Example Format Style:

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Analyze a Current Health Care Problem or Issue

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Instructor Name

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Analyze a Current Health Care Problem or Issue

Patient safety, as discussed in the previous assessment, is an important element of quality health care. This assessment will expand upon patient safety issues that occur when patients are exposed to inadvertent harm or injury while receiving medical care. Health care organizations should maintain and develop a safety culture to prevent patient safety issues. Patient safety culture is defined as a system that promotes safety by shared organizational values of what is important and beliefs about how things work. It also encompasses how these values and beliefs interact with the work unit, organizational structures, and systems to produce behavioral norms (Ulrich & Kear, 2014). As such, care should be taken to improve the infrastructure of health care organizations. Improving patient safety should be discussed and addressed by every individual associated with public health care.

Elements of the Problem/Issue

Research shows that while getting treated at health care organizations, patients might be at risk of experiencing the harm or injuries associated with medical care. The most likely causes of patient safety issues are preventable adverse events, which are adverse events attributable to error. These errors can be classified as diagnostic errors, contextual errors, and communication errors (Ulrich & Kear, 2014).

Diagnostic errors take place when health care professionals provide a wrong or delayed diagnosis or no diagnosis at all (James, 2013). An example of a wrong diagnosis is a health care professional diagnosing a patient with gastric troubles when the patient is actually experiencing a heart attack. An example of a delayed diagnosis is a patient not being notified of an abnormal chest X-ray, thereby delaying diagnosis of a serious medical condition. An example of a missed diagnosis is a patient not being diagnosed with heart failure despite warning symptoms.

Contextual errors occur when health care professionals fail to consider their patients' personal or psychological limitations while planning appropriate care for them. An example is a health care professional's failure to recognize that basic follow-up discharge instructions may not be understood by patients with cognitive disabilities (James, 2013). It is important for health care professionals to be aware of their patients' mental and physical abilities before they formulate a plan of care.

Communication errors occur when there is miscommunication or lack of communication between health care professionals and patients (James, 2013). They can cause severe harm to patients. An example of this is a nurse failing to tell a surgeon that a patient experienced abdominal pain and had a drop in red blood cell count after an operation, resulting in the death of the patient due to severe internal bleeding. Limited health care knowledge; language barriers; and auditory, visual, and speech disabilities could also lead to communication errors and cause safety issues.

Analysis

As a medical transcriptionist, it is important for me to be aware of potential transcription errors and privacy standards, which affect patient safety. Errors like these pose dangerous risks; therefore, it is necessary to have an overall quality evaluation of the transcribed documents. Also, I must ensure that serious difficulties in transcription resulting from poor-quality voice files are reported immediately to the manager, who will then convey this to the health care professionals involved in the process. This will help ensure that patient safety is not compromised.

Context for Patient Safety Issues

With the advancement of medical technology, health care processes have become extremely complex. Health care professionals are required to stay up to date with a lot of new

knowledge and innovations obtained from research. This often overburdens them as there is a need to apply the learning from research in their practice. Also, at the individual level, there is a dearth of well-balanced continuing education programs, which has resulted in a lack of attention to patient safety among health care professionals. At the system level, organizations fail to deliver optimum health care as a result of being understaffed, an inability to provide appropriate technology, and ineffective execution of patient care transfer (James, 2013). Overcrowding and understaffing delays initiation of treatment and puts critically ill patients at significant risk. All of these factors contribute to a rise in patient safety issues.

Populations Affected by Patient Safety Issues

Patients with a psychiatric history are also a vulnerable group of people who face patient safety issues because their psychiatric records are often combined with their current symptoms. Patients with a documented history of psychiatric illness may avoid seeking health care services as they feel that their care will be based on their past record of illnesses and not their present needs. Therefore, psychotherapists should implement measures such that their psychiatric data is concealed from their medical records before it is shared with the third party, which helps protect patients' confidentiality (Shenoy & Appel, 2017).

