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ELECTRONIC HEALTH RECORD SYSTEM

Effective and efficient activities within a healthcare institution are dependent on the qualification of the personnel and the resources available within the institution. Therefore, an information system refers to a collection of components put together for the collection, processing, and storage of information, data, digital services, and information (O'brien et al, 2005). Therefore, the essay focus on summarizing an interview with a nurse regarding the information system utilized within their institution.

The discussed information system was an electronic health record (EHR). An electronic health record is a version of records maintained on a timely basis by medical practitioners whose major aim is to share information with another practitioner within the organization. The major purpose of an electronic health record is to show the administrative and billing information. That is payment information and insurance details of a patient or the next of kin for minors. Secondly, it contains the medical history of the patient, such as allergies, the prior radiology images, previously taken medication immunization dates. Moreover, an electronic health record contains the present diagnoses which include, a record of the patient's vital signs, lab, and test results, and progress notes from the doctor in charge of observation and treatment of the patient.

The process involved in the implementation of an EHR is complex due to the risks involved with its potential failure. Therefore, the decision to implement the electronic health record was done by seeking opinions from the lead physician, project manager, the lead superuser, the lead nurse, the lead medical assistant, and the lead registration staff. Therefore, every end-user of the

system within the hospital was involved in the planning and implementation of the electronic health record through their departmental leaders.

The system is usable due to its friendly user-interface, simple commands, and most information can be viewed, saved, or edited with one click. The system was developed in a way that even the least experienced practitioner within the hospital can use it without difficulties. Moreover, the interface of the system can be used effectively by every department, and information about patients can be transferred with one click.

The electronic health record can improve patient care by providing timely and accurate information concerning medical records thus leading to better diagnoses, treatment, and management of illnesses. The workflow of the nurse involved listening to the patient regarding their health, recording the symptoms, performing their diagnosis, giving medication, and advising the patient to come back for a checkup. The system is consistent with this workflow since it offers a table where the practitioner has to enter previous and post diagnoses. Moreover, the system uses clinician support for the practitioner by helping in the generation of the differential diagnoses, the symptoms, and effective pharmacological and non-pharmacological treatment. This support is effective since it simplifies the work of the nurse practitioners making their work easier, thus allowing them to serve a lot of patients within a short time.

However, the major risks of electronic health records involve the availability of cyberattacks and are prone to timing discrepancies. That is, the online system may lead to theft of data and research, and may not be available promptly. The major workaround was ensuring that the EHR system is receiving constant upgrades and updates to ensure both grey hacking and black hacking are impossible.

The system has satisfied all McCall's factor model for all requirements of any software, satisfying factors such as correctness, integrity, reliability, usability, and reusability. Therefore, the data within the electronic health record is accessible to the authorized personnel whenever and wherever needed. Therefore, data can be retrieved from the system without any complexities. However, ethical issues may occur when a practitioner breaches the confidentiality and integrity of the patient's records by revealing them to unauthorized people. To solve this, hospitals should ensure that medical records are given to the people listed as the next of kin alone and that consequences should be present for those that reveal this information without the consent of the patient.

In conclusion, there was significant consistency between what was found in the literature and what was discussed in the interview showing that the hospital had followed all the ISO certification rules regarding software quality assurance. McCall's factor model requires software to meet the eleven requirements, which according to the interview were satisfied (Galin, 2018).

Reference.

Galin, D. (2018). Software Quality Factors (Attributes).

O'brien, J. A., & Marakas, G. M. (2005). *Introduction to information systems* (Vol. 13). New York City, USA: McGraw-Hill/Irwin.

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