IJHRIM

Intl J Health Recs & Info Mgt. Jan – Dec 2023;6(1):36-41

Perspectives

Print ISSN 2645-2464; E ISSN 2695-1770

Appraising the standards of a typical health records department

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ABSTRACT

Health Records Department is the sole department responsible for the creation and management of patients' health records. The department's prime objective is the provision of patient health records in a timely manner to different hospital units in order to assist physicians, allied health professionals and other hospital staff in the provision of quality care to patients.The department is not only the first port of call and last port of call but it is equally the image builder of the hospital. Its services cut across all specialties and this explains why the department is a pivot around which other departments revolve in any hospital. The importance of standards in ensuring uniformity and as measures established to serve as criteria or level of reference for determining the accomplishment of objectives was underscored. This paper examined the standards of a typical health records department and sections it should be organized into and the three different opinions of sections within the department reviewed were presented. It was concluded that for the department to carry out all its enumerated functions, it has to be a standard department, which is organized to establish structures that target the achievement of the set goals and objectives. If standard is to ensure quality of service, uniformity and better outcome then, the technology that will drive the change and improve the standards and service should be embraced. The paper therefore, recommended that the standards of a typical health records department should be based on the types of services available and the size of the hospital and that consideration should be given majorly to the deployment of Electronic Medical Records (EMR) as a way of improving the standards of the department.

Keywords: Health records; Health records department; Healthcare system; HIM professionals; Standards

Edited by *IT Adeleke; submitted on 08.02.2022; peer reviewed by AA Adebisi, JO Lawal, Sadiq SY; accepted 07.07.2023; published 09.11.2023.*

Please cite as: *Adio SO, Osundina SK, Adio RA, Adebayo TT. Appraising the standards of a typeical health records department . Intl J Health Recs & Info Mgt. 2023;6(1):36-41.*

Conflict of interest: None declared.

Funding disclosure: No funding was solicited for nor obtained for this study.

INTRODUCTION

Standards are set to get uniformity of doing thing so as to ensure satisfactory outcome. Standard is a means of measuring performance of individual or organization to sustain better outcome. According to Huffman standards are measures established to serve as criteria or level of reference for determining the accomplishment of objectives and those standards are embedded in the objectives and goals set in the planning function management[1]. Setting standard in health records department is one of the key components in driving the performance of the department, this is because health records is a vital reference document in healthcare. Health records, whether manual or electronics is a veritable tool used in documenting events that happen to patient during the visit or stay in the hospital. It takes accounts of all clinical activities about the patients, which is maintained, stored and retrieved to follow up patient's health or medical conditions and as such an important aspect of patient's health life.

Huffman defined Health records as a veritable premise that produces the much-needed best possible care, data for evaluation program and utilization research for the determination of quality in healthcare practice[2]. Adio opined that Health record is a communication tool between healthcare providers, a kit of evidence of procedures and treatments received by the patients and a planning framework into the future management of the patients[3]. Osundina *et al.* asserted that health records management is a discipline, which utilizes an administrative system to direct and control the creation, distribution, filing, retention, storage and disposal of records in a way that enables records to serve the purpose of creation[4].

The department responsible for creation and management of patients' records is referred to as the Department of Health Records. Over the years, there have been several changes in the title of the person in charge of the Health Records Department as well as the title of the department. These changes have come about due to a greater awareness of medical record systems and an increased emphasis on computerization and the development of computerized health information systems[5]. The name varies from country to country, although many countries including Nigeria prefer health record and health records department. In the year 2021 however, the name was changed in Nigeria through the circular emanating from the Office of the Head of Civil Service of the Federation re-designating health records practitioners to health information management practitioners and this invariably changed the department as well.

Health Records Department is an essential part of a hospital or a healthcare setup, which primarily stores records of the patients, who have been either treated in the OPD (Out Patient Department), IPD (Inpatient Patient Department) or Emergency Units of the hospital[6]. The Health Records Department is a busy department and the work of medical record staff is highly demanding. Although staff are not directly involved in invasive patient care, the information recorded in the patient's health records is an essential part of that care. The Health Records Department staff are therefore, required to perform essential services within the hospital. Sometimes, the nature of this work is not understood by the medical staff, hospital administrators and other hospital personnel, and HIM Professionals often feel isolated[5].

The department is the Health information centre of the hospital and mainly responsible for taking custody, control and retrieval of patients' health records.The department is not only the first port of call and last port of call but, it is equally the image builder of the hospital. Its services cut across all specialties and this explains why the department is a pivot over which other departments revolve in any hospital. Bali *et al.* described health records as the document that explains all detail about the patient's history, clinical findings, diagnostic test results, pre and postoperative care, patient's progress and medication. If written correctly, notes support the physician about the correctness of treatment[7].

