PATIENT SAFETY
April 2004

1: Acad Radiol. 2004 Mar;11(3):322-32.
Radiology and patient safety.
Borgstede JP, Zinninger MD.
Penrose St. Francis Health System, Colorado Springs, CO, USA.
PMID: 15035523 [PubMed - in process]

2: Am J Health Syst Pharm. 2004 Mar 1;61(5):434, 437-8.
Massachusetts moves ahead with patient safety initiatives.
Young D.
Publication Types:
News
PMID: 15018219 [PubMed - in process]

3: Am J Med Qual. 2004 Jan-Feb;19(1):25-7.
Commentary: quality improvement projects: how do we protect patients' rights?
Diamond LH, Kliger AS, Goldman RS, Palevsky PM.
Medstat, 4301 Connecticut Avenue, N.W., Suite 330, Washington, DC 20008, USA. louis.diamond@medstat.com
A recent ruling by the Office of Human Research Protection (OHRP) has renewed an ongoing debate over whether Institutional Review Boards (IRBs) should have oversight not only over clinical research but also over quality improvement projects (QIPs). The authors discussed the similarities and differences among clinical practice, QIPs, and clinical research, pointing out issues to consider when identifying the most appropriate method for QIP oversight and accountability. They note that potential solutions must address ethical issues (eg, patient safety, privacy, and self-determination) and weigh the effect of the underlying QIP goal (administrative versus clinical improvement) on an individual patient and patient populations. They conclude that because QIPs are an extension of clinical practice and have elements of clinical research, it too should have an oversight system. Institutional or regional quality improvement boards, operating parallel to current IRBs, are suggested as 1 means of ensuring that QIP participants are offered the same protections as those who take part in clinical research.
PMID: 14977022 [PubMed - indexed for MEDLINE]

4: Arch Intern Med. 2004 Mar 22;164(6):653-8.
Characteristics associated with physician discipline: a case-control study.
Kohatsu ND, Gould D, Ross LK, Fox PJ.
Medical Board of California, USA. neal-kohatsu@uiowa.edu
BACKGROUND: There has been increasing attention devoted to patient safety. However, the focus has been on system improvements rather than individual

physician performance issues. The purpose of this study was to determine if there is an association between certain physician characteristics and the likelihood of medical board-imposed discipline. METHODS: Unmatched, case-control study of 890 physicians disciplined by the Medical Board of California between July 1, 1998, and June 30, 2001, compared with 2981 randomly selected, nondisciplined controls. Odds ratios (ORs) were calculated for physician discipline with respect to age, sex, board certification, international medical school education, and specialty. RESULTS: Male sex (OR, 2.76; P<.001), lack of board certification (OR, 2.22; P<.001), increasing age (OR, 1.64; P<.001), and international medical school education (OR, 1.36; P<.001) were associated with an elevated risk for disciplinary action that included license revocation, practice suspension, probation, and public reprimand. The following specialties had an increased risk for discipline compared with internal medicine: family practice (OR, 1.68; P =.002); general practice (OR, 1.97, P =.001); obstetrics and gynecology (OR, 2.25; P<.001); and psychiatry (OR, 1.87; P<.001). Physicians in pediatrics (OR, 0.62; P =.001) and radiology (OR, 0.36; P<.001) were less likely to receive discipline compared with those in internal medicine. CONCLUSION: Certain physician characteristics and medical specialties are associated with an increased likelihood of discipline.
PMID: 15037494 [PubMed - in process]

5: Arch Pathol Lab Med. 2004 Apr;128(4):397-402.
Heparin monitoring and patient safety: a College of American Pathologists Q-Probes study of 3431 patients at 140 institutions.
Valenstein PN, Walsh MK, Meier F; College of American Pathologists.
Department of Pathology, St Joseph Mercy Hospital, Ann Arbor, Mich 48106-0995, USA. paul@valenstein.org

