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# The Role of Medical Records in Enhancing Collaboration Between Nurses and Physicians

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***Abstract*---Background**: Effective patient records both paper-based and more recent electronic health records (HER) are crucial in enhancing the relationship between the nurse and the physician. Facilitating communication and co-ordination but have had challenges which affects their efficiency. **Aim**: This study aims at examining the benefits of medical records on collaboration and its specific effects and significance on communication, patient care and staff productivity, with regards to opportunities and barriers there. **Methods**: A total of 23 quantitative and qualitative studies published between 2019 and 2022 were selected from databases such as PubMed and Science Direct, and analyzed based on the following thematic areas: EHR adoption, and interprofessional collaboration. **Results**: Health records allow greater Insight into the patient's details, also provide better and more consistent means of sharing valuable Information, all while furthering those involved in the decision-making process. However, concerns such as data security, user training, and system compatibility act as barriers to the full implementation of the system. **Conclusion**: Health records are very relevant In promoting interprofessional relations In the health sector. The phenomenon: Therefore, solving some of the challenges facing the team can enhance the efficiency of the technical team as well as that of the other members of the healthcare team and the patients' care outcomes.

***Keywords*---**Electronic Health Records, Health Information, Clinical Information System, Nurses, Doctors, Patients.

## Introduction

Today's arthritis of the different specialties is critical in the delivery of the patient-centered and effective healthcare services. The current paper identifies the medical record as one of the primary tools that fuels this integration with a specific focus on EHRs. In the past, many nurses and physicians practiced separately or communicated very little with each other and had no interaction with their colleagues while concurrently providing patient care, leading to the formation of an isolated system of care. Thus, the use of EHRs has brought a major change to the medical and nursing team work because they create the

unique shared environment for storing patient information and facilitating interprofessional communication. Medical records become a useful tool coordinating joint efforts of nurses and physicians; they provide them with the same up-to-date information and facilitate significant changes in decision-making processes. This paper aims at studying the role of medical records as a means of linking nursing and medical professional and overall, the improvement of result achieved.[1,2]

**Why Integrated Medical Records are Essential in the Health Delivery System**

Where medical records are implemented they form the core of the health care system due to their crucial role in documenting record important patient information. They perform the critical function of creating the atmosphere for teamwork with other health care teams such as nurses, physicians and other provider of allied health. The medical records guarantee that all members of a patient's healthcare team receives information on previous and current illnesses, treatments, therapies and medicines, lab work, and diagnoses in a timely and accurate manner which reduces error and promotes continuity of care. In a coordinate working environment it supports efficient inter-professional working since it provides access to information that is more current. For instance, if a physician has recommended treatment, a nurse may go through the records and give the patient the right dose of medication and effects therefrom thereby increasing safety.[3,4] Furthermore, several evidences showed that medical records facilitate interdisciplinary communication, a component that is essential for a particular disease involvement or for some other complicated case where several specialists can involve in the patient's care. For example, in the case of a diabetic patient the treatment management requires an endocrinologist, a dietician and a primary care physician who need to synchronize their approach. A beneficiary of such a record is Panforasm which can monitor progress, make amendments to the plan, and manage complications concurrently with the patient. It avoids cases where duplication of tests are done or where different doctors are giving contrary advice to the patient or where the patient is held longer than necessary.

The change of trend of moving towards electronic health records has made medical record the essential tool for healthcare cooperation. EHRs allow data to be readily shared among departments, or even between different care settings, than make it possible to have transitions of care. For instance, when a patient is moved from one hospital to the, the records of the patient can be passed immediately to the new team on hand. Besides, this technology-driven form avoids potential time gaps when key pieces of information may be missed or lost.[5,6] Moreover, the records give a basis for evaluating results and enhancing medical care's quality. Data trends help healthcare teams determine organizational weaknesses, that is, aspects such as response time to critical conditions or compliance with the best practices. These constant feedback loops create an environment of shared responsibility and to enhance patient's care. For these reasons, all specialty and subspecialty medical records are mandatory and fundamental to collaboration, communication and therefore the provision of health care that is optimal, patient-centered. The communication gap between the

nurses and the physicians has been acknowledged to be significant through medical records.[7]

