How to Cite:
Alotaibi, A. M. F., Alqahtani, Khalid M., Alshammari, Basheer G., Alharbi, Fahad A., Aldawsari, A. H. A., Alrashed, M. A., Alzahrani, Nader S., Jabal, A. M. B., Alqahtani, K. M., Alshammari, Basheer G., Aldawsari, A. H. A., Alrashed, M. A., & Alzahrani, Nader S. (2023). Improving patient care through effective medical records management: A nursing and physician perspective. International Journal of Health Sciences, 7(S1), 3842–3857. https://doi.org/10.53730/ijhs.v7nS1.15422

Improving patient care through effective medical records management: A nursing and physician perspective

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International Journal of Health Sciences E-ISSN 2550-696X © 2023.
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Manuscript submitted: 01 Jan 2023, Manuscript revised: 09 Jan 2023, Accepted for publication: 15 Jan 2023

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***Abstract*---Background:** Health information also oversees a very important function in relation to the safety of treatments and the general quality of a healthcare service. Over the recent past, with the adoption of Electronic Health Record (HER) with the decrease in the use of paper documentation there have been advancement in the documentation of health records from easy access to accurate documentation. **Aim:** This study seeks to understand how to improve the chances of positive health outcomes through the management of medical records on the part of health care givers; and potential strategies of interest include the views of stakeholders and benchmarks concerning management and ways of preserving the identity of patients. **Methods:** As a result of the literature review, the findings of studies on the effectively and ineffectively implemented HER system, records management by interdisciplinary teams, and measures of maintaining confidentiality of patients were reviewed. **Results:** The study also revealed that accurate medical record keeping play a very vital role to enhancement of health care delivery and work effectiveness. Increased use of technology especially in implementing EHRs has enhanced ways of accessing information, decision making and communication in a team. Coordination with the physicians, nurses and administrative staff was considered to be perfect during data recording and data collection process. **Conclusion:** Health information management is a critical component of health care systems to make them efficient. The use of technology, cooperation between different fields, and protection of patient's details will help health care organizations to get better results for patients, make work faster, and protect important information.

***Keywords*---**Charts and records, Electronic Health Records, health care efficiency, patient anonymity, multimodal care, Information Technology in health care, guidelines.

Introduction

Maintaining electronic health records is a key element of contemporary health care and it is considered as a core element of the effective provision of appropriate and safe patient-centered care and to inform over clinical decision making. The change from paper documentation systems to modern HER is a big step toward change in the documentation, accessibility, and usage of patient information. Medical records are no longer limited to clerical tasks in a healthcare organization; they are pivotal to the enhancement of patient care and organization of care givers' work, and patient privacy protection, In the contemporary data

environment of healthcare, the increased difficulty of patient management requires effective solutions for medical records. This involves embracing such technologies as Cloud, Teamwork among health professionals and complied confidentiality measures. Everybody starting from the physicians, nurses, administrative worker right to the IT team has their contribution to making sure that these medical records are complete, valid and safe. Technology has been used especially in HER systems to make patient data available, coordinate work and use evidence-based information. But it has also brought out issues like; cyber security vulnerabilities and the constant training of staff.[1,2]

These points make this research diverse as it considers Medical records management in relation to; improving health care outcomes, Nurses and physicians' perspectives, methods of optimizing records, and patient's privacy. Through exploring these elements, the study reveals how enhanced medical records management leads to the enhancement of clients' care and organization's efficiency through identifying tasks and barriers related to it Understood Role of Medical Records in Promoting the Health Care Outcomes. Health records act the main field arch in any health system since they are very vital in delivering high quality, efficient, safe and sufficient care to the patients. These records are combined cumulative files of patient's medical history, a source of certain data such as diagnoses, treatments, test results, medication, and progress notes. Since they give the exact history of a patient's health history, medical records help in avoiding errors and ensure that all the providers working on the patient provide a consistent approach to the patient's case. For example, on a PC, a physician can easily spot symptoms, disease stages or determine future treatment reactions based on previous outcomes. Such continuity becomes very important in the case of managing chronic diseases where constant follow up and consistent changes in the patient's treatment regimes may be needed to obtain the best outcome.[3]

