ELECTRONIC HEALTH RECORD IMPLEMENTATION

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**Introduction**

Electronic health records is an innovation from patients documentation on paper to digital mediums. As the electronic record system for patients started as late as the 1970s by the Regenstrief Institute. However, due to high implementation costs and unfamiliarity by the physicians, it was initially only taken into practice by hospitals and high-end institutions. Later, with the advent of the internet and affordability of computers by the '90s, came the electronic health care record systems. The electronic health record mandate was developed by Obama’s administration recognizing the role of information technology in the health care systems. Electronic health record (EHR) mandate was hence developed to share patients medical data and files with the healthcare providers and institutions like clinics, hospitals, research facilities and laboratories (Providers & Professionals). The system provides a comprehensive electronic account of the patient's health record. EHR provides an immediate record of the patient required, available to the user. The EHRs goes beyond just only containing medical treatments, history and immunization and allergy records of the patient; it cohesively goes beyond just standard data collection. The global health systems are increasingly adopting the EHR systems shifting from personalized style treatment to a collective one with the aim of reducing risks (Yu Cheng, 2016).

**Goals**

The ultimate goal of electronic health care mandate is to address the patient safety and improve on the essential gaps which delay care to the patients, reducing costs. Defining goals leads to determining needs. The digital mediums mandate therein offers to cater to such demands by identifying a particular set of goals. Hence the EHR system is critically established to improve physicians access to patients record on one medium, decrease time to get results and cost to run to labs for results hence providing real-time diagnoses and care to the patient. EHR thus enables efficiency and reduction in costs and improving coordination in care.

**Facility’s plan**

A hospital with an EHR system is required to fulfill specific computerized functions, from patients demographics to their prior treatment histories, physician assessments, laboratory tests, MRI reports and order for medications (Julia Adler-Milstein, 2015). The facility I’m working in also operates an electronic health record system to increase efficacy in care providing and reduction in costs. We use the system to update and digitally chart the patient records. This helps the staff and physicians in the hospital to easily access the patient’s prior treatment and medication history. The information updated by our system is also accessible to any other healthcare provider who uses the EHR system. The EHR system allows electronic verification of prescribed drugs, electronic prescription, clinical session record, conditions and medications, and electronic reporting. The comprehensive data of patient care within the hospital reduces medical interactions, errors, minimizes medical costs and helps the staff to cooperate. The patients are well informed about the usage of EHR system at our facility since their admission to discharge. This allows them to even access their records and treatment details from their personal space of comfort. The hospital has made a lot of progress in the past few years through the use of EHR and has also improved productively.

**Conclusion**

Electronic health care system can improve efficacy, reduce cost and digitalize electronic records; however, assurity of patients record safety is also paramount. It is central to ensure the privacy and access of patients details and to what information the patient wants to share with medical staff and on the system. (Nathaniel, 2013). Moreover the fact that strict attention to detail to patients information and their access is a vital responsibility of the staff (Nathaniel, 2013). Thereby adding to the meaningful use and trust of patients on the electronic health record systems.

# References

Julia Adler-Milstein, C. M. (2015). Electronic Health Record Adoption In US Hospitals: Progress Continues, But Challenges Persist. *AFFORDABILITY, ACCESS, MODELS OF CARE & MORE*.

Nathaniel, B. (2013). *Ethics and Issues in Contemporary Nursing.*

Providers *&* Professionals. (n.d.). Retrieved from HealthIT.gov.

Yu Cheng, F. W. (2016). Risk Prediction with Electronic Health Records: A Deep Learning Approach.