Covenant Journal of Business & Social Sciences (CJBSS) Vol. 10 No.2, Dec. 2019
ISSN: ***p. 2006-0300 e. 2334-5708*** **DOI:**

An Open Access Journal Available Online

Managing Health Records in the Context of Service Delivery: Issues and Challenges

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Received: 18th October, 2019 Accepted: 18th November, 2019
Date of Publication: December, 2019

Abstract: Records are considered as the memory of health organizations. Therefore, their management constitutes important component towards efficient delivery of service to clients. It is through records management that accurate data are made available for patients' care and administrative purposes. In spite of the roles of records in health organizations, the way they are managed in various health facilities is of serious concern. Accordingly, poor records management leads to the failure of health facilities to deliver efficient services. Health records in this article include detailed documented patient's information, which cover health problem, diagnosis and treatment over a period. This article therefore examines the issues and challenges associated with records management in the delivery of services to clients in health setting. In terms of methodology, the article employs secondary source of data/information where scholarly publications were reviewed to illustrate the subject matter. The article reveals that health records, if properly managed could perform important functions. These include provision of detail information about the patients' health conditions; serve as platform for detecting and neutralizing the incidence of medical errors and useful for health facilities in response to complaints from the clients about health services, among others. The article also discussed the challenges associated with records management in health sector. They include poor record keeping, inadequate/poor storage facility and ineffective medical records management policy. The article concludes that priority should be given to efficient records management to enhance appropriate service delivery in healthcare organizations.

Key Words: Records, Healthcare, Facilities, Service Delivery and Litigation

Introduction

The main goal of health institutions is the provision of efficient services that enhance health and prolong life of patients. Achieving this goal therefore requires that there is presence of reliable

and accurate health records. Records are used to hold health institutions accountable for the service delivery. Mogli (2009) considered health records as documents used by health institutions and caregivers to record patient history, illness, illness narratives and treatment. Luthuli and Kalusopa (2017: 2) conceived health records as written account of patients' examination and treatment that include the patients' medical history, illness narratives and complaints; the physician's findings; and the results of diagnostic tests, procedures, medications and therapeutic procedures. Connectedly, the World Health Organization (2006a) classified health records to include doctors' clinical notes; recording of discussion with patient /next of kin as regards disease; referral notes to other specialist(s) for consultation; laboratory notes; imaging reports; clinical photographs; drugs prescriptions; nurses' reports; consent forms; operation notes; video recordings; and printouts from monitoring records. Advancing the importance of health records, Adeleke (2014) stresses that health records are needed for delivery of services in health institutions. Among other purposes, records management provides availability of reliable and timely information to various end users.

The International Records Management Trust [IRMT] (2009) defines records management as the task of ensuring that all recorded information, regardless of form and medium, is managed in a proper and efficient manner to enhance effective service delivery to the end users. Luthuli (2017) also notes that records management involves accountability, security, integrity and comprehensiveness. Records Management is therefore considered as the process of controlling and governing important records of an institution in a comprehensive and complete cycle. The process includes identifying, classifying, prioritizing, storing, securing, archiving, preserving, retrieving, tracking and destroying of records. Health records management also involve appraisal, retention and disposal, which eventually eliminate ephemeral records that are no longer useful to healthcare institutions. The objectives of records management as highlighted by Feather & Sturges (2003) include cost reduction, improved productivity by quick access to needed records, enhanced litigation avoidance and support, increased audit compliance. The WHO (2006b) also illustrated that health records may be either in paper or in electronic forms. Where medical records exist in both paper and electronic forms, it is referred to as hybrid records. As a process, records management begins the moment a patient is admitted into healthcare facility until s/he is discharged.

Delivery of service is central to the establishment of health care institutions. Mdluli (2008) conceives service delivery as activities performed by an organization, in line with its mandate aimed at satisfying, responding and resolving community or citizen problems. Service delivery in healthcare therefore, is considered as a contact between service providers and consumers. Service delivery in

healthcare institutions manifests in forms of appropriate illness diagnosis, accurate laboratory tests, correct medication and follow-up treatment. Connectedly, Kemoni & Ngulube (2007) opine that effective records management is a key factor in the delivery of service in health institutions. Thus, achieving service delivery requires that health organizations develop, promote and implement effective records management philosophy and ideology.

There are agencies and professional associations saddled with the responsibility of ensuring that records generated by medical practitioners involved in the provision and delivery of services to patients are efficiently managed in the best interest of patients and healthcare institutions. With reference to Nigeria, Osundina, Kolawole & Abolaji (2016) identify Health Records Officers Registration Board of Nigeria; Nigeria Medical Council, Nurses and Midwifery Council of Nigeria, among others as agencies and associations that regulate the practice of medical records management.