Moreover, medical records also help to improve the communication and cooperation with another healthcare team. Atul Gawande points out that the latter is typical of modern healthcare when a patient is treated not only by a physician and a nurse, but also by various therapists and pharmacists, as well as other care givers. Complete, accurate, and updated record keeping means that all the members of a healthcare team are utilizing the same information, minimizing the possibility of mistakes, repetitions, or perhaps conflicting courses of action. Such an approach enhances the efficiency and central drive of focused coordination towards the optimum outcomes of the patients. Moreover, in some cases, people's identity is crucial for treatment: immediate access to patients' medical history can save lives since doctors can do not spend much time questioning the patient or repeating tests. Aside from the use at the individual patient level of care, medical records are of huge help in the surveillance of public health and research. Data collected from the patient's health records can be combined together thus showing the patterns of diseases, the efficacy of treatments, and new threats to human health. This information is of vital importance at the formulation of public health polices, in the formulation of preventive measures, and in research. Furthermore, the subsequent formation of digital medical records has further intensified their potential or uses by means of real-time, interoperability and immediacy of use with other high technologies such as artificial intelligence and analytical tools. These innovations thus add to

the practices in healthcare systems to increase efficiency and effectiveness of timeliness, customization and patient outcomes. Hence, records are not mere clerical assets but are core to enhancing health care results at personal plus organizational levels.[4]

Nursing Management of Medical Records

It has been observed that medical records run through the hands of nurses primarily as these professionals form the first line of interaction with the patient and it is their responsibility to document some important facets of the care giving process. Nurses record patient care by documenting patient's assessments, physical examination, administration of prescribed medications and treatments, and patient progress from admission to discharge. Along with these records, they help in painting an overall picture of the state of the patient, and in addition to this, the documentation maintains the line of service provision from shift to shift and provider to provider. To nurses, medical records are a record of the patient's progress, the documentation of significant information and a record of all that took place with the patient. Documentation is hence critical to ensure that patients' record is accurate and complete bearing in mind it will act as referential information in case of legal or ethical issues.[5,6] Another realistic reason to advocate for real-time documentation was learned from thepracticeofnursing. Writing it down as soon as possible and being as detail-oriented as possible is important to nurses since waiting too long prejudices patient's safety. For instance when a patient resident status changes abruptly, Early documentation help the medical team to take necessary action in proper and efficient manner. Nurses also keep emphasizing a thought that subjective findings, including a patient's emotions or body language, should also be included in the medical record. These findings may afford a more comprehensive picture of the holistic patient and their subsequent adjunctive treatment plans addressing both physical and mental health status.

The Issues of concern by nurses include; Availability of time to manage the medical records, technical issues with HER systems, and burn out among other challenges. This work coupled with the existing work load depresses the nurses, additionally it becomes hard for the nurses to have adequate time to do patient care work and also do documentation required for work. Most recommend HER systems that are easy to use and effective in saving time, so practitioners can spend more time on patients. Pre-service education and in-service training and support for nurse to navigate and apply technology are also important since not all are ICT (Information Communications Technology) literate.[8] Also, nurses confirm the ethical obligations of patient privacy regarding the records of medical practice. They are sometimes on the leading edge of compliance with mandated privacy statutes like the Health Insurance Portability and Accountability Act (HIPAA) and the protection of information that people might not want revealed. As this responsibility points out it is important to pay close attention to how patient records are accessed, shared and stored especially in the light of technology. Altogether, the current research suggests that nurses have important perspectives regarding the records management; they consider the importance of achieving both accuracy, on the one hand, and patient-oriented empathy, on the other. If the challenges that they encounter and even their perspective is considered the

healthcare system can extend the efficiency and better quality of the medical records.[9,10]

Physician- Related Sample Surveys – Physician Perspectives on Effective Documentation