The department's prime objective is the provision of patients health records in a timely manner to different units in the hospital in order to assist physicians, other healthcare providers and other hospital staff in the provision of quality care to patients. In addition, the department is responsible for maintaining health records in a standardized and professional manner in order to protect patient confidentiality, while allowing adequate access to providers in order to promote quality patient care[8]. According to Ajami *et al.* Health Records Department has become an essential department in every hospital, which provides multiple services not only to the patients but, also to running a hospital efficiently and plays a key role in health promotion and patient care quality. Evaluation of the services provided in this department is therefore critical to all services being rendered.

Functions of Health Records Department

According to Hinfoways, health records department is the whole soul of any information of the patient, who is discharged from the hospital after treatment. A health records department mainly functions to store the health records or treatment files of patients, who are either treated in the inpatient department or in the emergency unit. Health Records Department, where health records officers are based is one of the numerous departments in tertiary hospitals and has responsibility of creating, maintaining and producing patient records and information on demand.

This department in every hospital is supposed to have complete records of patient's admission, organizing outpatient and emergency health records, ensure

documentation in accordance with predetermined standards, medical information coding process, creation and maintenance of statistical information database for planning and budgeting for hospitals[9]. Huffman and Mogli enumerated health records department's functions and responsibilities of HIM Professionals as follows:

1. Organize and manage the health records systems that will provide efficient and effective health records services to the hospital
2. Develop health records standards which includes objective contents, confidentiality, staff management, policies and procedures, healthcare data collection, quality assurance, training and development programs and improvement planning.
3. Operates internal control mechanism to ensure adequate health records contents, completeness, information retrievals, quality and availability of services
4. Maintain a manual of approved health record policies, procedures, abbreviations and forms that govern the content, documentation and formats for the health records of the hospital's active and discharged clients; coordinate the process for the review and approval of additions/changes to the manual, which must be approved by the Medical Advisory Committee/ Clinical Services Advisory Committee.
5. Disseminate information and educate appropriate hospital staff about the hospital's policies, procedures and expectations regarding health records.
6. Store, safeguard and provide access to the health records of discharged clients in accordance with applicable laws, rules, policies, procedures and laid down standards.
7. Conduct ongoing reviews/audits of the hospital's health records, including reviews of the records of all discharged clients, reviews of random samples of active clients, and special/focused audits as requested/indicated. The purpose of the reviews/audits is to identify opportunities for improvement in compliance with established health record procedures/standards and in documentation in the records.
8. Code all client diagnoses and medical procedures for billing and for the client information system (BHIS - Behavioral Healthcare Information System) and statistical purposes.
9. Provide medical transcription services to all hospital physicians and to other professional staff as needed.
10. Comply with applicable laws, rules, policies, procedures and standards governing the confidentiality, security and integrity of the health record and promote compliance hospital-wide.
11. Provide support for the integrity of the information in BHIS (client information system), including verification of the daily census with each client unit, checking to see that all information on each admission is entered, and compiling reports of analyses of BHIS data entry errors for performance improvement.
12. Upon a client's discharge from the hospital, process documents to provide relevant client demographic and health information to the designated aftercare agencies to facilitate follow-up and continuity of the client's care. They also prepare the necessary documents, when clients are transferred to another facility.
13. Abstracts, codes and analyses cancer cases in the Cancer Registry and other disease registries.
14. Cooperate with medical, nursing and other healthcare professionals in order to obtain comprehensive patient records and to design and develop effective health record forms.
15. Observe the ethics of the health record profession and strive for new innovations to improve departmental functions.
16. Develop and maintain an information base and mechanism for providing statistical data and for submitting monthly reports concerning activities of the hospital and department and for providing suggestions for effective functioning and future development.

The department cannot function without staff and these staff are specifically trained to handle functions of the department. The functions of HIM Professionals in the department according to Huffman[1] are:

1. Data gathering for management planning, resources allocation,

organizational designs, policies as well as quality assurance programs.
2. Screening of health records for compliance with established criteria (for Medical Care Evaluation studies).
3. Participating in the selection and design of forms used in the health record and standardization of the same.
4. Developing mechanisms, which assure the privacy of patients and practitioners, whose records are involved in quality assessment activities.
5. Developing standards of practice to suppress ill-planned and ethics that worked against standard.
6. Participating in continuing education programs in and outside the department.
7. Monitoring and evaluation of primary healthcare programs including diseases Surveillance & notification as well as other forms of sentinel surveillance activities.
8. Generating data to raise alarm of imminent outbreak and provide same for the control of infectious/communicable diseases.

According to Mogli, the goal of health records department is to maintain a modern and scientific health record system in conformity with international standards in all hospitals and to ensure that health records contain comprehensive and accurate social, health and vital information, which will facilitate the provision of effective medical services[10]. For the department to be able to achieve its goals, it must be organized to create the structures that will target the goals set, and this requires the right leadership and followership. Health Records Department can only be efficient and effective, when it is staffed with the right and skilled personnel. The service delivery by HIM Professionals is therefore, essential in any hospital, it is not only important to quality service delivery in healthcare sector but it is equally a measure of effectiveness and efficiency of other service deliveries in the hospital[11].