CONTEXT: Appropriate laboratory monitoring of unfractionated heparin therapy promotes effective anticoagulation while minimizing hemorrhagic complications. OBJECTIVES: To measure heparin therapy monitoring in a "real-world" setting and to assess the degree of anticoagulation achieved. DESIGN: One hundred forty institutions abstracted laboratory and pharmacy data from up to 30 inpatients receiving standard-dose unfractionated heparin therapy for 72 hours. Institutions also reported their therapeutic ranges and described heparin prescribing and monitoring policies. RESULTS: Activated partial thromboplastin times or anti-factor Xa levels were measured at least once within the first 12 hours of administration for 95% of 3431 heparinized inpatients. Eighty-seven percent of patients had a platelet count performed within 72 hours of heparin administration. Seventy-eight percent of heparinized inpatients achieved therapeutic anticoagulation within 24 hours, but more than one third of patients entered the supratherapeutic range on at least 2 occasions during the first 72 hours. We found moderate variation in performance among the 140 institutions participating in the study, with more consistency in monitoring patients but less consistency in achieving therapeutic levels of anticoagulation. In one fourth of hospitals, more than half of the heparinized patients entered the supratherapeutic range on 2 or more occasions during the first 72 hours of therapy. None of 20 institutional practices we examined were meaningfully associated with more thorough monitoring of patients or with a higher percentage of patients achieving therapeutic anticoagulation. There was moderately wide variation in therapeutic ranges among the 140 sites. CONCLUSIONS: The prevention of heparin over-anticoagulation represents an important opportunity for improving patient safety in a significant number of institutions.
PMID: 15043451 [PubMed - in process]

6: Br J Surg. 2004 Apr;91(4):391-2.

Training and patient safety.
Thorpe P.
14 Jillinda Place, The Gap, Brisbane, Queensland 4061, Australia.
Patient Safety Leading Article Series, 2004 Over the rest of 2004 BJS will publish a series of leading articles dealing with issues of patient safety. A personal view of the matter was sought from the perspective of a trainee, Paul Thorpe, British trained but currently working in Australia. The trainee's view, sadly but typically, tends to come last-but not this time. Paul's article starts off the series. He notes that hospitals lag behind the airline industry and it is fitting, therefore, that the second paper is by Manfred Muller of Lufthansa.

PMID: 15048735 [PubMed - in process]

7: Can J Cardiovasc Nurs. 2004;14(1):3-4.
Patient safety--a recycled buzzword or a new approach?
Woodend K.
Publication Types:
Editorial
PMID: 15022526 [PubMed - in process]

8: Can J Nurs Leadersh. 2003;16(4):66-8.
Patient safety: springboard to nursing accountability.
Nicklin W.
The Ottawa Hospital.
PMID: 14983924 [PubMed - indexed for MEDLINE]

9: Can Nurse. 2004 Mar;100(3):29.
Strengthening the patient safety net.
[No authors listed]
PMID: 15077520 [PubMed - in process]

10: Can Nurse. 2004 Feb;100(2):30.
Adverse events. Focus on patient safety.
[No authors listed]
PMID: 15011495 [PubMed - indexed for MEDLINE]

11: Clin Lab Sci. 2004 Winter;17(1):35-9.
Francisella tularensis: possible agent in bioterrorism.
Gallagher-Smith M, Kim J, Al-Bawardy R, Josko D.
University of Medicine and Dentistry of New Jersey School of Health Related Professions, Newark, NJ 07107, USA.
Francisella tularensis, the causative agent of tularemia, is a highly infectious gram-negative coccobacillus. Due to its high infectivity it is of major concern to public health officials as a possible biological weapon. Although accidental exposure can occur through arthropod bites, handling infected animals, or breathing in aerosols, cases are usually isolated and contained. In the event of an intentional exposure such as in a bioterrorist attack, inhalation of aerosols can result in devastating consequences with much causality. Although a vaccine is available, sufficient quantities may not be readily accessible in an actual attack. Therefore, it is very important for both medical professionals and public health officials to be prepared to contain and control the situation should it actually occur.
Publication Types:
Review
Review, Tutorial

PMID: 15011979 [PubMed - indexed for MEDLINE]