Health information of patients are critical in facilitating the flow of communications between the offering nurses and physicians as well as in enhancing coherence of the Duo Treatment Triangle. All these records serve as a common reference language with unified information that both professions need to scrutinize a patient's condition, physician recommendations, clinical note, and diagnosis. Timely and comprehensive written communication in the patient record enables the Nurses and the Physic to know what the other is doing and the decisions that he or she has made. For example, when the attending physicians write down the intended treatment, the nurses can use it to give care, evaluate the patients' response to the treatment, and what they feel may be an issue or a side effect. Such structured flow of information avoids misconception and make sure that everyone is on the same page regarding the t patient's need and care plan.[8] In busy health systems including emergency department or intensive care units accurate and fast information exchange is essential. Electronic medical records give real-time information therefore nurses and even physicians are able to make sound decisions quickly. For instance, a doctor who has prescribed a new drug can make an entry in the chart thus; the nurse who assesses it can attend to the administration without a word from the doctor. This efficiency makes the input less likely to be delayed or erroneous especially when time frame is tight. Also, medical records favor asynchronous communication, which is critical once the nurse and the physician work during shift hours and may not always be online at the same time. Each professional makes sure that the patient chart contains important information to make sure that their care of the patient will not be interrupted if they have overlapping shift.[9] Furthermore, medical records assist in teamwork in complicated situations calling for an intervention of a number of departments. Nurses are typically at the patient's side longer than doctors, so they are more likely to notice signs of deterioration. When recording such findings in the EPMS, nurses give the doctors useful consideration that forms the basis of diagnosis and management. On the other hand, physicians can utilize medical records to enumerate the course of action or a general guide or intention behind some choices, enable the nurses to implement care maps in a more confident, precise manner. It also makes a bidirectional communication flow to improve the existing relationship between the nurses and physicians, in addition to enhancing their level of respect, and the focus on patients' outcomes.[10]

The use of HERs has gone further to compliment the trend for proper and improved communication between nurses and physicians. Ever since its inception, EHRs have provided occasion real-time patient data in the practice of the two professions. Tools such as automatically generated alarms for significant variations in the patient's status or possible adverse drug interactions guarantee that some highly significant information is not overlooked and that necessary action must be taken as soon as possible. Also, they mean that formatting of data, including key fields defining aspects of a patient's care, is standardized to avoid confusion that may come with subjective notes. Hubs of information are created to guarantee that both nurses and physicians know what information is available so that they can easily understand it and use it to foster

communication.[11] Therefore, medical records act as an important source by which nurses and physicians can readily share information. They increase knowledge, decrease misunderstanding, and errors, and facilitate the organization of the care delivery process. As the healthcare system adapts the medical records will undeniably play essential in effective communication between the nurses and physicians to provide excellent patients care.[12]

**How Practitioners Benefit Patients Through Medical Records**

The digital copies of the patient's records become highly useful in improving the quality of service delivery through providing coherence, accuracy, and efficiency of the healthcare services provided to a patient. They capture diseases, operations, therapies, reactions and current medications to give the complete status of the patient. The above information helps healthcare professionals to recommend unique treatments applicable to each individual client. For instance, if a patient has a history of allergies to some drugs every time he or she visits a hospital the records the doctor or the nurse will not prescribe sensitive drugs that can harm him or her. It also means that healthcare teams can also make sure that patient records across the continuum of care are contemporaneous, with all members of a patient's healthcare team being able to access a complete and updated record of a patient's care, regardless of whether they are dealing with the same specialty or in a different geographical location.[13]

Records of patient details reduce time consumed in diagnosing a disease, and in administering treatments, thus reducing operational inefficiencies. When lab results, diagnostic imaging, and consults documented in medical records are integrated, the healthcare provider can concentrate on the best possible management. This immediacy is perhaps more important in emergency conditions as decisions made quickly are life and death issues. For example, if it is a patient who was affected by a stroke, then records can quickly update health history and taking medications so that the medical team can respond with the right treatment instead of having to perform tests and discuss the patient's history. Such efficiency puts patients' lives in order and saves their money as no one has to go through unnecessary procedures and hospitalizations.[14] Moreover, records maintain efficient coordination of treatment among health care practitioners, and communication is a part of the quality care delivery process. Meaning, they allow physicians, nurses, pharmacists, and other specialists to share information with each other owing to a unified platform. For instance, a physician's treatment plan noted on the medical record can be easily referred to by a pharmacist to check for possible drug-interactions and by a nurse to determine the right method of administration. Such level of coordination is likely to decrease errors in care delivery, increase the safety of care delivery and also facilitate patient satisfaction. The patients also benefit directly when their records are used to involve them in their care. Hence, through their medical records, patients can navigate their health situation, and implemented treatment plan as well as the next course of action in a more effective capacity. [15]