Doctors regard proper documentation as an essential component of patient care in producing quality outcome. These are purely clinical documents that help the physician document diagnostic or clinical decision making and treatment or management plans or follow-up advice comprehensively. These records are not just other administrative records; they are core to patient safety since they reduce the chances of a provider giving the wrong treatment upon relying on another's notes. Documentation is very crucial to physicians since any confusion or lack of details could cause misunderstanding, cause physician delays or have negative consequences for the patient. For instance, recording of notes such as medication allergy or contraindication can eliminate potentially fatal mishap during prescription of drugs.[11,12] Documentation also plays the role of the interface of physician-physician communication and communication with other members of the healthcare team. In extended procedures involving multiple doctors, adequate and clear descriptions of a patient's history, and the care they have received by other doctors, can be effectively communicated to all professionals. This is especially important in situations where the physicians delegate responsibility of observing signs of deterioration in patients' health among the nursing personnel or other team members. From this view, documentation is no more simply the documentation of data; it is the organization of teamwork in a multidisciplinary setting.[13]

Physicians are aware of legal and / or ethical issues involved in documentation as well. Logging of specific and pertinent facts is critical when responding to a malpractice lawsuit, establishing that appropriate care was rendered and that (best practice) protocols were followed. Furthermore, physicians are patient advocates for their privacy and as a result understand the delicate balance that has to be struck between documentation and privacy. They invariably experience some difficulties either in compliance with certain requirements, such as HIPAA or in addressing the need of digital documentation in HER systems. However, physicians have often complained about feelings that good documentation demands a lot of time and energy. Some end up spending many hours in charting without necessarily being in touch with their patients physically. Due to this, there has been more pressure for changes in the HER systems with the aim of reducing overheads. Voice recognition, templates, and automation offer possibilities for changing documentation, so physicians can pay greater attention to patient care. The doctors indicate that education and training to improve on the documentation process and skills together with focus on the new systems are also valuable in improving the medical records as they also stressed on the issue of IT systems. [14,15] from the physician's point of view, documentation is clinical as well as a professional's paramount responsibility. By emphasizing accuracy, clarity, and collaboration, physicians ensure that medical records serve their primary purpose: that enhance good patient care into the future. The two major limitations are time and technology; it is therefore proposed that these issues can

be built upon to improve documentation leading to the overall improvement of results in patient care and the health care system.[16]

Examining the Difficulties of Maintaining Medical Records and Their Implications to Client Outcomes
Physician Interview Questions: Views on Documentation

Hierarchy of needs shows that physicians understand documentation to be a crucial component of patient care delivery. Thus, the main advantage of medical records is their orientation on the physician's thought process and the possibility to provide overall and detailed analyses of the cases as well as diagnoses and treatment plans and recommendations on the follow-up. As these records are also significant symbolic documents, they are crucial to patient safety because they provide providers with the important continuous information needed to avoid adverse medical events. A common statement made by physicians is where there is any wavering or contradiction or lack of sufficient documentation, then there would be severe implications. For instance, a bold note on a patient's medication allergy or contraindication can reduced extremely risky cartridge errors during prescription. [17,18] Documentation also plays another very important role of communicating the physician's intentions to the rest of the healthcare team. In extended oral presentations in complex cases involving interrelated specialists, such clarity of documentation enables all those involved to have an integrated view of the problem and its history of management. This is especially relevant in cases where the physician depends on the nursing staff, or some member of the team, to observe the changes in the patient's status. From this view, documentation is not just limited to a data recording process but it is a coordinated process within a team approach context that would have embraced the principles of multidisciplinary team. [19]

They also understand when documentation is legal and ethical implications of the matter occur. Among the reasons why detailed and accurate records are required in the clinical practice they serve a crucial role in defending against the malpractice claims, the documentation of care rendered and compliance with the governing clinical standards. Furthermore, physicians promoting patient rights are very sensitive to the conflict between record keeping and privacy. Consultants and advisors report that staff experience difficulties in maintaining compliance with rules such as HIPAA or fulfilling the requirements of such a digital documentation tool as HER systems.[20,21]

