

# Management of Records in Health Institutions

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**Abstract:** *Effective records management practice is a vital element of management of any health care service providing organisation. Despite the important role played by records management, there is evidence to suggest that many of the health care service organisations pay little attention to standardised management of records. This paper analyses the practice in different environments and suggests possible changes that would help make the program more effective and beneficial.*

**Keywords:** Health Record, Patient record, Health Record Management

## 1. Introduction

Health record management practice is imperative in any health service providing institution in ensuring quality service delivery. Health records are among the vital tools that hospitals require in order to attain the missions and visions of the respective hospitals. The purpose of health record management is to ensure quality, accuracy, accessibility, authenticity and security of information in both paper and electronic systems (The United States Department of Labour, 2013). Effective medical service delivery does not only depend on the knowledge of doctors and nurses but also records-keeping processes in the hospital. Health records are in of different types depending on the size and activities of the given hospital. Records managed in hospitals include patient case notes, x-rays, pathological specimens and preparations, patient indexes and registers, pharmacy and drug records, nursing and ward records. (International Records Management Trust, 2010)

The health records management program is run in diverse ways in different parts of the world, although differences depend on the needs and scope of service of the specific hospital or health institution. Iron Mountain (2014), notes that health care provider ensures competent service provision and proper health information management to keep costs down, secure patient data, and maintain compliance in rapidly expanding regulatory environment. This means that hospitals determine the priorities rolled by the record management policy. The role of the health record manager is to develop policies for health records management and procedures in order to promote better health records management practice in the hospitals as working together with heads of departments. (National Hospital Services, Portsmouth Hospitals 2011)

Jens-Uwe (2013) asserts that cross-enterprise records are electronic case files aimed at the patient and /or the treatment. This means that there is a deliberate move by the health record managers to move to electronic health record management. Norwegian situation concerning health records management is not perfect either according to Lillefjel (2013).

In Africa specifically in South Africa, record management is a practiced phenomenon, in spite of the standards of the practice being not as expected. The Medical Protection Society, South Africa (2014), notes that there is need for all

the health care professionals to appreciate the value of keeping records accurately. The only vast undoing is that many doctors are unaware of the record management practice and therefore at times the records are disposed prematurely.

In Kenya, it is a requirement by the government that records are properly created and preserved for use. According to laws of Kenya, public archives and documentation service act, chapter 19 (2003), the government recognizes the need for record keeping for the public. This includes health records since the records carry information that concerns the Kenyan citizens. Health record management system has faced constraints like lack of a written health information policy to ensure compliance and enforcement in reporting, low reporting rates (under 60% for most of the sub systems), making the data unrepresentative for management, planning and budgeting at all levels, un-timeliness/late reporting; resulting in delays in data processing, analysis, utilization and outbreak response, inadequate health records and information personnel and inadequate capacity for data analysis and management skills among others. (Health Metrics Network Kenya, 2008)

Putting into consideration the cases in the world, it is clear that there is a quest in every government, hospital heads, and even the health record managers to make the practice of health record management better than it is currently. Moreover it is also clear that that the health record management stakeholders face the more or less the same challenges. Nevertheless, as Jens-Uwe (2013), indicates, there is a need to address a few issues;

- i. How can these project and programs be analysed in an international view for the purpose of comparison?
- ii. What experiences and successes are found in the countries neighbouring Europe and the world at large?

The implication of this is that looking beyond one country across the world is vital in order to attain cost-benefit. Moreover it is important to cater for an ever increasing need for closer harmonisation across world of the health sector, precisely the health record management practices. Therefore, with this reason the study compared the specific areas in the health record management practice in Kenya, focusing on private and public hospitals since the two categories reflect the picture of the situation in the world basing on the citations stated above from different countries.

This paper focuses on types and sources of the patient records, determining the record management functions automation process, to analyse the patient record management policies and their contents and the challenges facing the management practice in Public and Private Hospitals.

## 2. Patient Record Management Practice

Health record management is a process that takes place gradually from one level to another until the point when the record is no longer needed for use. There are many descriptions to the process of record management. Most essentially, the life cycle and the continuum models of record management have been used over time to describe how records are created, used and disposed at different stages by different functions.

### 1. Types and Sources of Health Records in Hospitals

The major sources of health records are from the hospitals admissions office and the attending physicians. The source and the process of creation of the records are vital since the two determine the value of that record and its usability. Entries will be made in all inpatient, outpatient, and service treatment, dental and occupational health records by the healthcare provider who observes, treats, or cares for the patient at the time of observation, treatment, or care. This documentation requirement applies to both electronic and paper records. Entries are also subject to locally defined patient assessment policies (Department of the Army USA, 2008).

