

# Documentation of Patient Identification into the Electronic System to Improve the Quality of Nursing Services

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**Abstract**— Nursing documentation is one of the most important functions for care in providing nursing care. The process of nursing in the modern era is now a demand from various aspects for nurses. The current development is that nurses must carry out nursing processes based on nursing care standards. Use of documentation results Patient identification in nursing electronically can always evolve in line with technological developments, this can increase client life expectancy and reduce errors in taking interventions on the client. This IT-based documentation system will assist in meeting documentation standards, can improve the quality of documentation, facilitate decision making and provide information that is easily accessible, can minimize the potential for loss or damage to development records, increase information exchange and coordination between nurses or other health teams, documentation can be easily audited, helps improve the accuracy of client data, can access the progress of the client's health development and reduce maintenance costs so as to improve the quality of care services

**Keywords:** Documentation, Patient Identification, Nursing, Computerization, Information Technology

## 1 INTRODUCTION

Documentation of Patient Identification results in nursing is an integral part of care, nursing documentation is one of the most important functions of nurses. Here all information about the client is written so as to provide nursing care according to the client's needs. Through documentation the nurse can decide the right course of action for the client. The accuracy of client data in the nursing process in the modern era is now a demand from various aspects for nurses, various forms, efforts have been made over the years to improve nursing documentation, this is done in an effort to improve the quality of client care services (Paan et al., 2010). The general concern about nursing documentation is inaccurate and incomplete nursing assessment, intervention, implementation and evaluation records that do not meet nursing care standards. In this case the nursing record does not support information that can be legally justified (Chand, 2014). The current development is that nurses must identify patients in the nursing process based on standards of care. (Hickey et al, 2012). Smith et al (2005) say that this does not work properly because nursing documentation is done manually, data is recorded in writing or recorded in graphical form. And this documentation may not be read by other health teams, although it may contain important information. This cannot increase information exchange and coordination between nurses and other health teams. A lot of data is collected repeatedly and may be wrong. In 1988 nursing care reported more than a quarter of hospital costs. This IT-based documentation system will assist in meeting documentation standards, can ease the workload of nurses and can improve the quality of documentation with the resulting report will be read automatically. Reports can also provide immediately available data to find out client care days, reduce care costs, audits, control of health services (Nokes et al, 2012).

Electronic-based nursing records are expected to improve the quality of care provided to patients who are hospitalized. For nurses, the use of electronic documentation resources is very relevant because this is where nurses get and pour as much patient information as needed. There are not yet many integrative reviews of existing literature relating to research into the relationship between electronic nursing documentation and the quality of care provided to inpatients. There needs to be a deeper review of the empirical literature so that this method is easily applied in the field. Until now, the use of electronic nursing documentation to improve patient outcomes still does not need to be applied for further research. This research was conducted to find out how effective the daily interactions between nurses and electronic nursing documentation are to provide quality care for patients who are hospitalized. The majority of US hospital care units currently use paper-based nursing documentation to exchange patient information with quality care (Kelley TF, Brandon DH, & Docherty SL, 2011). Electronic nursing records are used in health care institutions to improve the quality and safety of patient care. This method is considered important and is recommended by health care providers in health care institutions for use. However, there are challenges associated with implementing electronic nursing records, such as the need for adequate facilities and the ability of qualified human resources to do so. However, challenges must be found for solutions, see their impact to improve efficiency, and this system has benefits. In health care organizations, doctors and nurses are the main service providers who benefit directly or indirectly from electronic documentation systems other than patients. Health experts have recognized that the ability of nurses and doctors to use electronic documentation is significantly very effective in patient care and improving patient welfare, reducing costs for training and reducing health care costs. However, nurses need the skills and knowledge to use electronic documentation effectively, they gain knowledge through training and job training (Powell-Cope, Nelson & Patterson 2008, 50 in Kamau, Nancy, 2015). Nowadays technology has developed rapidly, so has the technology developed to support nursing performance in terms of documentation in the form of an electronic nursing documentation system. This application is based on IT technology that will support the recording and documentation of nursing cases to clients. Like European countries that have developed technology to improve the

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documentation system which is a systematic method. Nursing documentation that has been aimed at improving client records and maintaining the quality of nursing care (Lovlien et al, 2007).

