Electronic Nursing Documentation

Sulakshana Chand* and Jyoti Sarin**


**Certified Registered Nurse (Maternal Newborn Nursing)
Northside Hospital, Atlanta, GA 30071**

**Director-Principal
MM College of Nursing, MM University, Mullana (Ambala)**

Corresponding Author
Jyoti Sarin
jyotisarin@yahoo.co.in

ABSTRACT

Nursing documentation has been one of the most important functions of nurses since the time of Florence Nightingale. It is a true representation of fact or act, expressing all actions undertaken in the care provided to the patient. Despite the importance of nursing documentation, often the nurses’ notes do not contain necessary information to support the institution and nursing in judicial case. Handwritten documents often omit patient’s data, including care plans, interventions, outcomes, because of inconsistent documentary methods. Incomplete medical records can hinder the clinician’s ability to access and analyze patient data. The need for quality nursing documentation cannot be brushed aside because failure to maintain records means failure of duty toward the patient. The fragmented nature of health care, the large number of transactions, and the need to integrate new scientific evidence into practice supports the advantage of electronic medical records over paper based documents in achieving improved quality and efficiency. The use of information technology in health care is a prominent feature of most recommendations. When the right technology is successfully implemented, it can increase efficiency and alleviate some of the burdens on nurses, freeing them to concentrate on direct care. Although electronic nursing documentation has multiple benefits, its implementation raises issues as any change in work system can have important consequences for providers as well as patients. Despite the challenges and factors that hinder adoption of computerized documentation, however, it is the best way ahead to meet the new challenges and changing needs of the health care.

Key Terms: Documentation, Nursing, computerized, Information Technology.

INTRODUCTION

Documentation is an integral part of safe and appropriate clinical practice and is a record of judgment and critical thinking used in professional practice1. Documentation is a fundamental nursing responsibility with professional, legal, and financial ramifications2. Nursing documentation has been one of the most important functions of nurses since the time of Florence Nightingale3. Nursing documentation is defined as, the record of nursing care that is planned and given to patients by qualified nurses or by other care giver under the direction of a qualified nurse4. Objective, contemporaneous and relevant documentation promotes consistency in client care and effective communication between members of the health care team5. The health care environment is continuously changing and evolving and nursing is not immune to these changes. The rapid expansion of technology into every aspect of modern nursing suggests that 21st century nurse must establish and maintain computer competency. In response, nursing in radically transforming to meet the evolving and complex health care demands. The transition to computerized documentation is one technological change that has significant implications for the nursing profession and the overall health care system6. Such systems relieve nurses of...
time consuming clerical duties and assist them in producing legible and comprehensive patient care plans and documentation.

NEED

Nursing documentation continues to draw criticism from professional, community, and regulatory organizations because of incomplete, substandard charting practices. Handwritten documents often omit patient's data, including clinical problems or care plans, interventions, and especially outcomes. Inconsistent and incomplete documents sabotage the medical records to be reliable and valid resource of information.

Most commonly observed problems with documentation include; poor record-keeping; poor planning of care; incomplete admission records; lack of documented care planning; failing systems of communication; ad hoc recording of vital observations; compromised fluid management; lack of reported care evaluation. Other problems in nursing documentation include; disruption, incomplete and inappropriate charting.

Quite often, complaints arising from clinical incidents lead to indefensible claims due to lack of thorough documentation and accountability. Therefore, standardization of nursing records is important with regards to adequacy of formal language, grammar, accuracy, brevity, clarity, identification and technical terminology. Computerized documentation can assist nurses in addressing problems that occur as a result of paper-based documentation thus enabling nurses to fulfill multifaceted roles and consequently enhance the quality and efficiency of nursing practice. It can also improve the accuracy and comprehensiveness of patient information and enhance the provision of quality nursing care.

COMPUTERIZED HEALTH RECORDS

Although methods of charting have evolved overtime to meet the changing needs in healthcare. Radical changes came with the introduction of computers in the healthcare in the late 20th century. Department of Family Medicine at University of South Carolina was one of the first known organizations to develop and use a computerized medical record in 1972. By the early nineties, the idea of widespread electronic medical records implementation was on the horizon. Health care information technology planners realized that the next logical step for health information system was a completely integrated computerized medical record. The health industry is beginning to fully appreciate the complexity of integration required to achieve comprehensive computerized health record.