The medical record should be completed within 48 hours after the discharge of the patient. The attending physician has the final and major responsibility for completeness and accuracy of the data entry in the record. The attending physician is also encouraged to raise the level of quality of the individual health record and sustain a high level of recording. Residents and interns may be delegated the duty of recording medical information as history, and discharge summaries. The entries made by residents and interns have to be reviewed, corrected, and countersigned by the attending physician. The Medical record practitioner assists the attending physician in reviewing records for completeness by checking for omissions and discrepancies and helps ensure that medical records comply with set policies and standards. (The Department of Health, Republic of the Philippines, 2002)

The general view of the above is that the main source of the health records is the hospital itself. The records are created when the attending health officer is attending to the patient. He can either create the record himself or it be done by a record management officer. Health Records Management Policies in Hospitals

Policies and standards are vital items in any form of management without which, it is difficult to evaluate the effectiveness of any process being undertaken. Policies and standards are benchmarks and guidelines used to check on the quality of work being undertaken. At present there are no conventional policies and standards that govern medical records management, (Health Matrix Network, 2013). Each hospital comes up with their own policies and standards

according the situation and condition of records management on the ground. Nevertheless, the World Health Organization (2006) recommends that when coming up with a policy the following should be considered;

- 1) Amount of time the record should be kept after the patient's last visit.
- 2) Separate rules for children's records.
- 3) How the records will be destroyed if they are not kept
- 4) If there are specific diseases for which the medical record must be kept for the life of the patient
- 5) Penalties are provided for breaking the rules.
- 6) Who is responsible for approving the destruction of medical records?

The State Records of Australia (2011) gives comprehensive health records management policy which states the policy must give guidance that ensures, records are created or captured, records should be disposed of systematically, records should be accessed, records should be found, records should be reliable, and records management training should be provided to staff.

In its policy, County Health Department, United Kingdom (2013) says that medical record is considered a legal document used to protect the legal interest of a patient as well as the health care provider. Information maintained within the record serves as a basis for review, study and evaluation of the care rendered to the patient. Essentially, medical records must be neat, legible, accurate and readily accessible for purposes of service delivery, audit and possible litigation proceedings. The medical record shall be locked in a container and handled and transported in a manner that ensures the security and confidentiality of the record at all times.

### 2. Automation of Patient Record Management Program in Hospitals

Most hospitals have embraced the aspect of implementing electronic health record management system. Kola, Shoewu.&Olatinwo, (2003, p 1) report that many hospitals are incorporating ICT into health record management due to the high level of the shortcomings of manual health records management, such as misfiling of patients health records, enormous amounts of space, legibility of doctors handwriting, transfer of medical records or files from one department to another. Mackenzie K. (2013), states that:

*“Medical errors account for 98,000 deaths each year in the U.S., according to a 1999 report published by The Institute of Medicine (IOM)...interestingly, the report claims that medical errors are not due to incompetent people, but to bad systems that include the processes and methods used to carry out various functions.”*

These, together with many other evidences make it clear that indeed automation of health records is a vital step in any health institution. The choice of a record management system depends on quiet a number of factors. The system of choice determines the safety and availability of records when needed. ISO 15489 (2001) gives criteria for auditing a record management system. The system must ensure; authenticity, reliability, integrity, and usability.

Maintaining records for as long as the records are required; records must be retained for a period of time that is in accordance with authorised legislative and jurisdictional requirements. Decisions about how long records must be retained are defined in disposition or disposal policies and rules. There will be some records that must be retained permanently while others will be required to be retained for varying periods or have a maximum retention period.

Automation of health record management program comes with other obligations. Dollar (2000), states that staff training on new record management systems is imminent if the system is expected to cause positive change in the record management program. Rothenberg, (2001), states that automation of record management practice is a gradual process.

### 3. Challenges in Health Records Management Practice

In the case of manual records, it is established that the greatest issue is lack space for the increasing number of health records. With concern to physical space for storage of paper health records, Dollar (2002) notes that it is a challenge many institutions will keep battling with. Hospitals producing hundreds to thousands of records each day means that after a given period of time the records accumulate huge volumes of paper records. This may bring about difficulty in locating some records and also lack of sufficient space to carry all the records before they are disposed. This becomes the major challenge for paper records.

For electronic records many challenges have been identified. These challenges include high costs of installation, system failure, cyber-crime, lack computers operational skill of the record management staff. The study focused on the aspect of legal requirement and technological obsolescence, in electronic records management.

Robinson (2008) explains one demerit of electronic records. Unlike paper, loss of electronic records is guaranteed unless actively managed. Paper can be ignored for 100 years, and when it is opened the information is perfectly readable. If the state ignores electronic records for 10 years, the fragility of the media and technological obsolescence will make access difficult. The longer one waits to manage these records, the less likely the data will be recoverable. Therefore, the condition poses a challenge of obsolescence of electronic records management systems, hence the record therein.

The Department of Technology Services, Philippines (2012), also points out that like the floppy disc, the CD, or its operating system, may become obsolete in the future, requiring State Archives to either maintain obsolete technology or to upgrade or convert information to newer technology formats. All the options mentioned above will be costly. This means that there is need to always keep up to date with the new technologies to make sure that the information available in the current formats can be accessed even in future when technology has changed.