## 2. METHODE

Documentation is anything that is printed or written that can be used as a record of evidence for authorized individuals (Potter, 2005). The use of patient identification documentation in nursing electronically can always be developed in line with technological developments, so as to increase client life expectancy and reduce the risk of mistakes in taking action to clients. Documentation of patient identification results in nursing makes decision making easy and provides information that is easily accessible, can minimize the potential for loss or damage to the client's development record, increases information exchange and coordination between nurses or other health teams, documents easily identifies patient identification results, helps improve accuracy of client data, can access the progress of the client's health development and reduce care costs (Kelley et al, 2011). Document nursing electronically using a system of security, confidentiality and access rights. Ensuring the privacy and security of client information by emphasizing the use of access through a password, access to information is only given to authorized people (Blair & Barbara Smith, 2012). System records that electronically document patient identification results that contain problems, patient demographics, medications, and progress notes, vital symbols, past medical history, laboratory data, immunizations, and radiological reports. Some important benefits in electronic documentation include the ability to easily access computerized documents and leave manual notes that may be difficult to read or misunderstandings due to unclear writing. This can cause errors in medical records. Electronic documentation systems are expected to increase the value of care and minimize costs at the level of the health service delivery system. These three main functions include the exchange of health information, supporting instruments for clinical decision making, and computerized doctor's advice. Electronic documentation using empirically supported medical decision-making instruments is associated with increased adherence to evidence-based clinical strategies and efficient care. Apart from the ideal goal of a health care provider, several factors can produce results in the experience of patients who do not adhere to guiding principles of best practice. However, nurses are in a better position to use this system so they can offer effective services (Menachemi & Taleah 2011, in Kamau, Nancy, 2015). Each nurse brings a tablet computer to do nursing documentation on the client, with proper care and confirmation of nursing orders, examination of medicines, providing uniformity in documentation and sharing information with other medical teams with the support of electronic nursing documentation. The data collected is rearranged to produce a printout in the form of situation, background, assessment, recommendation (SBAR) (Simamora, 2017). Documents can be read on one page and generate reports automatically and can be shared by all health teams. Includes patient diagnosis, care, prognosis, permitted activities, allergies, functional limitations, mental status, nutritional requirements, safety measures, frequency and duration of visits for appropriate nursing services. Implementation and evaluation can be accessed for 12 hours (American Hospital Association and Pricewaterhouse Coopers, 2001).

## 3. DISCUSSION

Documentation is the written and legal record of patient intervention and includes a series of processes. Documentation of patient identification results is made with the patient's personal records, which are the basis of information about his health situation. The

