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1. BACKGROUND
Cancer treatment remains a major challenge for health systems all over the world. GLOBOCAN’s 2021 report estimated a global cancer prevalence of 19.3 million new cases, with 10.0 million deaths by 2020 (1). Cancer treatment methods differ depending on disease stage, patients’ age and physical condition. Radiation, surgery, and chemotherapy are among the available options for treatment. Cancer therapy is complex and error prone and the adjustment of chemotherapy drugs dose is essential due to their toxicity and narrow therapeutic windows. Optimizing the provision of care to cancer patients often requires complex decisions, and coordination between care team (2).

Research indicates that dose adjustment is not error-free; it ranks second among pharmacotherapy errors resulted in death (3). The chemotherapy-related medication errors are reported 7.1% among adults and 18.8% among children (4). Research reported the errors in prescribing chemotherapy and its related harm confirming that the process is not error-free (5). The chemotherapy-related errors might be experienced in different stages including prescription, preparation, administration, and monitoring and its requires a high degree of precision due to the complexities associated with medication type and dose, diluents, injection sequences and durations, and dose modification based on laboratory findings or toxicity assessments (6).
Motivated by the significance of this issue and for patient safety, chemotherapy guidelines have been developed to help oncologists in treatment management and reducing therapeutic errors (7). The complex, multi-dimensional, and prolonged nature of the treatment process and the wide range of recommended doses make it difficult for physicians to comply with paper-based protocols, leading to a variety of medical errors (8, 9).

The clinical practice guidelines play a significant role in prescribing the correct chemotherapy regimen, and may become more significant depending on the stage of the disease and factors such as age, weight, and body surface area (10, 11). The chemotherapy regimens determined accurately and based on guidelines can decrease prescription errors by about 50% annually (12, 13).

As the clinical practice guidelines change over time, having access to computer-interpretable guidelines may facilitate and improve the drug prescribing process by updating regimens and reducing guideline complexity (12), automatic dose calculation, and creating automatic drugs interaction alerts (14, 15).

In addition to the above, the CPOEs developed based on clinical practice guidelines could improve the patient safety through minimizing the chemotherapy errors (16-18). Systematic reviews on drug dose monitoring and determination (19) and drug prescription and management (20) have demonstrated that the CPOEs supported with clinical decision support systems (CDSSs) improve drug order registration and reduce medication errors in the treatment process.

Some of the benefits of these systems include: updating guidelines and approved regimens; automatically calculating the drug dose and scheduling multiple-day treatments (21, 22), and oncologists will no longer need to recall complex equations for Body Surface Area (BSA) calculation, creatinine clearance, and drug concentration dose on the time curve, and this facilitates cumulative dose tracking (23). We appreciate that almost all of the recent CPOEs utilize a form of clinical decision support system, so the focus of this review was the utilization of guidelines in the development of CPOEs.

Limited research has been conducted on the effectiveness of guideline-based CPOE systems. A study by Pawloski et al. in 2019 aimed to examine decision support systems in oncology processes. Twelve out of 24 studies reviewed were related to the positive effect of CPOE on reducing prescribing errors, increasing safety, and improving work processes (21). Another study by Rahimi et al. (2019) conducted with the aim of investigating the impact of CPOE systems showed that CPOEs reduced drug-related errors, especially dose errors, and also reduced the time of the chemotherapy order process. However, there was insufficient evidence with respect to compliance with protocols and reduction of chemotherapy costs (24). Owing to the significance of guidelines as the most frequently used reference by oncologists in cancer treatment, the present study aimed to review the effects of guideline-based CPOE systems on chemotherapy order processes.

### 2. OBJECTIVE

The aim of study was to present review effects of guideline-based CPOE systems on the chemotherapy order process.