However, it is also one of the most important elements of work for physicians; at the same, time the process is often perceived as time-consuming and unrewarding. A lot of people end up having prolonged time spent on the charting, often at the peril of limited physical touch with the patients. This has lead to demand for enhancements of the HER systems cutting on the amount of time spent on paperwork. Such as voice controlled, template and automation, that allows certain paperwork to be managed and kept in check so as to let the physicians more dedicated on their patients. Physicians also expressed need for training and support to improve documentation to optimize the medical record accuracy and efficiency since this function is highly sensitive to training and new technologies. [22]

All in all, according to the physician, occasioned documentation is an imperative clinical and occupational mandate. By emphasizing accuracy, clarity, and collaboration, physicians ensure that medical records serve their primary purpose: supporting the best level of patient care. Taking time, and intake of appropriate technology into consideration can even more boost documentation practices which in the long run benefit patients and the potential of the health care system.

Medical Records Management in Health Facilities

Efficient management of medical records in clinical environments is an important factor to look at with a view of boosting patient outcomes as well as increasing work productivity while underscore legal issues that govern record keeping. Best practices are aimed at using information technologies, simplifying work, and promoting quantitative methods. HER systems are currently the most efficient approach of re-designing a friendly user-primary care environment. These systems collate the patient information making the records less centralized and more accessible to the caregivers. System attributes such as automatic data capture, voice recognition and clinical decision support systems have been considered to shave a lot of time off the documentation process and error-prone. Furthermore patient centered templates specific to the specialties of the physicians and nurses enable quick entry of specialized data into the records while making them comprehensive. [23] Education and awareness about disability for healthcare providers are also important include training and retraining. What we also realize when all staff members are well equipped with how to use the medical records it is very effective for documentation. Staff seminars are conducted and on-site assistance maintains awareness concerning changes in the system and newer methods. Further, feedback given to the submitted documents can be useful in promoting compliance with standards as well as record keeping systems. When wish-B property is communicating the consequences and the influence of the proper records for the patient and the legal structure, the employee will be willing to conform, and make precise records. [24]

Another approach is interdisciplinary work is another approach. This increases the chances of efficient documentation of the patient's care since all the members of the care team; physicians, nurses and the administrative staff work as a team. For example, every-day team meetings for going over patient case files are useful to look for any lost or missing records or discrepancies. As with interdepartmental documentation, standardizing the documentations also maintain consistency as well as reduce confusion in regards to documentation especially when multiple providers are involved in the case .The use of data analytics Is a relatively new approach to managing medical records. While documentation is often a tedious process, it is not difficult to use more sophisticated analytics to detect where there are patterns of errors, duplication, or inefficiency in documentation. For instance, analysis might show that some fields in an HER system are often left blank and then specific measures are taken. These ideas can also be applied to better understand the needs of users in terms of system design, documentation and overall workflow. [25,26]

Finally, patient's privacy has to be respected while maximizing records. Security features like encrypt and use of UTUAL multi-factor authentication prevent cases of leakage of patient information. Other ways to maintain the HIPAA privacy regulation is to perform frequent access audit of logs. The conflict between efficiency and security is the foundation for developing a trusted environment for medical records while maximizing their effectiveness.[27,28] enhancing of medical records in clinical environment needs the utilization of the technology, staff education, interdisciplinary cooperation, improvement based on the collected data and absolute confidentiality. Through the unveiling of these strategies, healthcare organizations are able to optimize the quality and availability of medical records thus leading to better patients' welfare as well as the operation systems within the facilities. [29]

Application of Information Technology in the Management of Medical Records

The use of technology in handling records has changed the health care sector in that information technology enables better management of records and greater accuracy and access to information about the patient. At the heart of this transformation is the Electronic Health Records (HER) systems that are gradually replacing paper based system with patient centered electronic systems. These systems enable the healthcare practitioners to view the complete history of a patient, his/her lab reports, scans, prescriptions and past treatments simultaneously. This integrated access reduces duplications, enhances accuracy, and guarantees that the clinicians get the necessary information on time to aid their decision-making process. For instance, getting a summary of a patient that can be retrieved in the shortest time possible will increase the response towards a patient in emergency.[30] complementing utilities in HER systems, including CDS, contribute to the improvement in medical records and management since they offer suggestions during documentation. They help to identify possible drug interactions, recommend corresponding tests, or draw attention to certain important changes in the patient's condition that can help clinicians provide safer and more efficient patient care. Automation goes a notch higher in increasing efficiency owing to the fact that manual entries of data are not only involving but also inaccurate most of the time. For instance, automatic speech recognition, about which physician's write notes to voice them, makes documentation easier and enables clinicians to spend more time with patients than writing their notes.[31]

