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- Introduction
Amayatakul writes that “ electronic medical record (EMR) is a digital version of a paper chart that contains all of a patient’s medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment (Amayatakul, 2012, p. 19).” This indicates that Electronic medical records will act as a supplement to nurse practitioners in that healthcare service will be efficient, which will be beneficial to both the patient and the staff members (Anderson, 2005, p. 123). In addition, a nurse practitioner need electronic medical record as a way of keeping track of the patient’s past records. This will help the nurse practitioners to give a high level of satisfaction to the patient’s because through electronic medical records, they can easily read the patient’s past medical history. The electronic medical records can also be assessed from anywhere and by everyone if one has the permission to encrypt the patient’s medical records (Gelijns, 1994, p. 113). Electronic medical records also show the plan to care that the employee may have and some of the vital sign that nurse practitioners may need to watch. This paper will discuss why it is important to implement electronic medical records as a way of improving the overall healthcare system.
- Leadership and Management Principles
Leadership is a significant attribute to ensure that the organization reaches its goals in any implementation program. As a leader in the implementation of the electronic medical records, it is important to follow up on all staff members to ensure that they have upgraded and are knowledgeable regarding new system through training (Joel, 2009, p. 34). The management team will accentuate that all the organizational goals are set and clear in terms of understanding when discussing the idea of implementing the electronic medical records to the stakeholders. Through the help of the management we will coordinate things such as meeting with the IT department that will upgrade our system electronically and ensure that all nurse practitioners are comfortable with the new form of technology (Khoumbati, 2010, p. 56). To ensure that the electronic medical records are implemented in the system, I will use practical authority where I will hire experts to train the staff member as a prime factor of meeting the organization’s goal. The experts on electronic medical records have enough knowledge and experience, which will be helpful to teach the staff members on the importance of EMR (Armoni, 2002, p. 78). In addition, social cooperation is significant between the management and the staff members to ensure that there is a smooth in terms of switching from paper medical records to electronic medical records.
According to Healthcare Information and Management Systems Society, “ democratic leaders invite team members to contribute to the decision making process (Healthcare Information and Management Systems Society, 2007).” As a democratic leader I scheduled a meeting with the key stakeholders in the office to ask their opinions about changing from paper to electronic records. I explained the problems that we have had with patient safety, and I mentioned the benefits of the implementation of the electronic medical records (Gelijns, 1994, p. 156). Some of the problems I explained are involved with prescriptions in that the doctor’s handwriting was unreadable, and the patient could not understand the name of the drug or the dose, which led to patient taking the wrong medication and the wrong dosage. Thus, electronic medical records are important because they assure patient’s safety (Armoni, 2002, p. 102). In addition, electronic medical records are advantageous they; improving the quality of the patient care by making the care more organized as well as having more control over the disease, follow ups, and screening; decreasing the errors; improving the communication between the providers; and for the office, it will reduce costs and save money (Joel, 2009). However, this change will require a large initial investment, but in the future we will receive many benefits, including financial benefits.
As a result of these advantages, the stakeholders and I have decided to implement the electronic medical system, which will ensure patient’s safety and promote efficiency of the nurse practitioners in their line of duty (Taylor, 2006, p. 139). Since this is a new program, we have decided to put aside funds for the staff member training as a way of them integrating into the new system. This gradual approach is necessary because it helps the staff member in adjusting to the new system.
- Clinical Decision Making
Clinical Decision Making encompasses the use of computerized data that provides nurse practitioner, staff members, patients and other individuals’ specific information regarding healthcare as a way of improving the healthcare service given to patients. Electronic medical records provide both the clinicians and patients some of the specific knowledge regarding the patients (Fett, 2000, p. 57). This is crucial to both the staff member and the patients because the nurse practitioners can weigh what type of treatment is needed for the patient’s well-being rather than conducting test from the start as a way of finding out what the patient is suffering from (Khoumbati, 2010, p. 198). Through this important information that is built in the system from the past medical condition of the patient, the nurses can easily filter some information and can evaluate the patient’s medical deterioration with a specific time and the number of times one has suffered from a prior health condition. In the long run, clinicians can use the electronic medical records as a way enhancing the patient’s health and the overall healthcare in the system.
In addition, Electronic Medical Records will also show electronical alerts and guidelines from the patient’s medical history (Fett, 2000, p. 72). These computerized alerts will show a patient’s data report and summary from other past hospital records, which will serve as a prime reminder to the nurse practitioner that is dealing with the patient. From the patient’s data physicians can access the clinical guidelines that are relevant to treat the patient in case he or she has had a prior synchronic of chronic diseases. In the long run, the medical physicians and nurse practitioners are able to give diagnostic support based on the patient’s data to the patient (Khoumbati, 2010, p. 178). Thus electronic documentation template ensures that physicians have thorough and clear notes regarding the patients such that in the future the next staff member will have a clear overview as to what the patient may need. In addition, it is crucial to note that the documentation template will outline the patient’s medical condition at that time through writing a condition-focused order sets. “ Efficiency has increased dramatically when an in-motion studied in our records room, which showed that electronically is 80 percent more efficient than manually and we’ve seen proof of that on a daily basis (Shoniregun, 2010, p. 134).” Thus, electronic medical records will improve the nurse practitioners efficiency due to the data built in the system, making it easy for the nurse practitioners to give maximum assistance to their patients.