The expansion of HERs or electronic medical records has raised the importance of medical records to a new level by adding capabilities that expand the reach, quality, and analysis of records on the patient. EHRs enable healthcare providers

to gain full access to the patient information at any time and any place which is even helpful with patients attending different care givers or in the remote fields where specialist may not be easily available. Further, EHRs contain decision support instruments, such as alerts on possible adverse effects, cross medications, or high/low labs and missed preventive services. Such tools assist in offering a preventive and anticipatory care with reduction of incidence of complications by the providers. Furthermore, the opportunity of big data analysis in medical records helps to introduce main tendencies in medical practices, to improve the treatment, and to select individual approaches for each patient depending on his/her needs.[16] electronic medical records are a major factor in improving patient care through good information available to the practitioners. They lead to the improvement of quality of care through increase in decision-making quality, enabling efficient working processes and better provider cooperation. With the development of technology, the function of medical records will increase further and create a basis for highly individualized, time and often results efficient healthcare.[17]

**Problems Encountered in the Use of Medical Records in Promotion of Collaborative Practices**

As important as the medical records are in improving cooperation within and between facilities, their use within healthcare practices may be a challenge that distorts cooperation and teamwork. The problem of documents being either incomplete or incorrect is one of the biggest challenges reported. While documenting, healthcare professionals in fast-paced health systems can be forced to record information that might be incomplete or missing fully because of the busy setting. For instance, a nurse might miss a patient's reaction to a medication or maybe a physician will leave out some detail about a diagnosis. Such omissions lead to development of communication gaps, missed information, delayed treatment, or even worst mistreatment. However, differences in organization of documents or even the use of terminology by various practitioners adds another level of complexity in understanding of records and thus makes them less suitable for use in multi-disciplinary environment.[18,19]

EHRs remain another large challenge due to various technological and infrastructural issues encountered in an environment of constant change. However, the use of EHRs has not been without challenges and it will be helpful to note some of the issues which emerge when implementing EHRs. These challenges are high implementation cost, technical challenges, and poor compatibility of systems used across facilities or departments. For instance, an HER system that a hospital has may not allow compatibility with a nearby clinic's software, thus no integration of the patient records. This breaks the spirit of having a single place to collaborate and share as providers are left to guess or use workarounds or process incomplete data. Moreover, unpredictable system downtimes, or low response rates will impact various unanticipated organizational operations., frustrating providers and delaying patient care.[20]

Issues of privacy and security are other factors that act as barrier to utilization of medical records in collaborative practices. Interprofessional communication sharing of patient data with other care teams or institutional counterparts is

achievable but provided that it meets legal and ethical requisite standards of patient data privacy. Nevertheless, such regulations as HIPAA in the United States can be an impediment to information sharing where caregivers are in doubt regarding the recommendations on the regulations. This can cause people to be very hesitant about sharing important information particularly when dealing with several healthcare givers or organizations. However, privacy issues such as the exposure to data breaches and unauthorized access to touch patient information remain an ever-deadly issue, adding more pressure to organizations' drive of promoting the sharing of records.[21] One more challenge is the reluctance by some healthcare professionals to prescribe use of medical records, including EHRs in their practices. There could be misperceptions about the elements of sources being cumbersome, tiring or time consuming relating to the use of electronic systems where providers are not well trained or Novice to digital interventions. This resistance can result in some providers falling back to paper-based systems or developing their ad hoc methods of communicating that are not as effective and less easily integrated into the collaborative processes. Furthermore, managing an extensive quantity and quality of records adds strain on staff since it increases workload, clearly a factor within the already pressuring schedules of nurses and physicians.[22]

Culture organization aspects can also threaten or support Medical Records implementation in collaboration processes. Lack of compatibility of the goals, action, and decisions between ML.Ps and RNs may lead to under-prescription of S.M.R. For example, detailed diagnosis may be viewed by physicians as having different purpose; hence, nurses can have contradictory agendas with regard to the everyday caring task, and this applies to the use and the interpretation of medical records as well. Furthermore, decision-makers' attentiveness to collaboration and/or inadequate or limited support of integrated medical records into teamwork may limit the applicability of medical records or transform providers into more or less self-contained 'isolated pockets. [23] medical records are incredibly useful collaboration tools although, the implementation of the records has been hampered by issues including lack of thorough documentation, technological constraints, issues to do with privacy and security, individuals' resistance to change and organizational constraints. Solving these problems would need specific measures and steps such as; appropriate training to the healthcare provider, enhanced compatibility of the systems used, sound privacy measures, and promotion of the teamwork within the healthcare organizations. Tackling these obstacles shall ensure that medical records play optimum roles as facets in more effective teamwork and hence in betterment of patients.[24,25]

**Medical Records Management and Information Technology Advances and Their Effects on Interprofessional Relations**

This paper seeks to show how the adoption of technological advancement in the keeping of medical records has digitally transformed health care by enhancing collaboration among health care professionals. EHRs are front and center of this change, offering an effective change management tool in that it provides a centralized digital record of patient data in real time. Compared to existing paper based systems, the use of EHRs enable nurses, physicians and other carers to review and document clinical records anytime, from any physical location.

