HOW TO INCREASE PATIENT SAFETY WITH TECHNOLOGY

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A recent report from Quality of Health Care in America puts to light the deviation between what is known to be good care in the hospital environment and the care that is actually received. This deviation in care is described as a "chasm of quality". In the report mentioned above, the Institute of medicine has identified the need for improvement in patient safety from the time of admission to discharge. It is important to reflect upon the facts, and the facts are over 200,000 people a year die from medical errors a number that is quite frankly unacceptable in this day and age for such a Country as ours nonetheless these are the facts.

The report suggests for lasting quality improvements in hospitals, a framework needs to be put in place. This sounds good in theory yet I wish the report extrapolated just what framework will be needed and just where to place it.

The safety risks when entering a hospital are high just by default but also very dangerous to give you an example nosocomial or [HAI] hospital acquired infections like MRSA are not a rarity anymore and the strain becomes more difficult to control over time. Medication errors, falls, restraint issues are just a few of the most common errors occurring in hospitals today. Each one of these errors can be reduced with due vigilance and research from the patient as well as safety initiatives to be put in place. There is no question that this country needs to update its healthcare system, lower costs and reduce medical errors and improve patient care.

The nation's hospitals should all have patient safety at the top of their priority list, as of yet this is not the case hence the consumer/patient needs to understand the magnitude of this problem and educate and empower themselves to be their own advocate in order to protect themselves and loved ones. The Joint Commission on the Accreditation of Healthcare Organizations proclaims national patient safety goals for hospitals, four of these goals are served through the introduction of new technology. The most harmful medical errors occur through mis-identification of the patient. A missed patient I.D. can lead to the wrong surgical procedure, the wrong blood or medications given just to name a few. Proper patient identification is a must and essential to render safe care to patients. A patient's identity should always be verified each and every time a medication is given as well as for every test and procedure performed. This is a very important issue when patients cannot speak for themselves. New advances in technology have allowed for a new generation of wristbands with bar coding ensuring that the patient's information does not wash or fade away.

Communication is key patient's safety risks most certainly arise when incomplete or inaccurate information is conveyed between caregivers [this happens more often than you think]. Verbal orders or reports may not be transcribed properly or remembered handwriting-{at least that's what some call it} may be easily misread. Therefore, the adoption of computerized documentation, reporting and order entry reduce the risk of the most common failures in communication that eventually lead to patient harm. As I stated previously over 200,000 Americans are harmed every year by adverse medication events either to the wrong patient, wrong medication, wrong dosage or the wrong time all of these errors can lead to catastrophic events. According to the CDC Centers for Disease Control more people die annually from medication errors than from motor vehicle accidents and breast cancer. Medication access and

distribution can be tracked and monitored now electronically, and administration of medications can be recorded electronically. These improvements help remove the possibility of human error so this way health care providers at each point in the patients care must know what meds a patients is taking in order to avoid over medication that once could have lead to death. Also, the transition to a single personal health record addresses the issue of multiple providers having different pieces of the patient's medical information, if you have ever tried to request all of your medical records you know what I am talking about. Each patient will have access to their own medical records online, and each provider will have your full complete medical history with complete access.

What hospitals should be doing is initiating this technology and enhancing the existing technology available. Under ARRA, hospitals that adopt a federally certified medical record, share information with other providers and report patient quality measures that will qualify to receive higher Medicare reimbursements than the hospitals that do not implement these measures. Dubbed the "IMPACT" initiative the projects long term goal is to ensure that medical providers have their records converted to electronic form and patients are able to access their medical records online by 2015. Once this step is in process the risk for human error and elimination of illegible handwriting being misread will be a thing of the past. Other technologies that will be available electronically are, graphing information from vital signs, blood work and user access audits. I am all for anything to reduce the needless deaths that occur each year, my only observation is as long as this technology has been available why is it that just now in 2010-2011 hospitals are finally waking up and taking notice. Let's put the patient and their safety first before profits and implement this technology immediately.