Against this background, this article provides proper knowledge and orientation of the subject matter of health records management in the context of service delivery in healthcare institutions. It is divided into six sections: the methodological approach towards understanding the subject matter, the historical development of medical records, issues of medical records management and service delivery in health organizations and the challenges associated with medical records management in healthcare institutions. The last section is the conclusion.

Methodological Approach towards Understanding Issues and Challenges of Managing Health Records in the Context of Service Delivery

The article adopts integrative approach of literature review. Through this approach, available publications focusing on health records management in different health facilities were accessed and reviewed. The articles were sought from Medline, PubMed Science, Google Scholar and other online resources. While searching for articles, proper attention was given to diversity, coupled with comprehensive explanation of the issues and challenges associated with managing health records in different health institutions across different countries. This was done to provide readers with better ideas of the subject matter.

The Historical Development of Health Records

This section of the article illustrates the context that influenced the emergence of health records. For centuries, scholars have always been interested in understanding the need for systematic documentation of health records in various health facilities. Historically, Akuso (2014:3) attributed the emergence of medical records management to the seventh century through a hospital set up by Benjamin Franklin in 1752 A. D. The hospital is known as Pennsylvannia hospital at Philadelphia, United States of America. The hospital introduced medical records

by preparing file cases where patient's name, admission date, discharge date, etc were written. With this development, it was recommended that no health facility should operate without establishing a medical records section. It also enabled health practitioners to analyze health data of patients. Consequently, the development encouraged hospital-accrediting bodies to insist on the availability of accurate, well-organized medical records as a condition for accreditation and certification. Similarly, Flexner's (1910) report on medical education in the United States and Canada was the first formal statement made about the functions and contents of health records. The report also compelled physicians to keep a patient-oriented medical record.

Health records are available either in paper or electronic formats. Gartee (2007) explains that paper format health records management had been in existence for quite a long period. It manifests in forms of handwritten notes, typed reports and test results, usually stored in a file. The paper format health records management is fraught with many challenges. First, it is time consuming and difficult for different health workers to interact concurrently with patient facing complicated health conditions. Secondly, paper based medical records are easy to misplace, thereby leading to disruption or discontinuity of treatment. Third, moisture, water, fire and insects can easily damage paper records. With the emergence of computers in late 1960s, a new form of health records management evolved, thereby neutralizing the challenges associated with the manual medical records management (Weed, 1969). Today, more and more health facilities in the world and especially in advanced countries are migrating from paper method of records management to electronic format characterized with the introduction of information technology (IT) resources, such as computer-based records, clinical information systems and telemedicine.

In the case of Nigeria, Akanji (2005) traced the act of health records management to the Second World War, which occurred in 1945. Following the devastating effects on the victims of the world war, it became imperative for the Nigerian government to collate comprehensive and systematic documentation of records and treatment received by the victims. This was considered as a motivating factor for the Nigerian government to introduce National Health Care Services for the war victims. In addition and having realized the importance of health records management, some Nigerian health researchers in collaboration with their Finnish counterparts in the late 1990s decided to expand their rudimentary hospital information system with the aim of developing efficient and comprehensive system suitable for use in all Nigerian Teaching Hospitals and medical centers'. The expectation then was that by 2001 all the Teaching Hospitals in Nigeria would have health informatics units, which could make use of standardized software. Unfortunately, the project was not successful, partly due to paucity of funds on the part of government to

purchase the enabling software. It is worthy of note to state that in spite of the spread of modern technology globally, especially in advanced countries, the management of health records in Nigeria is still characterized by filing of health records in paper format. This is largely because most of the health facilities in Nigeria have not yet embraced the use of modern technology for the management of health records.

Issues of Health Records Management and Service Delivery in Health Organizations

This section highlights the importance of records management in healthcare facilities towards better delivery of needed services to clients and for administrative purposes. Hospitals generate, receive and preserve records as part of their functions, activities and mandates. Record serves as an important source of information in order to enhance sustainability and continuity of organizations. Records management is therefore considered as integral component of health institutions used to facilitate the achievement of their routine activities. The purpose of records management includes the provision of relevant information to the end users. Relatedly, Hufman (2001) opines that health records are the lifeblood and essential tools in running the day – to – day services in health care institutions while Ngoepe (2004) considers it as the heart of service delivery, as interventions by healthcare providers rely on access to reliable and up-to-date records. Similarly, Osundina, Kolawole & Abolaji (2016) notes that health care institutions depend on health records for knowledge generation and dissemination, administrative and financial purposes. Dikopoulou, Mihiotis and Dikopoulou (2010) also submit that health institutions keep records to enhance accountability and proper planning.

