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Letter to the Editor

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An appraisal of health records and information management standards and influencing factors

Ajiboye Paul Oyebanji*

[1]Department of Health Information Management, University of Maiduguri Teaching Hospital, Maiduguri, Nigeria

Corresponding author*: E-mail: *paulyebanji@gmail.com*

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Dear Editor.

The healthcare record refers to all information collected, processed and held in both manual and electronic formats pertaining to the patient and patient care. It includes demographics, clinical data, images, unique identification, investigation, samples, correspondences and communications relating to the patient and his/her care[1]. The patient's health record serves many functions but their primary purpose is to support patient care[1]. Every time the patient moves from one place to another, information about his condition is registered[2]. Critical patient information is often not available when and where needed and this makes the whole process take much longer[2].

The principal purpose of health records and medical notes is to record and communicate information about patients and their care. If notes are not organized and completed properly, it can lead to frustration, debate, clinical misadventure and litigation[1]. The onus for improving records lies with individual healthcare professionals. Structuring the record can bring direct benefits to patients by improving patient outcomes and doctors' performance[1].

Structure and content standards are essential for ensuring that clinical data can be reliably stored, retrieved and shared between information systems[1]. The standards must be based on professional consensus that reflect best clinical practice, and then implemented into information systems by the IT professionals. Patients must be involved in all stages of development[1]. The standards should facilitate not hinder the process of writing, communicating and retrieving clinical information, so that care is safer and more efficient[1]. The steps required to make a standard begin with awareness of both the need for a standard and the fact that a business case could be made for removing trade barriers and expanding some markets with the introduction of a set of common procedures or a common protocol that would benefit a specific community[3].

No one has defined all of the standards that will be required to support interoperability for a national health information network[3]. The first major attempt to standardize health records in the UK came in 1965 with the publication of the Tunbridge report[4]. Healthcare and patient mobility is increasingly global, and eventually both costs and patient safety will be improved if we can reach global agreements on how to share and analyse EHRs. Standards to support EHR communication are at an advanced stage of development. This will help to ensure the clinical shared care can be delivered safely, underpinned by complete and unambiguous information[5].

Codes of Practice for Healthcare Records Management[6] include:

i. Individual responsibility for healthcare records management shall be clearly defined.
ii. The scope of responsibility shall include the competence of contractors where the hospital buys in services and professional liability where the hospital sells services to other organisations.
iii. Healthcare records management shall be a standard item on the agenda of the quality and risk management committee in the hospital.
iv. The health records professional shall submit regular reports on healthcare records management to the committee.
v. A twice yearly report on the effectiveness of healthcare records management shall be submitted to the quality and risk management committee for review.
vi. This committee, which shall include in its membership the hospital CEO/Manager or CEO/Manager nominee, shall present the report to the hospital management team.
vii. Each hospital shall identify a healthcare records manager.
viii. The duties of the manager shall not be confined to any one aspect of the healthcare records function but shall encompass all healthcare records processes wherever they occur within the hospital.
ix. The health records professional shall have responsibility and authority for developing and monitoring policies, continuous quality improvement and/or strategies for healthcare records management for approval by the quality and risk committee.
x. The health records professional shall attend appropriate meetings and conferences, local and national relevant to healthcare records management, which shall increase their knowledge and improve their ability to undertake the role.
xi. The health records professional shall undertake the dissemination of all information.
xii. The health records professional shall work with clinicians and departmental/line managers to develop and improve the systematic approach to healthcare records management.
xiii. The health records professional shall be responsible for ensuring that the healthcare records audit activity under the responsibility of each head of department has been completed.
xiv. The quality and risk committee shall be responsible for the implementation and monitoring of a healthcare records audit and monitoring programme in each hospital.
xv. Each relevant member of staff shall be made aware of their responsibility in relation to the healthcare record.
xvi. Each hospital shall have a specific and appropriate resource provision for the healthcare records service.

The benefits of structure and content standards according to Royal College of Physicians[1]

i. Standardisation of content will improve safety by reducing opportunities for ambiguity or omission of data.
ii. Paper proformas can be developed using these standards with confidence that they are likely to reflect best practice.
iii. Structuring records in this way will help to improve ease and accuracy in communication of clinical information, the quality and safety of clinical practice and the accuracy of clinical coding.
iv. When junior doctors move from one hospital or department to another, they will not need to familiarise themselves with new document structures.
v. Clinical information in electronic records will be recorded once, and made available when needed, thus improving efficiency and saving time.

vi. Implementation of new clinical information systems will be simplified; as the systems will all be built on the same professionally developed and agreed standards for clinical structure and content.

vii. Patients and carers were involved in the development of the standards and their considerations will become better embedded in clinical practice.

viii. Discharge summaries based on these standards should deliver the information that they want and need.

ix. National audits should be easier to conduct using comparable data from across the country.

x. Routine clinical data will better support research. Both prospective trials and retrospective epidemiological studies will be easier and more cost effective to carry out.

xi. It is likely that revalidation will include an evaluation of clinical performance with some evidence from medical notes.

xii. Structuring notes using the standards will contribute to a fair evaluation.

A preliminary finding from Nigeria reveals that very few healthcare professionals are aware of the available policies designed for health records and information management practice. This may be due to little or non-availability of HIM policies in Nigeria federal tertiary healthcare institutions or none functional of such policies.

In conclusion, it is important that all healthcare providers other health sector stakeholders join hands to improve healthcare data management by implementing formulated health records policy standards and create one where there is none.

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Authors Contribution:

OAP conceived of the study, initiated its design, participated in literature search, article selection and review, data analysis and coordination and drafted the manuscript.