

Understanding Medication Errors in an Electronic Reporting System

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Chamberlain University College of Nursing

NR 360: Information Systems in

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The use of technology in healthcare has transformed patient care, offering new opportunities for efficiency, communication, and safety, however; relying on technology also brings new risks, especially in critical areas like medication administration. Medication errors are a top cause of preventable patient harm and present a major challenge for healthcare professionals. This paper will look at a situation where a medication error harmed a patient, examining the legal, ethical, and professional issues involved. It will also discuss the benefits and risks of the technology used, concluding with a personal reflection on how this knowledge will influence future practice.

HIPAA, Legal, and Regulatory Discussion

The legal framework in healthcare is shaped by strict rules meant to protect patients and ensure accountability. One key law is the Health Insurance Portability and Accountability Act (HIPAA), which sets national standards for safeguarding sensitive patient health information (PHI). A medication error might seem like a clinical issue, but it usually involves accessing the patient's electronic health record (EHR) and other technology systems. Therefore, HIPAA and privacy rules are critical factors to consider. Any unauthorized access or mishandling of patient data linked to the error could lead to additional HIPAA violations.

Besides HIPAA, various healthcare regulations and legal guidelines govern how technology is used in nursing care. These regulations often require the use of specific systems, like Computerized Provider Order Entry (CPOE) and Bar-Code Medication Administration (BCMA), to improve safety and lessen errors. However, they also hold nurses and other healthcare workers legally responsible for using these technologies properly and knowing their limits. If a medication error related to technology happens, legal actions may be taken against the