Another advantage is that it allows for a continuous availability and thus smooth co-operation and possible timely interconnection. For example, in the environment of an emergency, the information contained in an HER can indicate the patient's allergic reactions, medical history and prescribed medication, allowing fast and knowledgeable decision making by everyone in the healthcare circle.[26] Convergence of Interoperability is another area of advancement witnessed in decision support systems of medical records. The following is a result of the governors and JGH working together since they ensure that HER systems used in the different facilities or departments are integrated hence facilitating the exchange of patients' details within the networks. This is especially important for those patients who receive treatment from several different practitioners or when they move from a PCP to a specialist. Interoperable EHRs thus make it possible, for instance, when a primary care physician has to refer a patient to a specialist, accurate transfer of the patient's relevant medical data is made easily avoiding repetition of the same tests by the specialist without query on the patient's history. Not only does it save time, but due to all the healthcare worker being linked to 'one chart', everyone has detailed insight of the patient's health status.[27] Yet another technology that has enhanced collaboration in the current generation is cloud based medical records. Experiences: This also means that cloud system provides solution for storage and sharing of patient data and make it possible for any healthcare team to access information through Internet communication. This capability is particularly valuable since in areas like remote areas or rural areas the specialists may not be physically present. Telemedicine application that is linked with cloud-based records also enhance cooperation between providers because during the virtual patient visit, they can consult with each other. For example, a rural based nurse can make a call to a specialist who is located in another distant location and they can discuss the patient records of the patient in real time to come up with treatment plan.[28]

More and more, AI and machine learning are contributing to improving medical records and facilitating cooperation. Application of AI in patient management involves the large amount of data that may be processed to reveal patterns of the outcome of the next course of action. For example, it is possible to identify certain drug-drug or drug-food interactions, or pointed out when some parameters on the lab tests are out of ordinary range and should be attended by a medical worker shortly. These ideas could be disseminated through the medical record system and may help physicians and/or nurses better in improving care to patients with challenging conditions. Furthermore, AI voice recognition tools include provider's notes which are transcribed into real medical record instead of having them to document manually. This minimizes on time spent on administrative work and makes sure that documentation is effectively and efficiently done making collaboration better.[29] Increased uses of smart phone based applications and wearable technologies have also affected medical records and team practices significantly. The majority of HER systems include mobile applications by which the providers can view or modify records using tablets or smart phones. This mobility is especially useful in situations such as during a bedside when a provider can click on the patient interaction or consult or when in outpatient when a provider can easily search for any information. Smart bands and smart watches can be synchronized with patient records so that data derived from the physical condition of a patient and or his/her activity, rate of breathing, cycles of

rest and wakefulness can be captured at a go. These data streams having the ability to be followed up by nurses and physicians collaboratively can lead to precision intervention.[30]

Therefore, according to the present civilization and communication advancement of medical record technologies like EHRs, interoperability, cloud computing, AI, and mobile apps, integrated collaboration in healthcare has altered. These innovations that have allowed the real-time sharing of comprehensive patient information, breaking down statics between care givers and enhancing the coordination of decisions have delivered notable quality changes. In the future as technology progresses so does its application in medical records, which will only serve to enhance co-ordination and consequently bring about a better future for the patient. [31]

**Impact Of Using Electronic Health Records On Teamwork In Health Care Organizations**

EHRs have changed the healthcare operational environment through enhancement of the efficiency of working teams in clinical contexts. As a result, EHRs reduce efficiency gaps, duplications, and fragmentation of tasks and information for multiple groups of care providers. The first way that EHRs enhance team productivity is through the timeliness of access to a complete patient's record. Being digital, longitudinal patient notes can be easily accessed and amended in real time by physicians, nurses and allied health care providers blazing the difficulties occasioned by the physical search of paper records. For instance, a nurse enters the blood pressure of a patient during the course of a hospital stay and the physician can change the care plan without having to refer physically to the nurse. It offers a smooth flow of data and hence reduces the time taken between people within the health care organizations and allows them to devote much of their time to patients.[32] There is another feature of EHRs that must be mentioned – the potential for the execution of existing clerical work in the course of patient care, which will save professionals' time. Basic services like appointment scheduling, prescription renewal and billing are incorporated in to the HER systems which were previously very cumbersome to execute. For instance, when a physician orders prescription via an HER, the system is capable of checking the drug interactions or even transmitting the prescription to the pharmacy or updating the patients' record, at the same time. The issue with manual tracking is that it can be prone to mistakes and keep team members aligned, and which in turn, saves time when working together.[33]