### 3. METHODS

**3.1. Information sources and search strategy**

All stages of this systematic review were based on the 2009 PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analysis). The search strategy was set for each database based on aims of research and the author’s opinions by combining two groups of relevant keywords: keywords describing CPOE systems, and those describing chemotherapy (medical subject heading [MeSH], Truncation symbols and Boolean Operators). The search was then performed in PubMed, Scopus, Embase, Web of Science, and IEEE Xplore databases. The keywords used for searching the literature are listed in Box 1.

**3.2. Eligibility criteria and study selection**

Inclusion criteria: studies examining the effect of guideline-based CPOEs on the chemotherapy order process were included. Exclusion criteria: studies that examined CPOE systems, but did not use of guidelines were excluded. Moreover, studies on the technical evaluation of CPOE systems, and those that did not investigate the effects of CPOE on the chemotherapy order process were excluded. Non-original articles (e.g., review articles, editorials, poster papers, and protocols) were also excluded. In addition, we exclude articles that were not available in full text.

In the screening phase, three authors independently reviewed the titles and abstracts of the retrieved articles and excluded irrelevant studies based on inclusion and exclusion criteria. In the eligibility phase, three authors independently read the full text of all the pre-selected articles. Eventually, articles meeting the inclusion criteria were selected. Cases of disagreement on article selection were resolved by the fourth independent researcher. The bibliography of the included articles was also checked to identify other eligible articles.

Hand-searching was also performed in the Journal of

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### Box 1: Search strategy in scientific databases.

<table>
<thead>
<tr>
<th>Limitations</th>
<th>Time Limitation</th>
<th>#1: “medical order entry system” OR “Order Entry System” OR “medication alert system” OR “Alert System” OR “Medication Alert” OR “computerized physician order entry system” OR “computerized physician order entry” OR “computerized provider order entry” OR “computerized provider order entry” OR “computerized provider order entry system” OR “CPOE” OR “Computerized prescriber order entry” OR “electronic prescribing” OR “e prescribing” OR “clinical decision support system” OR “clinical decision support” OR “Medication Systems Drug Distribution System” OR “computer-assisted therapy Medication Assistance Program” OR “Computer-Assisted Drug Therapy”</th>
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<tr>
<td>Search</td>
<td>#1 AND #2</td>
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**Limitations**