12: CMAJ. 2004 Apr 13;170(8):1235-40.
Ottawa Hospital Patient Safety Study: incidence and timing of adverse events in patients admitted to a Canadian teaching hospital.
Forster AJ, Asmis TR, Clark HD, Al Saied G, Code CC, Caughey SC, Baker K, Watters J, Worthington J, Van Walraven C.
Ottawa Health Research Institute, Ottawa, Ont. (Forster, Clark, Watters, van Walraven).
BACKGROUND: Adverse events are poor patient outcomes that are due to medical care. Studies of hospital patients have demonstrated that adverse events are common, but few data describe the timing of them in relation to hospital admission. We evaluated characteristics of adverse events affecting patients admitted to a Canadian teaching hospital, paying particular attention to timing. METHODS: We randomly selected 502 adults admitted to the Ottawa Hospital for acute care of nonpsychiatric illnesses over a 1-year period. Charts were reviewed in 2 stages. If an adverse event was judged to have occurred, a physician determined whether it occurred before or during the index hospitalization. The reviewer also rated the preventability, severity and type of each adverse event. RESULTS: Of the 64 patients with an adverse event (incidence 12.7%, 95% confidence interval [CI] 10.1%-16.0%), 24 had a preventable event (4.8%, 95% CI 3.2%-7.0%), and 3 (0.6%, 95% CI 0.2%-1.7%) died
because of an adverse event. Most adverse events were due to drug treatment, operative complications or nosocomial infections. Of the 64 patients, 39 (61%, 95% CI 49%-72%) experienced the adverse event before the index hospitalization. INTERPRETATION: Adverse events were common in this study. However, only one-third were deemed avoidable, and most occurred before the hospitalization. Interventions to improve safety must address ambulatory care as well as hospital-based care.
PMID: 15078845 [PubMed - in process]

13: Health Aff (Millwood). 2004 Mar-Apr;23(2):103-15.
What is driving hospitals' patient-safety efforts?
Devers KJ, Pham HH, Liu G.
Center for Studying Health System Change, Washington, DC, USA. kjdevers@vcu.edu
The Institute of Medicine's report To Err Is Human described the alarming prevalence of medical errors and recommended a range of activities to improve patient safety. Three general mechanisms for stimulating hospitals to reduce medical errors are professionalism, regulation, and market forces. Although some believe that market forces are becoming more important, we found that a quasi-regulatory organization (the Joint Commission on Accreditation of Healthcare Organizations) has been the primary driver of hospitals' patient-safety initiatives. Professional and market initiatives have also facilitated improvement, but hospitals report that these have had less impact to date.
PMID: 15046135 [PubMed - in process]

14: Hosp Peer Rev. 2004 Apr;29(4):suppl 1-2.
Patient Safety Alert. Beaumont makes patients partners in safety efforts.
[No authors listed]
PMID: 15069891 [PubMed - in process]

15: Int J Qual Health Care. 2004 Apr;16(2):125-32.
Handoff strategies in settings with high consequences for failure: lessons for

health care operations.
Patterson ES, Roth EM, Woods DD, Chow R, Gomes JO.
Veteran's Administration Getting at Patient Safety (GAPS) Center, Cincinnati, OH.
OBJECTIVE: To describe strategies employed during handoffs in four settings with high consequences for failure. DESIGN: ANALYSIS: of observational data for evidence of use of 21 handoff strategies. SETTING: NASA Johnson Space Center in Texas, nuclear power generation plants in Canada, a railroad dispatch center in the United States, and an ambulance dispatch center in Toronto. MAIN MEASURE: Evidence of 21 handoff strategies from observations and interviews. RESULTS: Nineteen of 21 strategies were used in at least one domain, on at least an 'as needed' basis. CONCLUSIONS: An understanding of how handoffs are conducted in settings with high consequences for failure can jumpstart endeavors to modify handoffs to improve patient safety.
PMID: 15051706 [PubMed - in process]

16: Int J Qual Health Care. 2004 Apr;16 Suppl 1:I27-I35.
Distinguishing hospital complications of care from pre-existing conditions.
Naessens JM, Huschka TR.
Divisions of Health Care Policy & Research and Biostatistics, Mayo Clinic, Rochester, MN, USA.
OBJECTIVE: To compare cases identified through the Complications Screening Program (CSP) as complications with cases using the same ICD-9 secondary diagnosis codes, where the identifying diagnosis is also indicated as not present at admission. DESIGN: Observational study comparing two sources of potential hospital complications: published computer algorithms applied to coded diagnosis data versus a secondary diagnosis indicator, which distinguishes pre-existing from hospital-developed conditions. SETTING: All patients discharged from Mayo Clinic Rochester hospitals during 1998 and 1999. The Mayo Clinic is a large integrated delivery system in southeastern Minnesota, USA, providing services ranging from local, primary care to tertiary care for referral patients. Approximately 35% of Mayo patients travel >200 km for medical care. STUDY PARTICIPANTS: Hospital patients (total = 84 436). The numbers of cases with complications ranged from 0 to 2444 per algorithm. MAIN OUTCOME MEASURES: Percent of algorithm complication cases indicated as developing in the hospital, and percent of acquired conditions of that type detected by the computer algorithms. Incremental hospital charges, length of stay (LOS) and mortality associated with acquired complications. RESULTS: The percent of cases identified through the computer algorithm that were also coded as acquired varied from 8.8% to 100%. The ability of the computer algorithms to detect acquired conditions of that type also varied greatly, from 2% to 99%. Incremental charges and LOS were significant for patients with acquired complications except for hip fracture/falls. Many acquired complications also increased hospital mortality. CONCLUSIONS: Complication rates based strictly on standard discharge abstracts have limited use for inter-hospital comparisons due to large variability in coding across hospitals and the insensitivity of existing computer algorithms to exclude conditions present on admission from true complications. However, complications do carry high costs, including extended stays and increased hospital mortality. Enhancing secondary diagnoses with a simple indicator identifying which diagnoses were present on admission greatly increases the accurate identification of complications for internal quality and patient safety improvements.
PMID: 15059984 [PubMed - in process]