Another major technological development which has raised the handling of medical records is interoperability. Contemporary HERs are developed to fit in other healthcare systems to ensure that information exchange of the patient is secure between the organizations. This is especially useful with clients who may consult with several specialists or who change residences often. Interoperability, as we have seen, provides continuative care since all the records of a patient are shared with all the stakeholders in the patient's care thus eliminating instances where information may be missing and jeopardies the treatment. [32] technological advancements have also led to connection of records with telemedicine systems and remote tracking gadgets; consequently, records encompass data derived from virtual conferences and remote smart health

monitoring gadgets. Due to this approach, health plans are more specific and offer a lot of preventive measures .However, incorporating technology to handle medical records has some disadvantages as will be discussed below. To develop and implement electronic documentation and record system is costly and time-consuming process because it involves certain changes in infrastructure, personnel, and technicalities. Resistance to change in the health care providers and employees also poses a challenge to adoption, encouraging the developers to come up with easy to use display and training modules. Two main risks are worth discussing; cybersecurity is an issue because the increase in medical records' digitization opens the possibility of cyberattacks and unauthorized access. Security controls such as, encryption and data authentication, use of passwords, accessing control and an audit of the data should always be in place to ensure that the patient's insecure data is protected.[33] Thus, it can be concluded that technology incorporation into medical records oriented processes has significantly enhanced logistics and quality of healthcare service organization. Through the use of HER systems, automation, as well as system integration and advanced tools, there is an enhancement of patients' information accuracy and availability and at the same time an achievement of reduction in health care work-related burdens. Despite these challenges, meeting them through appropriate investment and planning guarantees further development of technology to increase the efficiency of medical records management, and, therefore, enhance patient and provider satisfaction. [34]

The Interdisciplinary Approach to Medical Records Management

The tools of governance of medical records focus on the integration of MRM from various fields in healthcare to create effective records. This perspective acknowledges that MR are not just clinical tools but multi-faced documents that contain various aspects of patient care, diagnostic and treatment plans, nursing care plans, administrative and legal concerns. Every player in the health sector in the health sector including doctors, nurses, pharmacist, physiotherapist, secretary, and even information technology professionals play a role in managing medical records. These professionals can discuss, identify and correct shortcomings, and also raise the standards of documentation in care delivery.[19,20] This is because physicians and nurses are core in this approach since they record essential clinical data. Doctors make notes of diagnostic impressions, management plans and clinical observations, whereas nurses document patient status at the beginning of the day, changes in patient status, and response to interventions. The key roles include recording of the patient's medication profile, therapeutic duplication, and checking for compliance to Dosage/ survival directions. Clinicians contribute their ideas based on progress notes and/or therapy data helpful for multiple discipline treatment. The incorporation of such inputs into one patient record makes it easy to achieve an integrated, comprehensive view of a patient's health status while promoting an interdisciplinary approach to his/her care.[21]

The roles of other workers include administrative staff and IT specialists in this approach. Administrative personnel are responsible for record keeping and update as well as information compliance while the Information Technology personnel are concerned with system related issues of the Electronic Health

Record (HER) systems. They create compatibility which enables organizations and departments to share data and information. Another important measure used by IT teams is the measures to protect patient's privacy and data from hacks, which is one of the biggest issues in modern healthcare records. [22] Combined they improve the availability, safety and usability of medical records making it easier for healthcare providers to spend time with patients.