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<tbody>
<tr>
<td>Search</td>
<td>#1 AND #2</td>
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</table>
### Study Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Study Design</th>
<th>Sample Size</th>
<th>Guideline</th>
<th>Study Setting</th>
<th>Study Population</th>
<th>CPOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lichtner et. al (2019)</td>
<td>Australia</td>
<td>Observational</td>
<td>827 voluntarily reported incidents relating to oncology patients</td>
<td>Not-specified</td>
<td>Inpatient and outpatient and home-based care</td>
<td>Pediatric</td>
<td>EMM</td>
</tr>
<tr>
<td>Reinhardt et. al (2019)</td>
<td>Germany</td>
<td>Observational</td>
<td>18,823 prescriptions</td>
<td>Not-specified</td>
<td>Inpatient and outpatient</td>
<td>Adult</td>
<td>CPOE tool for chemotherapy ordering</td>
</tr>
<tr>
<td>Chung et. al (2018)</td>
<td>USA</td>
<td>Pre-Post</td>
<td>100 prescriptions</td>
<td>NCCN</td>
<td>Inpatient and outpatient</td>
<td>Adult</td>
<td>Beacon EPIC systems</td>
</tr>
<tr>
<td>Aziz et. al (2015)</td>
<td>Pakistan</td>
<td>Pre-Post</td>
<td>9,279 chemotherapy orders</td>
<td>ISMP</td>
<td>Not-specified</td>
<td>Adult</td>
<td>Inbuilt system with CDSS</td>
</tr>
<tr>
<td>Cuervo et. al (2015)</td>
<td>Spain</td>
<td>Pre-post</td>
<td>207 ASHP guidelines</td>
<td>Inpatient and outpatient</td>
<td>Not-specified</td>
<td>Beacon OPIS (Oncology Patient Information System)</td>
<td></td>
</tr>
<tr>
<td>Martin et. al (2015)</td>
<td>USA</td>
<td>Observational</td>
<td>Not-specified</td>
<td>ASCO/ONS</td>
<td>Inpatient</td>
<td>Adult</td>
<td>CPOE for inpatient chemotherapy</td>
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<tr>
<td>Gandhi et. al (2014)</td>
<td>Canada</td>
<td>Observational</td>
<td>Not Available</td>
<td>ASCO, COSA, and CCO</td>
<td>Not-specified</td>
<td>Not-specified</td>
<td>Beacon system</td>
</tr>
<tr>
<td>Meisenberg et. al (2014)</td>
<td>USA</td>
<td>Pre-Post</td>
<td>9,838 chemotherapy order sets</td>
<td>ASCO/ONS and ASHP</td>
<td>Inpatient and outpatient</td>
<td>Not-specified</td>
<td>Beacon system</td>
</tr>
<tr>
<td>Elsaid et. al (2013)</td>
<td>USA</td>
<td>Pre-post</td>
<td>1,192 chemotherapy orders</td>
<td>ASHP ASCO NCCN</td>
<td>Inpatient and outpatient</td>
<td>Pediatric and Adult</td>
<td>Siemens Medical Solutions’ + (CDSSs) + (EDDSs), + barcode point-of-care medication administration system</td>
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<tr>
<td>Hanauer et al (2013)</td>
<td>USA</td>
<td>Pre-post</td>
<td>228 clinician hours</td>
<td>Not-specified</td>
<td>Inpatient</td>
<td>Not-specified</td>
<td>commercial CPOE system</td>
</tr>
<tr>
<td>Chen et. al (2011)</td>
<td>USA</td>
<td>Pre-Post</td>
<td>212 medication-related events</td>
<td>ASCO</td>
<td>Inpatient</td>
<td>Pediatric</td>
<td>MLM programming</td>
</tr>
<tr>
<td>Hoffman et. al (2011)</td>
<td>USA</td>
<td>Observational</td>
<td>Not Available</td>
<td>ASHP ASCO/ONS</td>
<td>Inpatient and outpatient</td>
<td>Pediatric</td>
<td>CPOE for chemotherapy at a children's cancer center</td>
</tr>
<tr>
<td>Markert et. al (2008)</td>
<td>Germany</td>
<td>Observational</td>
<td>22,216 chemotherapy orders</td>
<td>CSC-Blue Book</td>
<td>Inpatient and outpatient</td>
<td>Adult</td>
<td>Electronic chemotherapy ordering and prescription (eCOP) system</td>
</tr>
<tr>
<td>Small et. al (2008)</td>
<td>UK</td>
<td>Pre-Post</td>
<td>1941 prescriptions for chemotherapy</td>
<td>ASHP</td>
<td>Outpatient</td>
<td>Not-specified</td>
<td>VARIS MedOnc system</td>
</tr>
<tr>
<td>Crossno et. al (2007)</td>
<td>USA</td>
<td>Observational</td>
<td>Not Available</td>
<td>Pediatric Antiemetic Guidelines</td>
<td>Outpatient</td>
<td>Pediatric</td>
<td>Ordering Pediatric Chemotherapy</td>
</tr>
<tr>
<td>Dubeshter et. al (2006)</td>
<td>USA</td>
<td>Pre-post</td>
<td>2,558 drug administrations in 235 patients treated with 26 different chemotherapy regimens.</td>
<td>ISMP</td>
<td>Outpatient</td>
<td>Pediatric and Adult</td>
<td>IntelliDose</td>
</tr>
<tr>
<td>Voefray et. al (2006)</td>
<td>Switzerland</td>
<td>Pre-Post</td>
<td>2,445 chemotherapy orders</td>
<td>Not-specified</td>
<td>Inpatient and outpatient</td>
<td>Adult</td>
<td>Inbuilt system (File Maker Pro)</td>
</tr>
</tbody>
</table>

### Data collection process

One author extracted the data from the articles, while the second and the third authors checked the extracted data. Cases of disagreement were resolved by discussions.