It also fixes the communication issue by having the communication tools to be built right in the EHRs. Most of the HER systems contain applications that enable practitioners to relay messages, assign tasks, and document work progress securely inside the system, thus eliminating the need for transmitting information to other platforms, which can be insecure. For instance, a nurse can write a direct message to a physician on the patient's statuses which would not require much phone calls nd meetings. Also, they also facilitate the synchronization of activities of a team, comprised of professionals from different fields such as health facility's Intensive Care Units or Oncology divisions, to guarantee excellent coordination in handling of complicated situations.[34]

Documentation that is done within EHRs is also made standard since this helps reduce all issues of conflict of one form or another. Healthcare teams benefit from structured templates and promps since information is collected systematically up to an acceptable standard. Such standardization is useful especially when there is patient handover from one department to another such as a patient moving from the emergency department to the ward. Having clear and well articulated documentation enables the receiving team to assess the patient states and the care plan without confusion or doing duplicative tests.[35] However, the benefits of EHRs for the efficiency of a multi professional team is not without drawbacks. Organizational learning is a factor and early on after the implementation of HER systems, the productivity may be negatively affected because the providers have to learn new interfaces and new ways of working. Also, the activity described may be suspended at some point due to the system failure or technical problem, therefore proper technical support and constant update are crucial. As with all technologies, there are challenges in implementing EHRs, however, making team work easier in the long run makes the challenge worth it especially if and when the systems are user-centered and interconnected.[36] Concisely, EHRs have revolutionized the way health care teams practice by enhancing work flow, eliminating or reducing paperwork, enhancing communication, and by promoting standardized writing. These developments help the health care teams to function rather comprehensively, meet patient's requirements faster, and provide effective health care. With the advancement of technology, EHRs are likely to undergo improvements to increase efficiency in Performance of health care teams as well as improving patients' experience.[37]

**Medical records as a bridging mechanism between nursing and medicine**

For the purpose of improving the interaction between people in the healthcare setting, records, especially Electronic Health Records have become instrumental in the integration of nursing and medical work. In the past, nursing and medical staff worked relatively autonomously of one another, both having their respective spheres of responsibility. However the use of medical records has brought about an understanding that they make the care process more team based and with the aim of offering whole patient care. With the help of medical records, both the nursing and medical personnel may get the same information about the patient, which will make these processes more coordinated, fewer misunderstandings, and more effective decisions.[38] The first way that medical records help to coordinate between nursing and medicine is data centralization. HER systems compile, maintain, and amend the patient information that include; medical histories, prescribed medicines, and known allergens, and diagnostic test outcomes among others. This centralized data is available to nurses as well as physicians meaning all the persons in the care team are having identical and updated information. For instance, a physician can view laboratory investigations as well as other images, and immediately share these with the nursing staff via the HER. Likewise, nurses can put down notes that include observations, temperature, or the patient's response to certain interventions which will be helpful to physicians. This flow of information guarantees that both disciplines are bound in care delivery and consider all aspects of the patient's need's meeting.[39]

Coordination of care plans in between nurses and physicians is also pull-off in medical records. Some of the specific care plans may be developed by physicians, who should be followed by nurses in delivering care but should also involve regular communication with feedback. When the physicians alter the management plan of treatment or give new drugs, the nurses can instantly refer to the medical records and change the plan and treatment as needed. Likewise, documentation of patient responses as submitted by the nurses could lead to changes by the physicians when necessary, at a real time. This integrated strategy enhances the treatment outcomes since the two parties work Coordinate with each other hence they are always aware of any change within the patient.[40] In addition, through the documentation of each client's medical history, integration is promoted through multi-disciplinary exchange. For example, in extended multimodal cases, medical records let each specialist – a cardiologist, an oncologist, a nurse, a general practitioner, etc. – have an organized and immediate access to the patients' records and change information concerning the patient. This is especially useful especially in areas of intensive care units, or the outpatient clinics that require cooperation between several providers. HER systems reduce redundancy through a need for repetitive documentation, and have the added bonus of updating each discipline, thus reducing opportunities for error and improving patient care delivery.

