Nursing documentation has been one of the most important functions of nurses since the time of Florence Nightingale. It is a fundamental nursing responsibility with professional, legal, and financial ramifications. Documentation is an integral part of safe and appropriate clinical practice and is a record of judgment and critical thinking used in professional practice. Nursing documentation is defined as the record of nursing care that is planned and given to patients by a qualified nurse or by other care giver under the direction of a qualified nurse. Objective and relevant documentation promotes consistency in client care and effective communication between members of the health care team. The healthcare 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 is radically transforming to meet the evolving and complex health care demands. The transition to computerised documentation is one technological change that has significant implications for the nursing profession and the overall health care system. Such systems relieve nurses of time consuming clerical duties and assist them in producing legible and comprehensive patient care plans and documentation.

Computerised Documentation

Nursing documentation continues to draw criticism from professional, community and regulatory organisations because of incomplete, sub-standard charting practices. Handwritten documents often omit patient’s data, including clinical problems or care plans, interventions, especially the 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 disruptive, incomplete and inappropriate charting. Quite often, complaints arising from clinical incidents lead to indefensible claims due to lack of thorough documentation and accountability. Therefore, standardisation of nursing records is important with regards to adequacy of formal language, grammar, accuracy, brevity, clarity, identification and technical terminology. Computerised 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.

Computerised Health Records

Although methods of charting have evolved overtime to meet the ever 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 organisations to develop and use a computerised 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 realised that the next logical step for health information system was a completely integrated computerised medical record.

Advantages of computerised nursing documentation

Computerised nursing documentation has distinct advantages as listed below.

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1. Improves quality of nursing documentation by:
   a. Providing clear, accurate, legible, comprehensive patient records and eliminating handwritten patient notes.
   b. Replacing incomplete, fragmented, and sometimes difficult to find paper-based records.
   c. Providing a single, shareable, accurate, up to date, rapidly retrievable patient data.
   d. Reducing documentation redundancies.

2. Improves patient care by:
   a. Facilitating use of structured tools for assessment as a basis for setting priorities and deciding the appropriate nursing interventions.
   b. Enhancing patient safety by reducing medical errors.
   c. Unifying the pieces of information to create an entire picture of patient care accessible to individuals involved in patient care.
   d. Facilitating prompt decision making by providing quick access to patient information and decision support system.
   e. Minimising the potential of lost/damaged information.
   f. Reducing duplication of diagnostic evaluation and risk of treatment delay.
   g. Enhancing continuity of care.
   h. Ensuring confidentiality.
   i. Providing access to patient information by multiple users at one point of time.

3. Improves communication, exchange of information and coordination among nurses: between nurses and members of health care team; between different health care facilities.

4. Facilitates clinical nursing audits.

5. Reduces cost by consolidating patient data in one place and eliminating the need for maintenance and storage of paper records.

6. Assists in meeting regulatory and legal documentation requirements by improving the accuracy of patient information.


8. Facilitates data mining for quality assurance and research purposes.

9. Provides opportunity for computerised self-tutorials to keep nurses abreast of the latest updates and advances in the health arena.

10. Enables epidemiological monitoring and disease surveillance.

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

**Challenges to Adoption of Computerised Health Records**

Embracing computerised health record technology is a daunting task even for those who claim to be computer savvy. Apprehension and fear of a paperless system is brought to the fore by those who are deemed to commission the computerised health record technology. Its implementation is a course of action that requires time and attention.

Transition to computerised documentation creates stress, uncertainty and role confusion. The computerisation of nursing documentation systems necessitates both structural and behavioural change. Since some nurses are resistant to change, the implementation of computerised documentation can be a challenge. Lack of nurses' acceptance and their attitude has been cited as factors that hinder computerised health record implementation. Widespread implementation of computerised health records can also be hampered on technical grounds; 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. Computerised 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 computerised reporting systems, cases of wrong classification of patients and their conditions have been reported. These barriers may be minimised by:

a. Clearly communicating to nurses the need for change from paper- to-computer-
Communicating the benefits of computerised 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 computerised documentation.

Training programme for nurses regarding computerised 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 computerised nursing documentation.

Ensuring privacy and security of patient information by emphasis on non-sharing of passwords: access of patient information to authorised persons only; and encryption of information so that it cannot be read by an unauthorised 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. Firm evidence has increasingly shown that current systems are not delivering sufficiently safe, high quality, efficient and cost effective healthcare, and that computerisation, with the electronic medical records at the centre, is effectively the only way forward.

Computerised 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 in terms of time, money, process change and human factor reengineering.

Although computerised nursing documentation has its own challenges, yet it can provide uniformity in documentation of nursing activities across the health care organisation. The benefits certainly outweigh the risks. Despite certain challenges and hinderances, adoption of computerised documentation is the best way ahead to meet the new challenges and changing needs of the health care.

**References**