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National Comprehensive Cancer Network and Google Scholar. The most prominent authors were contacted with a request for grey literature, including conference papers having a full text, unpublished studies, and reports.
between four authors.

3.4. Quality assessment

Quality assessment was performed for all included articles using 12 criteria selected based on the objectives of the study and the consensus of the research team.

Quality scores showed the overall application and effect of the studies. None of the studies met all the 12 criteria, but their total scores were moderate to high and, thus, acceptable for inclusion in the study.

4. RESULTS

4.1. Study selection

In the preliminary examination of the five databases, 9225 articles were retrieved and exported to Mendeley 1.19.4. In this stage, 4248 duplicates and 4957 irrelevant cases were detected based on checking the titles, abstracts, full texts, and the list of selected articles, and finally, 19 articles remained.

4.2. Source of studies

Of the 4977 retrieved articles, 19 articles met the eligibility criteria (Figure 1). The US had published the most papers (n=9) (5, 14, 25–31), followed by Germany (n=2) (8, 13), Spain (n=2) (32, 33), Canada (n=1) (34), Australia (n=1) (35), the UK (n=1) (36), Switzerland (n=1) (37), France (n=1) (38), and Pakistan (n=1) (39). The studies had pre-post (n=10) (5, 14, 26, 27, 29, 30, 32, 37–39), observational (n=7) (8, 13, 25, 28, 31, 34, 35), and cross-sectional designs (n=2) (33, 38).

4.3. Study characteristics

All of these studies were published between 2001 and 2019 and examined different aspects of CPOE systems discussed below. The extracted data on the efficacy dimensions and study parameters are listed in Table 1.

Medication errors from different perspectives

In two studies, after CPOE system implementation, chemotherapy drug prescription errors generally decreased by 75% (29). Moreover, the prescription errors reduced drastically from 30.6% to 2.2% when traditional handwritten method was replaced by a CPOE, and the incidence of errors that could harm the patient was reduced from 4.2% (with handwritten prescription) to 0.1% (with the CPOE system) (5). In a study by Small, computerized prescription decreased the errors by 42%. Moreover, errors occurred in 12% of the computerized prescriptions and 20% of spreadsheet prescriptions (36).

Two studies examined different dimensions of error reduction. One study was conducted on prescriptions issued five years after the system implementation. Before the implementation, 270 errors (37.5% of the total prescriptions) were detected from 143 prescriptions for 114 patients, and after implementation, 9 errors were detected from 134 prescriptions for 82 patients. These findings indicate that the CPOE’s implementation significantly decreased medication errors (32). Another study compared the incidence of errors in CPOE and in manual prescriptions. The findings showed that at least one error was detected in 100% of the manual prescriptions and 13% of the computerized prescriptions. False-negative errors were dominant in the manual approach. Errors in interpretation, the use of abbreviations, and illegible handwriting were frequent in handwritten prescriptions but were not identified in computerized prescriptions (33).

Eleven studies investigated the effect of CPOE on medication errors (5, 8, 14, 26, 29, 32, 33, 36–39), while other studies examined other aspects of CPOE efficacy.

The incidence and severity of chemotherapy protocol errors and the time of the chemotherapy order process

Two studies compared the incidence and severity of chemotherapy protocol errors between manual and CPOE in an adult setting. The first study reported a decrease in the number of medication errors in the manual system compared to the computerized system (2.43 vs. 0.26), as well as a reduction in the chemotherapy duration while dispensing in chemotherapy protocols. Drug intervention acceptance was higher with CPOE (85.3 vs. 91.1%), demonstrating a higher accuracy. Therefore, the chemotherapy CPOEs significantly decreased the incidence and severity of medication errors, improved the chemotherapy order process during dispensing, reduced the chemotherapy time, and decreased the chemotherapy costs (39).