It means that communication between health professionals who work in different fields is particularly valuable and important when it comes to cases like the ones mentioned above: inadequate documentation or care fragmentation. Daily team meetings, protocol specifying and following, and group training sessions may help to bring practices consistent in different disciplines and avoid mistakes and duplication. For instance, a single format for documentation or checklist means that all players will be in harmony with the records. Further, feedbacks in the team are facilitated with feedbacks which may improve documentation with each discipline giving feedback to the other. [23] It also aligns with other more global health Initiatives that are now embraced; like quality improvement, research, and population health. The data collected in well-organized records allows healthcare organizations to study and compare trends, evaluate results, and consider opportunities for change. For example, analysis of data from records from various fields can present an understanding of patterns of readmission of patients for care improvement. The records accumulated in research serve as large, reliable sets for understanding disease development, interventions' effectiveness, and healthcare inequality. [24]

Some of the Most Effective Methods to Adhere to Patient's Identity Privacy

The principle of patient confidentiality is one of the main principles in ethical and legal practice, while providing protection for patient data and preserving their trust for their healthcare givers. Strategies used for maintaining confidentiality include; policy measures, technical measures, staff measures, and patient measures. These measures aim a t diminishing the likelihood of different people gaining access to patient information despite it is crucial for use in clinical practice.[25] The first of the best practices is to ensure that there are strong access controls in place. This is particularly important if patient records can be accessed by non-healthcare professionals, or several professionals within a healthcare facility, where permissions must be granted depending on the employee's importance level. For example, while physicians and nurses will require full information about a patient's history, the administrative staff will require some information on the patient's condition to facilitate billing. Such boundary conditions include the advanced systems that limit access these data; for instance role-based access controls reduce the probability of unauthorized access. Additional access logs can also be audited more frequently to identify other breaches if any and then attend to them. [26]

Technology also ensures compliance with privacy since the use of Electronic Health Record (HER) systems has become popular. Encrypting patient's data is therefore necessary to secure both information in transit and data at the database level. S authentication is the act of employing more than one factor to ensure that if the common log in details are stolen then access is denied. Heath care

organization also should also use secure methods in communicating patient information including encrypted e-mail or messaging. Moreover, timely update and patching, to the software systems, mitigates vulnerability that hackers can take advantage of, and enhances the security position of digital records. [27,28] Another important factor is informing all the staff about the major importance of maintaining confidentiality. It is imperative that healthcare workers understand the policies of the privacy laws and rules and regulation of the country such as the HIPAA for health care organizations in United States and GDPR for Europe. Training should include matters like how to identify phishing scams, how not to talk about patients in audible or public settings and how to deal with paper records. By conducting staff training periodically, the staff members are knowledgeable to new threats and the new practices to safeguard the patients information.[29]

The patients also need to be Involved when it comes to the issue of confidentiality as it is with engagement. The patient should be enlightened on how they can privacy be given when it comes to data especially their medical records with some rights being allowed to access, change or even deny use of their records. Understanding how your information will be used and shared can do much towards enhancing trust and enabling the confidence of the patients. Seeking consent just before sharing the learning, especially when for study or non administratively requisite uses is another prerequisite in conductress.[30,31]

Conclusion

Medical records systems are critically important to overall delivery of care, administrative, and patient satisfaction elements within the clinical setting. Using high technologies, encouraging the cooperation of different departments, and being scrupulous about confidentiality requirements, it is possible to construct a system in healthcare that will not only improve patients' condition but also work efficient, legal and ethical. The implementation of HER systems, along with training and collaboration, has greatly improved the availability and quality of data in health care organizations by also allowing evidence-based decision making in the health care field the advanced integration bring several issues such as cybersecurity threats and constant staff awareness. These issues have to be managed pro actively; security controls and audits must be implemented and any lapse in standard must be immediately reported and rectified by the healthcare providers. In addition, interdisciplinary coordination improves the containment of the medical record since it caters for the work of unique physicians, specialist, nurses, pharmacists, and other significant personalities.