Integrating between nursing and medicine, especially through medical records, is not only limited to reporting the diagnosis or the treatment of the case. It also assists in navigation of preventive care, education of the patient and follow up care. For examples, when the nurse takes information about the discharge instructions interview or follow up appointment schedule with a patient this data can be retrieved by the physicians to check whether the patient has well understood his/her care plan and whether or not he/she requires some sort of assistance or not. The of use of medical records for documenting preventive care such as immunization or health check or screening also helps in the integration of both groups because nothing is left untouched with regard to the patient's health status. Records also enhance coordination between nursing and medicine whenever the practice is in the production of research and evidence. This means that nurses and physicians inform clinical research by entering data into the same electronic medical records and they can work together on studies. Group analysis of DE identified clinical data allows the coordinated care team to recognize patterns within medical histories, adjust practices for the better, and design clinical interventions based on a combined knowledge database. It provides a basis for nursing and medical, so that both specialties walk together for better patient outcomes.

As such, medical records play the role of an important link between nursing and medical treatment processes and helps in achieving better collaboration between the teams; Improved communication, integration of patient needs, care and coordination of care plans and working effectively in teams, are key benefits which makes medical records a valuable tool in managing patient care. While the integration that stems from medical records increase the effectiveness and runway of healthcare business models, it is the quality of patient care that benefits from providing a comprehensive care blueprint that coordinates all aspects of the patient's total health care needs. [40,41]

## Conclusion

Medical records, especially EHRs, form an essential mechanism of increasing the synergy between nursing and medical teams in delivering patient care. Through the administration of data from patients and the availability of real-time data, EHRs guarantee that all the caries involved in a patient's treatment employ same accurate information, thus reducing the chances of lane errors and enhancing healthcare decision making. In addition, entities like care plans, better communication, and the possibility of sharing work among professions are valuable additions to total healthcare organization. With advancement in technology, medical records will gradually play an even bigger part in achieving integration between the nursing and medical professions, which in turn positive impact the quality of service provided to the patient. In this way, health-care organizations shall be able to maintain that the patients are provided with complete, on time and coherent therapy at each stage of the sickness.

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**دور السجلات الطبية في تعزيز التعاون بين الممرضين والأطباء**

**الملخص**

**المقدمة:** تعتبر السجلات الطبية الفعالة، سواء كانت ورقية أو إلكترونية (السجلات الصحية الإلكترونية)، أساسية في تحسين العلاقة بين الممرض والطبيب. حيث تسهم في تسهيل التواصل والتنسيق بين الفريقين، ولكنها تواجه بعض التحديات التي تؤثر على كفاءتها.

**الهدف:** تهدف هذه الدراسة إلى فحص فوائد السجلات الطبية في تعزيز التعاون وتأثيراتها المحددة على التواصل، رعاية المرضى، وإنتاجية الموظفين، بالإضافة إلى الفرص والعوائق المرتبطة بها.

**الطرق:** تم اختيار 23 دراسة كمية ونوعية نشرت بين عامي 2019 و2022 من قواعد بيانات مثل PubMed وScience Direct، وتم تحليلها بناءً على المجالات الموضوعية التالية: تبني السجلات الصحية الإلكترونية، والتعاون بين التخصصات المهنية.

**النتائج:** تتيح السجلات الصحية مزيدًا من الفهم للتفاصيل المتعلقة بالمريض، كما توفر وسائل أفضل وأكثر استمرارية لمشاركة المعلومات القيمة، مما يعزز عملية اتخاذ القرار. ومع ذلك، فإن القضايا مثل أمان البيانات، تدريب المستخدمين، وتوافق النظام تعد من العوائق التي تحد من التطبيق الكامل للنظام.

**الخلاصة:** تعد السجلات الصحية ذات أهمية كبيرة في تعزيز العلاقات بين التخصصات المهنية في قطاع الرعاية الصحية. لذلك، فإن معالجة بعض التحديات التي تواجه الفريق يمكن أن يحسن من كفاءة الفريق الفني وكذلك من أداء الأعضاء الآخرين في فريق الرعاية الصحية ونتائج رعاية المرضى.

**الكلمات المفتاحية:** السجلات الصحية الإلكترونية، معلومات صحية، نظام المعلومات السريري، الممرضون، الأطباء، المرضى.