Another study evaluated the effect of the CPOEs on the number of prescription errors recorded by the pharmacy service. Before the CPOE implementation, 141 errors were recorded for 940 prescribed chemotherapy regimens (15%), after launching the system, 75 errors were recorded for 1505 prescribed chemotherapy regimens (5%). Of these errors, 69 cases (92%) were recorded in prescriptions that did not follow the computer protocol. A remarkable reduction in the number of errors was observed when 50% of chemotherapy protocols were prescribed by the CPOE system (37).

Safety, policy compliance and communication between health care providers

Four studies examined the effects of CPOEs in pediatric settings. In the one study, over nine months, 30 medical logic modules and 110 prescription sets were developed for pediatric oncology support. The ratio of chemotherapy orders submitted using a specific research protocol or a set of standard care prescriptions was increased from 57 to 84%. The number of drug-related patient safety events was reduced by 39% after CPOE system (30).

A study of the four studies examined the use of a CPOE for improving safety, accordance with policies, and the communication between healthcare providers during chemotherapy prescription. According to the findings, the system could promote a safe chemotherapy prescription process, the accordance with policies, communication between physicians, pharmacists, and healthcare personnel. Indeed, it could help automatic calculations and could standardize the chemotherapy prescriptions.

Another study demonstrated that with careful planning, CPOEs could be safely used for chemotherapy. Moreover, the extensive use of electronic prescription sets, re-designing the official process and system analysis, accurate and strategic use of CDSS, a stepwise implementation approach, and interactions with software providers are essential for a safe and usable CPOE or chemotherapy (28). An analysis of patient safety event reports revealed that, of 827 candidate events related to pediatric
oncology patients, 79% (n = 651) were drug-related, of which 45% (n = 294) were Electronic Medication Management system related. The drug-related events included: prescription, dispensing, management, administration, forgetting the chemotherapy protocol and current treatment stage information, chemotherapy management coordination, and medication handling.

**Physicians prescribing behavior**

A study was conducted on therapeutic decisions for breast cancer patients before and after the use of a CPOE to assess the system's effect on the physician prescribing behavior. After four months, 127 decisions were recorded, and the physicians' compliance with the system was significantly improved to 85.03%. A comparison of the initial and final decisions revealed that physicians modified their prescriptions in 31% of cases, most of which were based on system recommendations (62% of the cases). In the clinical trial, the adherence rate was enhanced by 50%. This study was conducted on a small sample, and a larger-scale assessment was suggested for further analysis (38).

**Errors related to the dose and time required for chemotherapy prescriptions**

Some studies evaluated the medication dose errors and the time required for chemotherapy order preparation. These studies also identified medication errors and the potential rate of adverse drug effects (ADE) in the chemotherapy setting. Out of 2558 prescriptions for 235 patients treated with 26 chemotherapy regimens, no errors occurred in dose calculation, decimal places, or medication choice. The dose alarm level exceeded the limit in 152 cases of prescription (6%) but the users were not allowed to override the alarm. The mean time saved per prescription was 10 minutes (26).

**Quality and safety of treatment**

In a study by Markert et al. conducted to improve cancer treatment quality and safety using a CPOEs, over two years, 22216 chemotherapy prescriptions were sequentially analyzed, of which 83.5% were completely error-free. Moreover, 17.1% of medical and administrative errors were detected and refined, 3.8% of which dealt with chemotherapy, 4.5% of which with patient data, and 8.7% with a lack of informed consent form. The chemotherapy errors were fewer in outpatients than inpatients (3.3 vs. 4.5%). In outpatients, the chemotherapy errors were reduced from 4% in 2005 to 2.8% in 2006; however, no change was reported for inpatients (4.4% in 2005 vs. 4.7% in 2006). Only three out of 3,792 identified errors were patient related (0.079%) (13).