17: J Healthc Inf Manag. 2004 Winter;18(1):65-71.
Using BPI and emerging technology to improve patient safety.

Frank L, Galanos H, Penn S, Wetz HF Jr.
INTEGRIS Health, Oklahoma City, USA.
Capitalizing on existing IT investments, INTEGRIS Health, a 15-hospital system in Oklahoma, is applying business process integration (BPI) methodology and technology to leverage legacy systems and staff resources. The resulting project uses manual (human) and system tasks to compare real-time information across systems to eliminate preventable adverse drug events caused by medication ordering errors. Clinicians can quickly see where potential safety risks are occurring and change medication orders to prevent harm to the patient.
PMID: 14971082 [PubMed - indexed for MEDLINE]

18: J Healthc Inf Manag. 2004 Winter;18(1):18-23.
Alamance Regional Medical Center improves patient safety with CPOE.
DiFrancesco M, Andrews T.
Alamance Regional Medical Center, Burlington, NC, USA.
While it is widely written that advanced clinical information systems can help healthcare organizations reduce adverse medical events and increase patient safety, Alamance Regional Medical Center (ARMC) has proven that it truly does. ARMC chose Eclipsys' Sunrise Clinical Manager for its ability to provide knowledge-based clinical decision support and its alert capabilities at the time of order entry. Since its organization-wide rollout in summer 2000, ARMC has been using the computerized physician order entry (CPOE) system with widespread success and has transformed the care delivery process.
PMID: 14971075 [PubMed - indexed for MEDLINE]

61: J Healthc Inf Manag. 2004 Winter;18(1):30-5.
Assessing recommendations from the IOM's quality chasm report.
Staggers N.
Health Sciences Center, University of Utah, USA.
The most recent Institute of Medicine report recommends immense changes for healthcare institutions and places information technology as a central component of proposed changes. This paper gives an overview of the IOM report, analyzes several key IT topics, and suggests required actions to effect the IOM's recommendations.
PMID: 14971077 [PubMed - indexed for MEDLINE]

19: J Healthc Inf Manag. 2004 Winter;18(1):36-45.
CPOE systems: success factors and implementation issues.
Sengstack PP, Gugerty B.
Adventist Healthcare, MD, USA.
The medication error dilemma has come to the forefront of most hospitals' improvement agendas. The most often cited solution to the problem has been computerized provider order entry (CPOE) systems. These systems have significant potential to improve errors associated with illegibility as well as inappropriate drug use and dosing. On the other hand, CPOE system implementation is fraught with barriers that impede acceptance and use of these systems. Knowing what strategies have proven successful and what upfront analysis is required can help increase the chances of success and ultimately improve the quality of patient care.
PMID: 14971078 [PubMed - indexed for MEDLINE]

20: J Healthc Qual. 2004 Mar-Apr;26(2):42-8; quiz 48-9.
Medical errors: excess hospital costs and lengths of stay.
Nordgren LD, Johnson T, Kirschbaum M, Peterson ML.
Health Care Improvement Resources Department, Allina Hospitals & Clinics, Roseville, MN, USA. leslie.nordgren@allina.com

To focus on effective patient safety strategies in an environment of intense competition for resources, a method of quantifying the effect of potential sources of medical errors was developed. This study assessed excess length of stay (LOS) and hospitalization costs associated with patients who experienced errors. The distribution of the errors occurring within the mean LOS experienced by others with the same diagnosis and severity was also examined. Patients with errors had longer stays and greater costs when compared to controls.
PMID: 15060959 [PubMed - in process]

