the same date of birth as mine.

...could find nothing that indicated those prescriptions ever came from the practice.

Having informed DHS of my progress, the eHealth team then spoke to the PBS section, which came up with the probable solution: the original prescriptions both came with a number of repeats. When they were erroneously dispensed using my name and Medicare number from the first pharmacy, those details were then probably added to the patient's repeat script, which was then dispensed from the second pharmacy under my name.

It is not definite that this is the case, but it is the most likely. The second lot of repeats have been cancelled in the PBS and have not made their way to my PCEHR.

The case is probably closed, although I have given DHS permission to keep monitoring the situation. However, the experience does raise a number of questions, not the least of which is the potential for danger had I had an accident and any resulting diagnosis or treatment was affected by the incorrect information.

In all likelihood no clinician would have acted only on those small pieces of information in my PCEHR, and DHS reminds both patients and healthcare practitioners that PBS data is administrative only, and is certainly not clinical data.

In a positive light, the error would never have come to attention without the PCEHR, and it certainly reinforces the benefits of patient engagement with their medical information. Then again, the error wouldn't have been magnified if the PCEHR didn't exist and it would have just been a matter between the pharmacist and the government.

On a negative note, one suspects that had I not been a journalist, it is doubtful that the problem would have been escalated so quickly, and I did have to do a lot of the legwork myself, which could prove too much of a burden for other patients.

Several readers also commented on the difficulties I faced with my first point of call for assistance – the PCEHR help desk. The requirement for identity verification is so extreme that despite me providing my full name, date of birth, IHI, Medicare card number and expiry date, and the details of my last visit to a doctor and that doctor's name, it still was not enough to allow the help desk to actually help me.

Perhaps the Department of Health and Ageing, as the system operator, could look into instituting Paypal's method for identifying users over the phone, which involves a one-off code. With more than 150,000 people registered for the PCEHR and that number growing, without doubt errors are going to appear more frequently.

The development of a streamlined system for correcting those errors would seem the best way forward.

COMMENTS

#1 **Henry** 2013-05-27 15:10
PCEHR, and DHS It's called integration. This is testing a system that has been rushed? Maybe. Good reporting Kate, you are now the tester ;-)

Quote

#2 **Stephen Wilson** 2013-05-29 12:00
I sill don't follow the explanation.
Kate wrote: "the original prescriptions both came with a number of repeats. When they were erroneously dispensed using my name and Medicare number from the first pharmacy, those details were then probably added to the patient's repeat script, which was then dispensed from the second pharmacy under my name"
But I thought neither of the original scripts were for Kate. Has an erroneous prescriptions in the pharmacy system somehow been duplicated into Kate's record? Never mind whose name and Medicare Number the scripts were in, what about the IHI? Isn't this sort of basic records mismanagement precisely what the IHI was supposed to fix? How is it that dispensing events at two different pharmacies have both led to erroneous details being copied up into the PCEHR?
This is DEEPLY worrying from all sorts angles.
Steve Wilson, Lockstep.

Quote

#3 **Kate McDonald** 2013-05-29 12:36
Hi Steve

Neither of the original scripts were for me, and we aren't sure who the prescribing doctor was. The scripts had at least five or six repeats, so what we think happened was a patient with my name (or similar) went into the first pharmacy, the pharmacist mistakenly typed in the script and added it to my existing record without checking the Medicare number or address. When he handed over the meds and the new repeat scripts, they had my details on them. When those scripts were handed to the second pharmacist, he or she didn't check the Medicare number either. Both dispense events were then automatically sent to the PBS, and from there to my PCEHR.

I'd imagine that neither of the original scripts had an IHI attached, and I imagine these sorts of errors are very common. Without the PCEHR, no one would have known.

Quote

#4 **Stephen Wilson** 2013-05-29 13:09
Wow!
So off the top of my head:
- Why isn't the name of the prescribing doctor available from the script? I worked on systems 10 years ago where digital certificates would irrevocably bind the name of the prescriber, which would have been great but for some reason that still hasn't happened. But now it seems we don't even have the prescriber named at all? How can that be audited?
- Why are scripts automatically uploaded to PCEHR without some better quality checking? What other sort of data is uploaded automatically?
- I thought the IHI was essential for indexing data entered into (and retrieved from) the PCEHR? Especially when data is uploaded automatically!! I thought there was a rigorous matching protocol that checked the consistency of name and Medicare Number and other data. But it seems in this case a script with the wrong Medicare number and a similar name to yours can be uploaded to your PCEHR. Twice!
- What are the odds that two different pharmacists failed to check the Medicare number?
- Has anyone checked the PCEHR and IHI Threat & Risk Assessments to see how they dealt with this scenario? If it's happened twice in one record, then there is likely a systemic problem.
All very worrying.
Steve Wilson, Lockstep Consulting.

Quote

#5 **Kate McDonald** 2013-05-29 13:29
Hi Steve

- The name of the prescribing doctor was available from the script, but no one was allowed to tell it to me.

- The only data that is uploaded to the PCEHR automatically, as far as I know, is PBS, MBS and childhood vaccination data. As mentioned in the story, this is administrative data, not clinical.

- With the IHI, that wouldn't have been available to the prescribing doctor back in 2012, and as most pharmacies aren't registered for the PCEHR or have electronic access to the HI Service, they wouldn't have checked for the patient's IHI.

-When I signed up for the PCEHR, I linked my Medicare Online account to my PCEHR account. Anything sent to the PBS with my name, address and Medicare number would appear in my Medicare Online account, which is linked to my PCEHR. (At least I think that's how it works - will have to check.)

In answer to your question on the odds of two different pharmacists not checking the Medicare number? Pretty high, I imagine.

Quote

#6 **Stephen Wilson** 2013-05-29 13:52
So is no IHI needed to index the automatic upload of "administrative" data to the PCEHR?
I wonder if the PCEHR Threat & Risk Assessment took account of this possibility of erroneous uploads? Maybe as you say, the clinical safety impact of having erroneous scripts in PCEHR is minimal, but we