**Discussion1:**

Currently, I work in a Critical care unit at the University of North Carolina Health Care as a Clinical Nurse II. We are the largest group of healthcare professionals responsible for the quality and safety of the patient. We enter patient information every day in the flowsheet in EPIC which helps us understand how to care for our patients. We are educated on how to interpret data whether entered flow sheets or as smart phrases or narratives. One of the important databases that we use in our organization is Electronic Health Record (EHR).

Patient information such as vital signs and other measurements are compiled into flow sheet rows and for the context of the individual patient’s story and the narrative that explains why he or she sought health care and what may have led to the problem, we partner with the vendors of EHR systems to improve this workflow so that the important narrative information can be captured to improve health for all patients. (Glassman, 2017) Along with important measurements, lab values, and patient stories, EHR bring data together from a collection of sites of the same type or different types such as EHR databases from general practitioners and oncology clinics only or data from integrated health systems and include combination of outpatient primary care, outpatient specialty, and inpatient settings allowing a complete view of all of the medical care a patient receives within that health system (Miner et al., 2017)

The database administrators are responsible for managing this database where they also manage access control, backup, database security, and disaster recovery.

EHR has been a game-changer in health care. As a Nurse, I have experienced both paper documentation where we had to store all patient information on paper, and now electronic documentation and I can see the difference that can make in patient care just because of this upgrade in health care. EHR is making it easier to access and aggregate clinical data, there is a huge reduction in medication errors, nurses' work burden is less, and many more.

Because of the development of EHR researchers are using machine learning algorithms to analyze EHR to predict disease progression, complications, and mortality, and for early diagnosis, self-care, preventive care, and clinical decision support (Luan et al., 2023).

Healthcare information must remain confidential to the public, but easily accessible for the healthcare professionals who use this data to save lives. Healthcare Databases have provided us with a proper system for storing, organizing, and managing critical health statistics such as labs, finances, billing and payments, patient identification, and more. Databases in healthcare promote the clear, consistent storage of critical data like patient demographics, admissions sources and length of stay, discharge status, diagnoses and procedures, and relevant charges. All this information helps healthcare professionals learn more about which operations are working well, which could use improvement, and which are absent entirely. To meaningfully interpret and present data various techniques can be employed within the database such as the use of charts and graphs. These visual representations allow us to compare different data points, identify patterns, and draw meaningful conclusions.

**References:**

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**Response1:**

Hi Emily,

Thank you for the post,

We also use EHR in our organization which helps us store large amounts of patient data maintaining their privacy. I completely agree with you that The EHR provides nurses quick and easy access to patient data but there are also some situations where we need administrative permission to access those data which can take some time resulting in delayed care. In a situation like this, in my organization, we must break the glass, that can be applied in your organization to prevent delaying of care in emergencies. According to healtheconnections.org, Break the Glass is an emergency access that allows users to access health information without patient consent, only in the event of a medical emergency.

When we access information through Break the Glass, it needs to be carefully monitored by doing security audit trails regularly to identify any use of the emergency accounts. According to the HIPPA Act 2020, systems can alert the security administrator in the event an emergency account is activated.

**References:**

*Break glass procedure: Granting emergency access to critical ePHI Systems*. Break Glass Procedure: Granting Emergency Access to Critical ePHI Systems | Health Insurance Portability and Accountability Act. (2020). https://hipaa.yale.edu/security/break-glass-procedure-granting-emergency-access-critical-ephi-systems

Break the glass emergency access faqs - healtheconnections. (2021). https://www.healtheconnections.org/wp-content/uploads/2021/09/Break-the-Glass-Emergency-Access-FAQs.pdf

**Response2:**

Hello Saumini

Thank you for the informative post. I also found EHR very effective and efficient when coordinating care for our Surgery and off-service patients. Care coordination can occur within and across care settings and has been shown to provide quality care at a lower cost (Hsiao et al., 2015) and this is possible via electronic health records.

We can get updates from Nurses and providers in the operating room for our patients who are in the operating room, and I found that to be very helpful with the smooth transition from OR to our Unit. This helps us make assignments, prepare the bed, and notify the provider on the unit because patients coming to the unit just a few minutes after getting the report make the Unit chaotic and stressful mainly when we are also getting other admissions. EHR can help us reduce fragmentation, making it available to all authorized physicians participating in the patient’s treatment in real-time. EHR’s ability to seamlessly access patient information before, during, and after the procedure has helped in providing quality and timely care to our patients. Providers and labs are available with the touch of a button rather than many phone calls and traditional faxes. Using EHR for care coordination ensures the patient’s medical information is accurate and current and provides for higher-quality outcomes ( Rajaee, 2023) and because of this, I would use your strategy and use EHR more frequently to coordinate care for my Patients.

**References:**

Hsiao, C.-J., King, J., Hing, E., & Simon, A. E. (2015, February). *The role of Health Information Technology in care coordination in the United States*. Medical care. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7472643/

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