21: J Healthc Qual. 2004 Mar-Apr;26(2):6-12; quiz 12-3.
Patient safety: a case study in team building and interdisciplinary collaboration.
Horak BJ, Pauig J, Keidan B, Kerns J.
Health Systems Administration Programs, Georgetown University, School of Nursing and Health Studies, Washington, DC, USA. bjh28@georgetown.edu
This case report presents specific steps taken to address potential patient safety problems, particularly those regarding collaboration between nurses and house staff at The George Washington University Hospital. Issues affecting patient care (e.g., lack of communication and teamwork) were identified through interviews, focus groups, and observations. The actions taken were team-building meetings that included a sensitivity session; coaching with nursing managers; and ground rules for nurse and physician collaboration. This report also describes the agenda for the team-building meetings, results, and lessons learned for implementation at other sites.
PMID: 15060954 [PubMed - in process]

22: J Nurs Care Qual. 2004 Apr-Jun;19(2):100-4.
Applied informatics for quality assessment and improvement.
Johnson T, Ventura R.
New York-Presbyterian Hospital, NY 10032, USA. trudy@nyp.org
In our hospital, transition planning for order entry and clinical documentation has presented an opportunity for process changes and the ability to capture quality initiatives into data warehouses, where they can be utilized for building evidence-based practice. For example, the order entry and clinical documentation system allows for data retrieval of performance measures set by organizations including the Joint Commission on Accreditation of Healthcare Organizations, Centers for Medicare & Medicaid Services, and National Quality Forum. These data will reside in one system where they can be mined and extracted for reporting. Details of this magnitude are crucial when developing a CPR that will serve as the primary data source of clinical information. As we continue to seek IT solutions to improve patient safety and provide quality care, the use of informatics as a foundation in quality programs will provide the structure and database needed to support evidence-based practice at the point-of-care and reduce potential for error.
PMID: 15077826 [PubMed - in process]

23: J Nurs Care Qual. 2004 Apr-Jun;19(2):88-91.
National patient safety goals guide safe care.
Harris J, Schmitt L.
University of Rochester Medical Center, Strong Memorial Hospital, Rochester, NY 14642, USA. Jan_Harris@urmc.rochester.edu
PMID: 15077823 [PubMed - in process]

23: Jt Comm J Qual Saf. 2004 Mar;30(3):125-32.
Using a multihospital survey to examine the safety culture.
Weingart SN, Farbstein K, Davis RB, Phillips RS.

Stoneman Center for Quality Improvement, Division of General Medicine and Primary Care, Beth Israel Deaconess Medical Center, Boston, USA. sweingar@bidmc.harvard.edu
BACKGROUND: A culture of safety survey was used to study features of the safety culture and their relationship with patient safety indicators. STUDY DESIGN: Anonymous written surveys were collected from 455 of 1,027 (44%) workers at four Massachusetts hospitals. Respondents characterized their organizations' patient safety, workplace safety, and features of a safety culture, such as leadership commitment, professional salience, presence of a nonpunitive environment, error reporting, and communication. RESULTS: Employees universally regarded patient safety as an essential part of their job. Two-thirds of workers worried at least once a day about making a mistake that could injure a patient; 43% said that the work load hindered their ability to keep patients safe. Workers' overall assessment of patient safety was associated with their perceptions of workplace safety (odds ratio [OR] 1.87, 95% confidence interval [CI] 1.02-3.43, p = .044) and leadership commitment to patient safety (OR 3.20, 95% CI 1.97-5.19, p < .001). Incident reporting rates correlated with survey results, while adoption of best practices and expert opinion did not. DISCUSSION: Patient safety is salient to workers, who universally embraced patient safety as an essential part of their job. Independent indicators of patient safety did not line up neatly with safety culture survey results. Incident reporting rates correlated directly, while adoption of best practices and expert opinion varied inversely with survey results. The safety culture is a complex phenomenon that requires further study.
PMID: 15032069 [PubMed - in process]

24: Med Care Res Rev. 2004 Mar;61(1):3-37.
A review of the literature examining linkages between organizational factors, medical errors, and patient safety.
Hoff T, Jameson L, Hannan E, Flink E.
University at Albany, State University of New York, NY, USA.
The potential role of organizational factors in enhanced patient safety and medical error prevention is highlighted in the systems approach advocated for by the Institute of Medicine and others. However, little is known about the extent to which these factors have been shown empirically to be associated with these favorable outcomes. The present study conducted an intensive review of the clinical and health services literatures in order to explore this issue. The results of this review support the general conclusion that there is little evidence for asserting the importance of any individual, group, or structural variable in error prevention or enhanced patient safety at the present time. Two major issues bearing on the development of future research in this area involve strengthening the theoretical foundations of organizational research on patient safety and overcoming definitional and observability problems associated with error-focused dependent variables.
PMID: 15035855 [PubMed - in process]