Considering Options

Patient safety in hospitals can be achieved by creating a culture of safety that involves effective communication, correct managerial leadership styles, and the use of Electronic Health Records (EHRs). Effective communication while passing patient-specific information from one health care professional to another is essential in ensuring continuous and safe patient care. Training the team could likely improve consistent successful communication and help prevent errors. Standardizing critical content that needs to be communicated by the initial health care professional ensures safe transfer of care (Farmer, 2016).

It is essential for leadership teams to adopt organizational strategies that would improve patient safety and transform their organizations into reliable systems for enhanced patient satisfaction. They should set strategic safety goals, which could include adhering to standards of health, assessing quality, using patient satisfaction reviews, and analyzing adverse event reports to determine improvement in safety issues (Parand et al., 2014).

An EHR is another potential solution to prevent patient safety issues. It is a digital record of a patient's medical information that includes history, physical examination, investigations, and treatment (Ozair et al., 2015). It helps manage multiple processes in the complex health care system and prevents errors. EHRs utilize less storage space compared to paper documentation and allow an infinite number of records to be stored. In addition to being cost-effective and preventing a loss of records, EHRs help conduct research activities and provide quick data transfer (Ozair et al., 2015).

Solution

In health care, because transmission of information takes place among different people and electronic devices, there is a high likelihood of errors occurring. For example, transcription errors (which occur due to poor audio quality or the lack of a quality evaluation process) can be prevented by using recording equipment with good sound quality and by maintaining proofreading and quality checks. However, integrating transcription processes with the HER system helps prevent errors, helps access the required information faster, and allows health care professionals to take accurate decisions about patients' care.

Implementation

An EHR is an important mechanism for improving patient safety. Its advancement has made it a viable option to prevent medical errors. However, the use of EHRs has certain ethical implications such as security violation, data inaccuracies, lack of privacy and confidentiality, and

challenges during system implementation. Security violation takes place when patients' confidential health information is accessible to others without their permission. To avoid security violation, data should not only be password protected but also encrypted to restrict access to unauthorized individuals. Firewalls and antivirus software should be used to protect data (Ozair et al., 2015).

Though EHRs improve patient safety by reducing medical errors, data inaccuracies are increasing. Loss of data during data transfer leads to inaccuracies that affect decision-making related to patient care. A problem of concern related to data inaccuracy is medical identity theft, which leads to incorrect information being filed into a person's medical record, which in turn leads to insurance fraud and wrong billing (Ozair et al., 2015).

In health care, information that is shared during physician–patient interactions should be kept confidential and should be made inaccessible to unauthorized individuals. Enabling role-based access controls based on user credentials will restrict access to the EHR system to authorized users. The user should also be made aware that he or she is responsible for any information that he or she misuses (Ozair et al., 2015).

As EHR is a complex software, there is a high likelihood that software failure may result in inaccurate recordings of patients' data. Therefore, EHR system implementation may have ethical implications due to the violation of data integrity (Ozair et al., 2015). EHRs can safeguard patient confidentiality by using various methods that prevent security breaches. In addition to this, creating reminders that ask for a confirmation before accessing confidential information can help protect data. A nesting system could be developed, which would allow, for example, a health care professional from a specific specialty clinic to access patient records by signing into the specialty domain (Shenoy & Appel, 2017). These methods will enable the safe and efficient use of EHRs and ensure patient safety.

Conclusion

Patient safety involves preventing the risk of harm or injuries to patients by establishing a safety culture and providing high-quality medical care. Health care organizations must understand patient safety issues and find solutions for these issues by designing systems that prevent errors from occurring. Potential solutions include effective communication, changes in leadership style, and the use of EHRs. The ethical implications of these solutions should be considered before implementing them in a health care setting. It is also important that health care professionals undergo continuous education and effective training, provide appropriate medical care, prevent errors, and follow safety practices to improve clinical outcomes.

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