**Effect of CPOE on prevention of chemotherapy prescription errors**

In 2019, Reinhardt et al. studied the reasons, potential consequences, and prevention of chemotherapy prescription errors. Within 24 months, 406 chemotherapy prescription errors were tracked which affected 375 cases (2%) of all prescriptions. In 279 cases (1.5%), the errors were categorized as clinical. In these cases, some potential consequences, e.g., reduced therapeutic efficacy (0.44%), the need for enhanced monitoring (0.48%), prolonged hospitalization (0.55%), and mortality (0.02%), were prevented. The most efficient common measures to prevent errors include examining the prescription history and the patient's medical records, and having accurate knowledge about chemotherapy protocols. The findings showed that 61% of errors were prevented following further software development. The identified improvements were implemented through the next generation of the CPOE system (8). One study explored the effects of standardized electronic chemotherapy prescription models on the incidence of prescription errors in an ambulatory cancer center before and after implementing a CPOEs. The results showed a 30% reduction in prescription errors after the intervention. Implementing standardized chemotherapy-prescribing templates significantly reduced all types of prescribing errors and improved chemotherapy safety (14).
Errors (11 out of 19) (5, 8, 39, 14, 26, 29, 32, 33, 36-38). Although chemotherapy improvement and error reduction were reported by all these studies, and most of them only used systems with a basic CDSS (29).

The use of computer systems in healthcare has played an important role in improving service delivery to patients (40, 41). In the treatment of cancer patients, there is evidence of the effectiveness of using CPOEs in the chemotherapy orders process (34). Studies exploring the effects of CPOE on the chemotherapy order process revealed that, during dispensing, the incidence and severity of medication errors (39), the rate of medication errors (29, 34) and especially chemotherapy-related medication errors (32, 33), the number of errors during prescription, and the number of errors recorded by the pharmacist (37) were considerably reduced after computerizing only 10% of the protocols in CPOE compared to the manual system (39). However, according to Meisenberg et al., although CPOE reduced the number of problematic and erroneous chemotherapy prescriptions, it did not completely resolve all the errors (5).

Based on these findings, a reduction in prescription errors in chemotherapy led to optimal outcomes, including patient safety. Based on the literature, a reduction in chemotherapy errors by using CPOE can contribute to a safe chemotherapy prescription process (25). It can also improve chemotherapy safety by implementing standard chemotherapy prescription models and significantly reducing prescription and dose calculation errors (14).

Medication prescription errors have the potential for adverse outcomes for patient care. The use of CPOE in medication prescription directly affects the reduction in medication errors, the number of prescribing errors, and patient safety; this effect is long-term and improves patient safety indices (34, 37). Thus, by CPOE implementation, it is possible to ensure that chemotherapy orders processes are followed safely (33). If CPOE is updated and popularized in various treatment centers, the level of safety standards will increase, thereby benefiting more patients (8). Cooperation and giving feedback to software vendors is critical to a safe and usable CPOEs for chemotherapy (28).

In addition to decreasing medication errors, CPOEs can improve chemotherapy dispensing time, reduce chemotherapy costs (39), and provide a cost-effective treatment approach (14). Moreover, by using error analysis algorithms, several chemotherapy prescription errors can be resolved without loss of system efficiency (26). CPOE can also have other important functions, e.g., clinical decision support, improvement of adherence to clinical practice guidelines, and data collection (34). Planning for the extensive use of electronic prescription sets, re-designing processes and system analysis, accuracy and strategic use of clinical decision support, and a stepwise implementation approach are critical to safe CPOE implementation for chemotherapy (28). Other advantages of CPOEs for institutes include user satisfaction (29); improved communication between physicians, pharmacists, and the nursing staff; automatic calculations and standardization of chemotherapy prescriptions based on institution policies (25); compatibility with healthcare institutes of various scales (14); qualitative support for nurses (42); the use of standard prescribing templates, ongoing medicinal control and nursing to reduce prescription defects (43). CPOEs can also eliminate safety issues with the chemotherapy dose through creating a chemotherapy dose summary for the physicians and pharmacists. A customized display system was embedded in the EMR to provide a single screen view of the relevant parameters of chemotherapy doses including current and previous patient measurements of height and weight, dose adjustments, provider verifications, prior chemotherapy regimens, and a synopsis of the standard regimen for reference (31).

