Research paper on standardized coding system

Health & Medicine, Nursing

Nursing practice has evolved greatly to meet the health needs of the changing population. One of the significant changes has been the introduction of electronic health records. An electronic health record can be easily shared and enhances a patient's care in different facilities. For example, electronic health records are useful when a patient is transferred to another facility for nurses in the receiving facility to determine the medical history and interventions already undertaken on the patient. A major problem of electronic health records is standardizing the language used in nursing documentation. This is because every nursing specialty field has its own language used for nursing documentation. To be useful, the electronic health records must be clear and understandable to all health practitioners. Having a standard nursing language ensures health records are universally understandable by practitioners in all nursing fields.

Paans et al., asserts that using standard nursing language promotes accuracy of health records hence makes them applicable in nursing practice (2010). A standard nursing code for making health records is also useful in interdisciplinary teams. In my facility, the team leader needs to communicate relevant patient information to the team members. When standard nursing language is used, the interdisciplinary team meetings spend less time on clarification of patient data because every member understands the data well. Therefore, using standard nursing language has enhanced cohesiveness and productivity of interdisciplinary teams. By contrast, every nursing specialty field has its own language for documenting care. If these non-standard languages are used, the application of electronic health records would be limited to the specialty field that understands the

language used (Thoun, 2011). Therefore, the language used to document care for electronic health records should be standardized.

References

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