importance of nursing documentation is neuralgic, provided that without it, there would be no complete qualitative nursing intervention and even no effective treatment for patients. The objectives of nursing documentation include research on more effective care of problems that have been detected, programming of care through the organization and modification of patient care plans and more direct communication between professionals from the health system, who collaborate on patient care. Many documentation methods and among the most basic are methods directed at the source or problem, system-intervention-evaluation problems, focused registration, focus diagrams, exceptions registration, electronic files and home documentation. The patient file must describe the current situation and reflect the entire nursing process. Apart from the documentation system used by an institution, nurses continually register various evidence of nursing activities, during the useful life of care. Electronic documentation is a computer-based recording system that records the activities carried out by nurses in nursing activities, namely documentation of nursing care. Written records inform all nurse visits in the form of brief summary notes of patient care needs and interventions that have been applied. It is estimated that in 200 most health facilities will implement several types of electronic documentation and electronic documentation systems. In 2003, Tommy G. Thompson, Secretary of the Department of Health and Human Services, requested two prestigious organizations, the Institute of Medicine and Health Level 7, to form a national task force to set standards for electronic documentation. The task force has proposed a standard model for use in several electronic documentation pilot projects. To date, the electronic documentation model has had a broad impact on the entire health care community, from large companies to individual practices, with many countries forming advisory boards to develop strategies for how electronic documentation can be applied across the state. Through the Health Information and Management System, a definition model has been developed that details eight important attributes and requirements for electronic documentation, from the need for safe records that can be accessed in real time to records that can help support clinical trials. All health service agents are expected to have electronic documentation in the near future to ensure safety and better care documentation. For many reasons, moving to paperless health service records is a daunting and costly endeavor for health care institutions, and not everyone is enthusiastic about using electronic documentation. Thus, the rate of adoption varies greatly from one region to another. Many problems are faced in implementing electronic documentation of an organizational nature and behavior, and can be related to attitudes towards the use of electronic technology or the failure of implementers to seek input from potential users (Moody, Elaine Slocumb, Bruce Berg, & Donna Jackson, 2004). This documentation reports the actual condition of the patient so that it can speed up the health team in making the right decision in providing patient care and setting priorities and deciding which treatment is appropriate for the intervention. Furthermore, the data collected is stored in a database as written evidence about the patient's progress. The Nursing Practice Committee recommends consistency in evidence-based care procedures, which consist of patient data and strategic plan data, in and ultimately in all treatment situations. An assessment of the quality of appropriate care can only be prepared when a consistent process and commodity prevails (Lavin, et al 2015, in Kamau, Nancy, 2015). If nurses or nurse experts use their resources and cannot make maximum use, such as not being able to apply according to the abilities that must be possessed by nurses who can use electronic documentation. Thus nurses will feel comfortable doing their work. According to Arevalo (2005, in Kamau, Nancy, 2015) inaccurate and inefficient scheduling

tasks in the provision of health services many difficulties in providing quality client care and managing medical costs, such as lack of labor. The author further points out that one way to achieve efficiency is to prevent inconsistencies in providing health care procedures so that they can make good use of the available workforce. Most health institutions now expect nursing staff to consider the average patient's needs. However, the symbol of demand creates pressure for nurses and impacts on the quality of care. Likewise, a statement from the American Nurses Association (ANA) states that improving work arrangements ultimately depends on the ability of nurses to phase. (Fathi, 2019)

#### 4. CONCLUSION

Documenting the results of patient identification in IT-based nursing is very necessary in the modern era, in addition to being able to provide data accuracy to clients and planning to produce quality and performance of nurses in performing good nursing care. As a health service provider, the hospital is also greatly helped by the electronic nursing documentation system because it can provide quick access to provide information, minimize the potential for loss or damaged information, reduce the budget costs incurred. Can reduce the risk of errors in interventions, assist in fulfilling responsibility responsibilities through accurate information and patient data, facilitate epidemiological data, improve communication in information exchange and coordination between nurses and other health team members, improve patient safety by reducing medical errors.

#### 5. SUGGESTION

Provide input to health care providers to be able to document the results of patient identification and nursing care with a technology-based system, especially in Medan City Hospital where clients who have returned home can return for treatment at the hospital. By using this system, client's medical history records will be more easily accessed. Hospitals can support the quality of services intended for client satisfaction. Technology-based nursing care documentation can also spur the progress of nurses, other health professionals, hospitals have a high competitiveness because it can reduce the risk of mistaken nursing care so as to improve the quality of client safety. The documentation system of patient identification results in electronic nursing is a good system if implemented in Indonesia because it is more efficient, many nursing actions require a long time, this of course reduces the nurse's time in writing and makes nurses more concerned for clients but this is a challenge for nurses in meet the needs of clients various obstacles that can be experienced such as human resources, the need for training and service systems in hospitals in the use of management information systems.

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