

Information Technology and Medication Error Prevention



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A health information system (HIS) is a system used to handle healthcare data. This comprises systems for collecting, storing, managing, and transmitting a patient's electronic medical record (EMR), hospital operational management, and healthcare policy support. The integrated effort combines to enhance patient outcomes, inform research, and impact policy and decision-making (Brook, 2024). The goal and function of health information technology would be to increase accountability, improve patient and population health outcomes, and improve healthcare efficiencies while lowering healthcare costs. Increase accountability by digitizing the healthcare data; information technology makes it easier for medical facilities, governments, and other stakeholders to abstract and assess data and provides real-time insights into the charts. HIT systems can incorporate tools and applications to address safety and outcome concerns in patient care and population health. For example, computerized physician order entry (CPOE) is a significant tool for quality patient care outcomes. The IOM (Institute of Medicine) recognizes the substantial use of digital orders rather than written ones. Thereby reducing medication errors by flagging potential errors such as inappropriate dosage, drug-drug interactions, and patient drug allergies. Additionally, HIT improves healthcare efficiencies that benefit patient care, such as appointment scheduling, improved communication, and coordination, by providing easy access to test results and medical records. However, a delay in transmitting these records can be a challenge in efficacy and a timely manner (Jen et al., 2023).

The paper report explores the definition of health information technology and its contribution to healthcare organizations. The topic discusses the benefits of HIT on medication safety administration that impact patient safety and delivery efficiency, develops the best solution