ADVANTAGES

Computerized nursing documentation has distinct advantages as listed below.

- Providing a single, shareable, accurate, up to date, rapidly retrievable patient data.
- Reducing documentation redundancies.
- Facilitating use of structured tools for assessment as a basis for setting priorities and deciding the appropriate nursing interventions.
- Enhancing patient safety by reducing medical errors.
- Facilitating prompt decision making by providing quick access to patient information and decision support system.
- Minimizing the potential of lost/damaged information.
- Reducing duplication of diagnostic evaluation and risk of treatment delay.
- Enhancing continuity of care.
- Protecting patient’s privacy.
- Providing access to patient information by multiple users at one point of time.
- Improves communication, exchange of information and coordination; among nurses; between nurses and members of health care team; between different health care facilities.
- Facilitates clinical nursing audits.
- Reduces cost by consolidating patient data in one place and eliminating the need for maintenance and storage of paper records.
- Assists in meeting regulatory and legal documentation requirements by improving the accuracy of patient information.
- Improves nurse productivity, patient satisfaction, and overall success of health care institution.
- Facilitates data mining for quality assurance and research purposes.
- Enables epidemiological monitoring and disease surveillance.

Despite existing evidence that supports the benefits of computerized documentation, the transition from paper-based to computerized documentation still presents major challenges within health care organizations.

CHALLENGES

Embracing computerized health record technology is a daunting task even for those who accredit themselves to be computer savvy individuals. Notions of apprehension and fear of a paperless system is brought to the fore front by those who are deemed to commission the computerized health record technology. Its implementation is a course of action that requires much time and attention. Transition to computerized documentation creates stress, uncertainty and role confusion. Although computerized nursing documentation can be very beneficial, barriers exist that impede its implementation. The computerization of nursing documentation systems necessitates both structural and behavioral change. Since nurses are often resistant to change, the implementation of computerized documentation can be a very challenging endeavor. Lack of nurses’ acceptance and their attitude has been cited factors that hinder computerized health record implementation. Widespread implementation of computerized health records can also been hampered by; technical matters; financial matters - particularly applicable to non-publicly funded health service systems; resources issues, training and re-training; resistance by potential users; implied
changes in working practices; certification, security; privacy, confidentiality and access rights; doubts on clinical usefulness; incompatibility between systems; ethical, legal and technical issues linked to accuracy. Computerized documentation can lead to loss of human touch which still remains one of the vital components of nursing care. Because of the lack of flexibility of many computerized reporting systems, cases of wrong classification of patients and their conditions have been reported.

Despite these barriers, there still exists intensive support for computerization. These barriers may be minimized by;

- Clearly communicating to nurses the need for change from paper to computer based documentation.
- Communicating the benefits of computerized documentation in terms of nurses improved performance, time saving and improved quality of nursing care.
- Involving nurses in the change process from conception to post implementation of computerized documentation.
- Training program for nurses regarding computerized nursing documentation that is tailored to their needs and competency level.
- Continuous updating, hand holding, evaluation and feedback.
- Recognition and rewards for nurses who aptly adapt to computerized nursing documentation.
- Ensuring privacy and security of patient information by; Emphasis on non-sharing of passwords
- Access of patient information to authorized persons only.
- Encryption of information so that it cannot be read by an unauthorized viewer.

CONCLUSION

Record keeping is an essential part of nursing practice and is linked with improvements in patient care. The quality of nursing documentation has consistently been found to be failing to meet recommended standards, thus hampering efforts to ensure continuity of care. Incontrovertible evidence has increasingly shown that current systems are not delivering sufficiently safe, high quality, efficient and cost effective health care, and that computerization, with the electronic medical records at the centre, is effectively the only way forward. Computerized health records represent a huge opportunity to improve patient care and health system operations. However, it is based on carefully constructed set of systems that are highly integrated and require significant investment of time, money, process change and human factor reengineering. Although computerized nursing documentation has its own challenges, yet, it can provide uniformity in documentation of nursing activities across the health care organization. The benefits certainly outweigh the risks. Despite the fact that there exist certain challenges and factors that hinder adoption of computerized documentation, however, it is the best way ahead to meet the new challenges and changing needs of the health care.

REFERENCES