A study conducted by Polit, Beck & Hungler (2001) establish that there is a strong relationship between efficient records management and communication among clients and health professionals while in the view of Berg (2001) records management constitutes tool for monitoring and reporting patients' progress. Similarly, the World Health Organization (2006a) highlights that health records contain facts about a patients' health status with specific emphasis on events affecting them during their admission at the health care facility. Comeford (2003) also alluded that the purpose of medical records management is to provide evidence of the quality of patient care. Other important information accessible from health records provided they are properly managed include patient's history, medical prescription, medical processes adopted, decisions made, actions agreed and sometimes where there is disagreement, who is taking decisions and who is agreeing to the decisions, among others. When these are done, they provide a platform for continuity of care among several health practitioners to measure and determine the patient's past and current health conditions. By implication, when there is efficient records management, various individuals involved in the delivery of

health services to patients will have a good understanding of challenges faced by patients, coupled with pathways towards neutralizing the identified challenges. It also means that without proper records management, lives of patients are at risk; whereas physicians' practice may suffer and may also lose credibility and trust.

In addition, proper records management acts as legal document that gives details of a client's management, especially when patient treatment in healthcare facilities is questionable. In view of this development, medical records can be used to prove the innocence or otherwise of healthcare providers (Wetter, 2005). When this happens, documented health records become defense shields for the health practitioners in the court of law or medical tribunals. Importantly, medical records assist hospitals in identifying competency of medical practitioners. Therefore, medical negligence litigation is built around comprehensive and accurate health records; hence, proper maintenance of such records is critical.

Establishing the relationship between records management and patients' health conditions, Maponya (2013:6) reported that Polokwane Hospital in Limpopo, South Africa failed to provide medical records for a cervical cancer patient, thereby having negative impact on health conditions of the patient. Similarly, Marutha (2011:3) revealed that doctors could not operate on a patient because of missing file at Nkhensani Hospital, Limpopo, South Africa; thereby worsening the health condition of the patient. Marutha (2011) also established that, in the Limpopo Province, public hospitals are using manual records management systems, reported to be hectic and tended to negatively affect the record retrieval process. The absence of efficient health records management therefore, can cause adverse effects including deaths and injuries that could have been avoided.

Challenges associated with the Management of Health Records in Health Care Institutions

This section of the article x-rays the challenges confronting the management of health records in different contexts. This is done in order to state in clear terms that managing health records in the context of service delivery requires clearly defined efforts and commitments from concerned individuals and healthcare institutions. One of the major challenges affecting the management of health records is poor records management by people who are saddled with the responsibility in various health institutions. Wong and Bradley (2009) reveal that an efficient medical records management is often lacking in most of the developing world characterized by lack of requisite infrastructure. A study conducted by Ojo (2009:95) also reveals that staff with inadequate or poor knowledge of information and communication technology manages health records in most of the health facilities in Africa, while some facilities are faced with inadequate well-trained personnel. Similarly, Gunnlaugsdottir (2008:33-34) documents that lack of management support, lack of effective system training to employees and

resistance to change contribute to poor records management in various health facilities in developing countries. A study by Al-azmi, Al-enezi & Chowdhury (2009) reveal that records officers saddled with the responsibility of managing health records in Kuwait took long time in locating records. A study by Zulu (2008) attributed epileptic electricity supply in various health facilities in Africa makes it impossible to maintain a conducive and sustainable technological environment suitable for electronic health records management. Thus, a country that is faced with epileptic power supply will not be able to deploy good Information and Communication Technology (ICT) services for efficient management of health records to its people.

The safety and security of medical records is a challenge to personnel in-charge of records in various health facilities. This is linked to abuse of patient information. Inadequate security in the management of medical records may expose the patients' records to several dangers including unauthorized access. Nicholson (1996) revealed that there were numerous instances where case notes were not kept in secure conditions, as they were found unattended to; left in clinic areas because records management unit had closed. In addition, the occurrence of disasters such as fire, water damage, ants and vandalism poses a challenge to proper medical records management in various health facilities. With specific focus on Nigeria, Yaya, Asunmo, Abolarinwa & Onyenekwe (2015) highlighted that preservation and conservation of hospital documents and records has posed a serious problem.

Conclusion

This article examines medical records management in the context of service delivery, where evidence from the existing studies affirms that medical records constitute a crucial segment of patients' management. The literature reviewed was in relation to the role of medical records management in the delivery of healthcare services in health facilities. The article shows clearly that the importance of accurate, comprehensive and objective management of health records cannot be over-emphasized. Health records are an integral part of healthcare and their proper management aids the performance of healthcare institutions. Medical records constitute tools for the promotion and sustenance of accountability, ethical and legal requirements in health institutions. Hence, the way and manner records are managed in healthcare setting has a significant influence on the ability of healthcare institutions to achieve their goals and optimize their philosophy. The article therefore submits that efficient management of health records will enhance the efficiency of medical practitioners, as well as welfare of patients. Thus, those individuals saddled with the responsibility of managing health records must be given adequate supports, such as the provision of routine training and technological facilities capable of promoting and sustaining proper records management to enhance effective service delivery.

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