An EMR system is vital for the overall care provided in a given clinical setting, performance of administrative tasks and the overall satisfaction score of the patient. If there is the attempt to use new technologies and uncover the conflict of the cooperation of the different departments besides adhering to the strict legal and ethical requirements pertaining to the confidentiality of patient-related information, it is feasible to develop in the healthcare industry the system that will not only improve the patients' conditions and the efficiency of the work but also the legal aspects of the field as well. Huge advancements have been made through the integration of Electronic Health Record (HER) systems, combined

with appropriate training that increases the availability of data, and cooperation that leads to enhanced quality of the records. Moreover, these systems enhance practice of evidence-based decision-making in the area of health care. Nevertheless, the highly implemented integration of these technologies has some issues like security breach and staff training. All these matters have to be addressed before the fact; security controls and auditing processes should be rigorously adopted and any slippage of these standards must be reported and corrected by the healthcare organizations. In addition, interdisciplinary cooperation enhances documentation since the work of different health care professionals is involved including the physician, specialist, nurse, pharmacist and other staff. Furthermore, their adoption implies that proactive and mandatory CME for healthcare workers should be in a position to know the ethics and the laws around EHRs and patient's data. Lack of knowledge, understanding or improper management of medical records may cause adverse consequences such as violation of patient's rights to privacy or that incorrect medical decisions may be made. Thus, in any healthcare institution, continuing education should be regarded as obligatory, and the rules for working with such information should be strictly defined. Another is the challenge of patient centeredness particularly in the light of unfolding technological innovations. On the other hand, organizational systems of HER systems increase efficiency but causes dehumanization of communications if well managed. Therefore, the use of technology to improve outcome because of disease burden should not destroy the culture of health provider –patient relationship. Evaluating information technology from the prism of a robust ethical platform of healthcare care systems benefits both patients and health care workers.

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تحسين رعاية المرضى من خلال إدارة السجلات الطبية بشكل فعال: منظور التمريض والأطباء

الملخص

الخلفية: تلعب المعلومات الصحية دورًا هامًا فيما يتعلق بسلامة العلاجات وجودة الخدمات الصحية بشكل عام. في الآونة الأخيرة، والحد من استخدام التوثيق الورقي، تم تحقيق تقدم كبير في توثيق السجلات (HERومع اعتماد السجلات الصحية الإلكترونية (الصحية، من خلال تسهيل الوصول إليها إلى التوثيق الدقيق.

الهدف: تهدف هذه الدراسة إلى فهم كيفية تحسين فرص تحقيق نتائج صحية إيجابية من خلال إدارة السجلات الطبية من قبل مقدمي الرعاية الصحية؛ وتتضمن الاستراتيجيات المحتملة التي تهم هذا المجال آراء المعنيين والمؤشرات المتعلقة بالإدارة وسبل الحفاظ على هوية المرضى.

المنهجية: نتيجة لمراجعة الأدبيات، تم استعراض نتائج الدراسات حول أنظمة السجلات الصحية الإلكترونية التي تم تنفيذها بشكل فعال وغير فعال، وإدارة السجلات من قبل الفرق متعددة التخصصات، وكذلك التدابير المتبعة للحفاظ على سرية المرضى.

النتائج: كشفت الدراسة أيضًا أن الحفاظ على السجلات الطبية بدقة يلعب دورًا حيويًا في تحسين تقديم الرعاية الصحية وفعالية العمل. وقد أسهم الاستخدام المتزايد للتكنولوجيا، خاصة في تنفيذ السجلات الصحية الإلكترونية، في تحسين طرق الوصول إلى المعلومات واتخاذ القرارات والتواصل داخل الفرق الطبية. كما تم اعتبار التنسيق بين الأطباء والممرضين والطاقم الإداري مثالياً خلال عملية تسجيل البيانات وجمعها.

الخلاصة: تعد إدارة المعلومات الصحية عنصرًا حيويًا في نظم الرعاية الصحية لجعلها أكثر كفاءة. إن استخدام التكنولوجيا، والتعاون بين مختلف التخصصات، وحماية تفاصيل المرضى سيساعد المؤسسات الصحية في الحصول على نتائج أفضل للمرضى، وتسريع العمل، وحماية المعلومات الهامة.

الكلمات المفتاحية: السجلات الطبية، السجلات الصحية الإلكترونية، كفاءة الرعاية الصحية، سرية المرضى، الرعاية متعددة الأوجه، تكنولوجيا المعلومات في الرعاية الصحية، الإرشادات