Another challenge of electronic health records management, according to the International Record Management Trust

(2006) is that of legal requirement. The Trust argues that, in hospitals where the introduction of a patient administration system is feasible, it may be possible to dispense with certain types of records needed in a paper based environment. In particular, the patient registers are likely to be deemed irrelevant or less necessary. Where the registers above constitute duplicate records of the same information in different formats, their use can be discontinued where appropriate computer systems are in place. Nevertheless, where the content of paper registers may be needed for legal or archival purposes, appropriate measures must be taken before any decision is made to rely solely on the electronic system and to abandon paper altogether. These legal requirements may include the need to sign, by hand, a document to authorise for instance a medical operation on a patient.

### 3. Empirical Studies

Ochieng and Hosoi (2005) carried out a study on factors influencing diffusion of electronic medical records in three healthcare institutions in Japan. This study examined the effect of three factors: information technology (IT) skills of healthcare workers, present status of computerisation in their organisations, and workers' attitudes on the diffusion of electronic medical records (EMRs) in the healthcare environment. The study found out that respondents need expanded EMR capability to include decision support systems and reminder systems, and that diffusion of EMR is heavily influenced by attitudes of healthcare workers. Nevertheless, targeted training of healthcare workers is needed to foster positive attitudes about EMR, and build confidence in the benefits of these systems.

Sekoni (2010), in the study on use of ICT in health records management towards attaining vision 2020, gives importance of automation. The reason for wanting to change to an electronic system is important. Many persons involved in healthcare today expect to move from a paper to paperless environment. This is a major step and has been successfully achieved in some health institutions. Institution should not focus on just going paperless. Institutions should focus on encouraging departments and health care practitioners to move to an electronic system. Sekoni concludes by stating that the principal benefits identified for the introduction of an electronic health record system are supporting patient care and improving the quality of that care.

Park (2012) carried out a study on understanding authenticity in records management. This paper reports the result of a pilot study for the long-term research project and focuses on practitioners' understanding of the concept of authenticity as derived from a small set of survey data. This survey was undertaken to examine how different communities use and understand the concept of authenticity in creating, managing and using records. This project examined particularly how people currently consider issues related to authenticity in their professional activities, as the people use and transmit paper records and electronic records, and the language that professionals actually use when talking about authenticity. The study concludes by stating that it is very vital that records managers insist on health records' authenticity to ensure value of those records.

In Kenya, the Health Metrics Network (2008), with authority from the Government of Kenya carried out a study on Health Information Systems and established that the health record management systems and practices in the hospitals face challenges, shortcomings and inconsistency. This has been caused by “lack of a written health information policy to ensure compliance and enforcement in reporting, low reporting rates (under 60% for most of the sub systems), making the data unrepresentative for management, planning and budgeting at all levels, un-timeliness/late reporting; resulting in delays in data processing, analysis, utilization and outbreak response, inadequate Health Records and Information Personnel and inadequate capacity for data analysis and management skills among others.”

#### 4. Conclusion

There is need for proper planning for review of the issues raised below.

##### 1) Need to Standardise Record Capture Point

With reference to the fact that a record creating officer hospitals creates a record at the point of desire, the study recommends the point to capture a new patient record to be at the time the patient is admitted into the hospital. In case of emergency cases, the attending physician should have a record clerk to put down details of the patient as the treatment process continues. This will help not to skip or forget any detail that may need to be in the patient record.

##### 2) Update the Electronic Record Management System

There is need to update the automated system to avoid frequent system failure, and for the functions that have not been automate to be automated. This is because most staffs prefer, and would find it easy to use the electronic record management system. However there is also need to train the staff on the use of the electronic record management system in place. The problem of frequent blackouts can be avoided by installing a standby generator that will serve at the times of blackouts.

##### 3) Review the Health Record Management Policy

The record management policy requires to be reviewed and key issues on record management process are included and put clear. There is need for staff awareness and training on the content of the record management policy. This is because most staffs seem not to be conversant with the content of the record management policy in place. This will enable uniformity in the process of record management.

There is need to make clear the policy on the process and conditions for selection of an appropriate record management system, maintenance of the record management system, maintaining a hybrid system, records disposal plan in the existing record management system and Security regulations for the record management system in place.

##### 4) Frequent Consultation between the Health Record Handlers and the Hospital Management

Frequent consultation between the Record Management Staff and Stakeholders with the Hospital Management will be very helpful to enable the management to get the challenges being faced by the staff. This will enable

handling each issue as it arises hence providing a conducive environment for the record staff and stakeholders to work. The challenges that affect the staff include, frequent blackouts, lack of enough knowledge on computers, and frequent system failure. For this reason, there is need to have Uninterrupted Power Supply (UPS) systems to work with the stand by generators in place, training of the staff on computer use and specifically on operating the system in place and also to have a system that it more reliable to avoid frequent failures.

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