In addition to the benefits of CPOE, there are other points to consider. First, the appropriate design and ease of use for physicians can minimize human errors and, eventually, promote patient safety (32). Second, according to Reinhardt et al., 30-40% of the electronic errors cannot be prevented; therefore, medication monitoring practices are still necessary (8). Third, the automatic nature of CPOEs has contributed to the occurrence of some incidents. Considering the effects of high-risk settings on patient safety, the users should be aware of the automatic system capabilities and receive training for troubleshooting (36). The use of multidisciplinary teams can potentially influence patient care (44), but therapeutic protocols for chemotherapy prescription should not be neglected in the design of the system. Comprehensive evaluation of system performance with appropriate user interfaces and staff training to ensure the optimal use of such systems are also essential (36). The automatic rounding off in these systems can reduce the time of chemotherapy prescription and dose fragmentation (45). Still, the presence of oncology pharmacists is crucial to ensuring safe and appropriate chemotherapy prescription (46) because, in some CPOE systems, the computer cannot evaluate the chemotherapy protocols or adjust antineoplastic drug dosage based on patient conditions. Based on the review of the studies, their limitations, and the diversity in CPOEs, it appears that no definitive conclusion of the findings can be made. Some of these limitations include:

a) The system evaluation results are not generalizable due to implementation in a specific setting or a center with few patients or prescriptions or data collection in a single university center with fully standard procedures;

b) The clinical outcomes related to medication errors have not been examined, such that the clinical outcomes of reduced medication error cannot be used. Additionally, it is impossible to assess why there are so few medication errors with CPOE implemented;

c) Error classifications in some studies reflect only the pharmacist’s opinion and belongs to the prescribing stage only;

d) The evaluations are biased, e.g., conducting a survey six months after implementation and during major system progress, uncontrolled evaluation in which the increase/decrease in the recorded safety events cannot be attributed to the interventions. Furthermore, the actual side-effect incidence rates might differ from what the re-
porting systems show because these systems may not detect the actual rate of medication side effects;

e) Inferential statistics have not been calculated and the prescribing system has not been integrated with therapeutic program documents;

f) Management has been disrupted, indicating that workflow issues following CPOE implementation;

g) The benefits and effectiveness of such systems in relation to errors events were not reported by users.

Considering the evaluation of different studies on CPOE and the sharing of experiences with other institutions, it is expected that any institute will be able to achieve a safe and successful system implementation with maximum efficiency.

6. CONCLUSION

There is still a dearth of clinical outcome evaluation data about CPOEs in relation to patient care and safety during chemotherapy. Evidence indicates that these systems can positively affect the quality of care for patient with cancer. Most of them merely discussed improved patient care quality and reduced rate of medication errors; however, these systems cannot decrease all types of errors, and new sources of errors can emerge after implementation and process alteration. Nevertheless, the sources of new errors are not mentioned in any of the studies.

Finally, there has been limited research concerning the design of CPOEs based on guidelines there is little information in this regard; Therefore, further studies are required to determine the advantages or disadvantages of these systems.

• **Author’s contribution:** S.S., R.R. and Hr.M contributed to the conception and design of the work. S.S. drafted the manuscript, performed data collection and conducted the analysis in collaboration with R.R. and Hr.M. A.R. analyzed the data in collaboration with R.R. and S.S. and revised the manuscript critically. Hr.M. contributed to the interpretation of data and revised the manuscript critically. M.Sh. revised the manuscript critically. All authors approved the final version of the submitted manuscript.

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