Electronic medical records are also a crucial element to the staff as a whole because some patient’s records may have clinical guidelines as to how to go about treating a patient. This is because “ electronic data allows easy data transaction making it accessible from remote sites to many people at the same time (Bryan, 2002, p. 98).” In addition, it gives the clinicians a rule of thumb as to how to handle a patient based on the past medical records and through the family past medical records as well (Armoni, 2002, p. 67). Thus, this indicates that the electronic medical records give patient’s data report and summary, which is crucial to all the staff member and it improve the healthcare given to the patients. Computerized patient’s medical report give diagnostic support to both the patient and the clinicians in that clinicians can stipulate the health problems that the patient has gone through in the past, which is easier to track electronically (Spekowius, 2006, p. 49).
- Evidence Based Care
Evidence Based Care is the outlook use of evidence based on valid research and diagnostic tests to make a certain decision that may be derived by physicians with the aim of improving the individual patient’s care based on current situation (Anderson, 2005, p. 65). The clinicians speculate some of the autonomy and dangers that may be associated from exposure of different health services that may be provided to the patients. Some of the things that clinicians have to ensure before giving any medicinal service are things like allergies and past medical records (Atkinson, 2006, p. 89). Through this ideology, electronic medical records are ideal to ensure that clinicians and nurse practitioners have enough background knowledge on the patient before administering any drugs. Thus, through computerized medical records for different patients, the health care facility can offer the best health care quality and will reduce any chances of medical errors (Shoniregun, 2010, p. 187).
A good example of a computerized data system is the DRG Program. The DRG has a grouping system in their data analysis, that records all their patients in a given year and the clinical data obtained from the patients. This data is then sent to the INCDS, which is a requirement by the ministry of health (Goldsmith, 2011, p. 94). The Ministry of Health, which responsible in distributing the funds to the various hospitals reviews these data and then decides how much money to inject in a given hospital. These data encompasses patient’s personal information such as age, gender, the duration of one being at the hospital, illness diagnoses, surgery or other therapeutic procedures given, past patient’s clinical data (Goldsmith, 2011, p. 95). It is significant to note that these records are confidential and in most cases they are encrypted as a way of ensuring document security. This form of patient’s data is crucial to not only the government to give funds but can also help the physicians and nurse practitioners in their day to day work. Through this record they can analyze careful the patient’s needs and the type of care needed (Bryan, 2002, p. 87).
In addition, electronic medical records can help the nurse practitioners to note any vicious cycle occurring in a given community in case of an outbreak of chronic diseases. Thus, the electronic medical records can be standardized as a way of promoting any early detection in terms of chronic disease outbreak (Amatayakul, 2012, p. 156). Through this, the nurse practitioners can form a plan as to how they can curb the outbreak by preventing and managing the chronic diseases. Thus, electronic medical records are crucial and relevant to our society so as to enhance efficiency.
- Change Theory
Spradley’s change theory is an eight step process that was derived from Lewin’s theory of change (Blobel, 2002, p. 67). This theory has been used widely by nurses to evaluate their patients and as a way of finding out some of the medical need required by certain individual patients. This evaluation process is static and nurse practitioners have to follow through to ensure success in their line of work. This paradigm outlines some of the requirements that nurses and patients have to go through and is often chronological (Atkinson, 2006, p. 78). Some of the processes embedded in this theorem are: determine the symptoms, evaluate the problem, analyze alternative solutions, determine the change, plan the change, implement the change, evaluate the change, and stabilize the change (Bryan, 2002, p. 64). This process is acknowledged by the nurse practitioners as a way of ensuring that proper healthcare service is given to the individual patient. However, it is important to know that it is time-consuming for the nurse practitioner and the patient. It is crucial to note that this process require the nurse practitioners to conduct some tests for the patient as a way of evaluating his or her condition (Blobel, 2002, p. 69-72). Thus, if electronic medical records were integrated into the system, the nurse practitioners could easily diagnose the problem based on the patient’s medical history in that symptoms may be a replica of another time the patient was ill. This indicates that medical electronic records are essential in the healthcare system as it is less time-consuming and patients can get immediate help from the hospital staff.
- SWOT Analysis
- Conclusion
It is evident that electronic healthcare system is essential because different physicians can access patient’s background on his or her medical condition prior to being admitted in a different healthcare facility. Given that the 21st century is mainly technology-oriented, electronic medical records are crucial to physicians as they improve health care quality and at the same time will decrease medical errors. Electronic medical records also give clinical support when nurse practitioners have to make important decisions. Computerized data from the patient’s record helps decrease any health disparities and that in the long run both the patient and the nurse practitioners benefit because improved healthcare is less time-consuming. Thus shows that Electronic Medical Records is an important program to implement. Given that I have the support from the stakeholders, I believe that this method will be successful and will improve the quality of healthcare provided by leaving no room for any medical errors.

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