25: Nurs Manage. 2004 Mar;35(3):47-8.
Optimal patient safety a computer chip away?
Abrahamsen C.
HealthWorks Consulting Associates, Palatine, Ill., USA.
Discover the latest technologic initiatives used to increase patient safety.
PMID: 15021802 [PubMed - in process]

25: Okla Nurse. 2004 Mar-May;49(1):16.
ANA commends IOM report outlining critical role of nursing work environment in patient safety.

[No authors listed]
PMID: 15067996 [PubMed - in process]

26: Prof Nurse. 2004 Mar;19(7):360; author reply 360.
Patient safety.
Egerton K.
Publication Types:
Comment
Letter
PMID: 15027396 [PubMed - in process]

27: Qual Manag Health Care. 2004 Jan-Mar;13(1):53-9.
OSF healthcare's journey in patient safety.
Whittington J, Cohen H.
OSF Healthcare System, 800 NE Glen Oak Ave, Peoria, IL 61603, USA. john.whittington@osfhealthcare.org
This article describes OSF Healthcare's recent journey in patient safety. It discusses the involvement of its 6 hospitals in collaboration with each other and the Institute for Healthcare Improvement. OSF focused on a strategy for decreasing adverse drug events (ADEs). They worked on impacting 4 major areas: safety culture, high-risk medication, dispensing of medication, and medication reconciliation. By doing this, OSF decreased its rate of ADEs per 1000 units of medication administered from 3.84 to 1.39 over the course of 20 months.
PMID: 14976907 [PubMed - indexed for MEDLINE]

28: Qual Saf Health Care. 2004 Apr;13(2):136-44.
Video capture of clinical care to enhance patient safety.
Weinger MB, Gonzales DC, Slagle J, Syeed M.
Anesthesia Ergonomics Research Laboratory of the San Diego Center for Patient Safety, Veterans Affairs San Diego Healthcare System, and the Department of Anesthesiology, University of California, San Diego, USA.
Experience from other domains suggests that videotaping and analyzing actual clinical care can provide valuable insights for enhancing patient safety through improvements in the process of care. Methods are described for the videotaping and analysis of clinical care using a high quality portable multi-angle digital video system that enables simultaneous capture of vital signs and time code synchronization of all data streams. An observer can conduct clinician performance assessment (such as workload measurements or behavioral task analysis) either in real time (during videotaping) or while viewing previously recorded videotapes. Supplemental data are synchronized with the video record and stored electronically in a hierarchical database. The video records are transferred to DVD, resulting in a small, cheap, and accessible archive. A number of technical and logistical issues are discussed, including consent of patients and clinicians, maintaining subject privacy and confidentiality, and data security. Using anesthesiology as a test environment, over 270 clinical cases (872 hours) have been successfully videotaped and processed using the system.
PMID: 15069222 [PubMed - in process]

29: Qual Saf Health Care. 2004 Apr;13(2):86-7.
Pursuing patient safety.
Malone B.
PMID: 15069210 [PubMed - in process]

30: Qual Saf Health Care. 2004 Apr;13(2):86.
Patient safety: global momentum builds.

Donaldson SL.
PMID: 15069209 [PubMed - in process]

31: Respir Care. 2004 Apr;49(4):361-6.
Respiratory care in the computer age.
Stewart KJ.
Medicine Services, Charleston Area Medical Center, 3200 MacCorkle Avenue SE, Charleston WV 25304. karen.stewart@camc.org.
Computerization in health care is rapidly advancing and is improving patient safety (eg, computerized physician order entry decreases the frequency of medical errors) and practitioner effectiveness and efficiency. Computerization and other developing technologies raise concern about the privacy of health information. In 1996 Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which included privacy provisions that went into effect in April 2003. HIPAA has important impacts on health care providers. With the tremendous growth of health care information systems comes the need to standardize the storage and sharing of health information, so there is an initiative underway to develop a National Health Information Infrastructure, which will set standards for health information exchange among consumers, providers, and the public health sector, as well as consolidate the "silos" of health information that are in place today.
PMID: 15030609 [PubMed - in process]