Computerized Documentation and Nursing

Lauren Rockwell

IT 103-007

Daniel Garrison

October 4, 2010

The world of information technology is constantly changing. There is always new technology coming in the eyes of humans. This is certainly the case in the world of nursing. Nursing is a very conservative field of people who have worked with paper documentation for hundreds of years. These nurses carry pages and pages of charts and notes around like college students carry their text books. The field of nursing has recently become changed by the use of the computer and computerized documentation. This type of documentation allows for people to communicate faster, causes less mistakes, and allows for the possibility of a universal computerized health care documentation.

The use of computer technology in hospitals is sweeping the nation. It has become a huge part of new training for nurses all over the world. Computer technology has been used in hospitals as a faster, more effective way of communication among nurses and doctors. This allows information to be put into a computer for doctors to see even if they are not right beside the patient. By allowing a doctor to see newly obtained information anywhere in the hospital, he or she will be able to further analyze the patient. By this easy access to information, the doctor or nurse will be able to help the patient faster and more effectively. The idea of outpatient care is also very important today. This is the care of patients that have already left the hospital. This is much easier to accomplish with the use of computers. Computers are an easier, faster mode of communicating between everyone dealing with the healthcare system. This mode of communication benefits doctors, nurses, and even patients. Computers are also help to cut down on errors based on handwritten charts and orders. "Studies have shown that computerized systems can enhance time efficiency, direct client care time, user satisfaction, accuracy of data, and completeness of records" (Harkreader, 251).

With a computerized system of charting and note taking, there are usually less mistakes made on the part of nurses and doctors. "Data now shows that information technology can reduce the frequency of errors of different types and probably the frequency of associated adverse events" (Bates). This includes medication errors due to the doctor's famous sloppy handwriting. There is less likely to be a major medication error with the use of computers because typed medication orders are much neater than handwritten orders. This is also true when it comes to notes pertaining to nurses. If a nurse has messy handwriting it is going to be much more difficult for other nurses to read and comprehend her hand writing. This is why a computer system is necessary and valuable for the health care field. By having computers available for reference, nurses are also making less medication errors. This is based on the ability to use the computer for reference on dosage and as a way to help calculate medication dosage for a specific patient. This technology is cutting down on overdose of medication because it is a way for nurses to check themselves before they administer mediation. Computers have also allowed us to create a system to help doctors all over the world to obtain information for patients that they are now taking care of.

The concept of a universal health care documentation system has been really considered in the past few years. This would be a computer system that consists of information from all doctors that have worked on a patient over their lifetime. This system would include all procedures, general information, and issues dealing with a patient's medical history. This information could be crucial in helping to save someone's life. For example, a patient who comes in who is unconscious could be allergic to a medication that is needed to be administered to the patient. If we do not have any information on this patient then it is going to be very difficult to learn about this allergy without actually attempting to use the medication. However if

we have a universal health system, then by using information like a social security number, we could have figured this information out with no problem. Electronic medical records are records that are available for all clinical doctors and hospital workers to see. These documents tell a doctor about the patient's history of surgery and basic information regarding medication allergies and history of their lives. "Electronic medical records also help keep records of health information that patients tend to forget with time, i.e. inoculations, previous illnesses and medications" (Electronic Medical Records). This information is vital to knowing how to treat patients. For example, if a patient has already had a vaccination in the past there is no need to give the patient the same vaccination. By having this universal system that allows all doctors to see the information, there are going to be fewer issues because of lack of information based on the patients lack or inability to give the information. "Substantial benefits realizable through routine use of electronic medical records include improved quality, safety, and efficiency, along with increased ability to conduct education and research" (Bates). This shows that electronic medical records are useful for many reasons not just for information necessities. They are extremely beneficial to doctors and nurses and could save some people's lives.

The concept of computers in healthcare is a very exciting and necessary move. The use of paper records and charts has been outdated due to the fact that computers are much more reliable, cause less errors to be made based on handwriting, and allow for an electronic records system to be put into place for all doctors to see health histories of patients. These advances show that the health care field is ever growing and is going to continue to grow as advances in technology continue to benefit the field. Computerized systems are extremely beneficial to nursing staff and medical staff all throughout the hospital. These systems are going to continue to show growth and will be seen in a lot more hospitals all over the world in the years to come.

Bibliography

- 1. D. W Bates and A. A Gawande, "Improving safety with information technology," *New England Journal of Medicine* 348, no. 25 (2003): 2526.
- 2. D W Bates, Ebell Mark, et all. "A Proposal for Electronic Medical Records in U.S. Primary Care," Journal of American Medical Informatics Association no 10 (2003).
- 3. "Electronic Medical Records: The Pros and Cons". http://healthworldnet.com/HeadsOrTails/electronic-medical-records-the-pros-and-cons/?C=6238 Oct 3, 2010.
- 4. H. Harkerader, Hogan, Mary-Ann, et all. <u>Fundamentals of Nursing.</u> (2007). Saunders Elsevier, Canada. P 251.