Sections within the Health Records Department

Health Records Department, like other departments, consists of sections/units for effective and efficient service delivery. The types of service to be rendered and size of the hospital determine the numbers of sections or unit the department should have. Usually in a specialized or teaching hospital, department has more sections or units than general hospital. Adio following the sections in Health Records department of National Hospital, had recommended that the department should be organized into related sections and appropriately staffed for efficient and effective service delivery[13]. The following are recommended sections of the department:

1. General Outpatient section (Family Medicine Department) to see to registration of and follow up of general cases
2. Accidents & Emergencies/Ambulatory Service Section to provide 24 hours emergency services in medical, surgical, including trauma cases, Obstetrics and Gynaecology.
3. Specialty/Consultative Clinics Section to render specialized care and schedule appointments for follow up cases.
4. Library service section to support other sections and users in retrieving and filing of patients records to ensure availability through tracing or tracking
5. Admissions and Discharge Section to manage inpatient records, arrangement, deficiency identifications, repairs of wears and tears, Coding and Indexing of cases
6. Statistics/Data Processing Section to collect and process data from various sources including radiology (X-Ray), laboratory, hemodialysis, mortuary etc.and prepares various reports to meet the users demands
7. Administration section to support head of department's functions, treatment of correspondences, research requests and other secretariat duties

From the above listed sections, it could be seen that the usual appointment and coding and indexing sections are no longer stand alone sections in health records department of National Hospital Abuja due to computerization. Appointment can be booked at any part of the department through the central database while Admission and Discharges section has taken over the coding and indexing section. University College Hospital, Ibadan, in its 2015 report organized Health Records department into the following sub-units:

Inpatients Services

Ward Services which is responsible for collection of case notes of discharged patients from wards, scrutinizes and re-arranges the case notes before transfer to coding and indexing unit

Outpatients Services

Give appointments and maintain an appointment system, patient's coding and indexing, assist physicians and other healthcare professionals in research by making records available on the instruction of the Research and Education unit and routine statistics to the same unit.

Central Record Library

Records staff come from various clinics to file and retrieve case notes, though decentralization filing system is maintained because of space and distance of the central library to various clinics.The library is opened 24 hours and movement of people to the library is restricted.

Education and Research Unit

This unit is in charge of Coding & Indexing of disease, conditions and operations. Each disease is assigned a code number using the International Classification of diseases published by WHO.The unit also compiles noticeable and infectious diseases from each ward monthly. The unit also goes to the theatre to compile number of operation. The unit also compiles inpatients and outpatients statistics for the whole hospital. They receive daily ward statement and outpatients attendances every day. The unit also collates analysis and disseminates statistical information for decision making.

Administration

This unit is in charge of issuance of birth certificate and re-issuance of death certificate and they also process case notes for medical reports because of its sensitivity, the unit is placed directly under the Head of Department.The unit processes incoming and outgoing correspondences and ensures necessary tools and equipment are procured for the department.

Computerization of Health Records Department

Of the standards to be considered in health records department is computerization of the service. This is because of the problems posed by manual records keeping. Manual health records keeping otherwise known as paper-based health records poses serious challenges on healthcare sector. This is largely as a result of difficulty in retrievals of records, lack of adequate space to store, inaccurate, unreliable and incomplete patients' records. Adeleke *et al*. had observed lack of effective health information management system in Nigeria due to the prevalence of cumbersome paper-based and disjointed health data management system as being responsible for the inability of healthcare managers in making informed healthcare decisions[14].

Institute of Medicine (IOM) had also noted that paper records have serious overriding limitations that frequently frustrate users and perpetuate inefficiencies in the healthcare system as the system becomes more complex. The IOM then postulate that the right time is now to make Computer-based Patient Records (CPR) a standard technology in healthcare[15]. It is generally believed that the adoption of EMR appears to be the solution to the problems of health records keeping and this brought about serious consideration of electronic health records platforms to keep patients record.

The benefits of computer-based records are enormous and outweigh the cost of procurement and other associated risks. Boyinbode and Toriola[16]. asserted that the adoption of EMR in healthcare sector is to improve on the availability and reliability of patients care at a reduced cost, increase patients' access to care while ensuring seamless workflow. There cannot be a standard health records department today if new trends such as computerization, telemedicine, patients' portal system and e-mobile health are not taking into consideration.

CONCLUSION

Health Records Department has been identified as one of the important departments in the hospital[16]. Its service cut across all other departments and this make it to be a pivot on which other departments revolve. It can therefore be concluded that for the department to carry out all its enumerated functions, it has to be a standard department, which is organized to establish structures that target the achievement of the goals and objectives. If standard is to ensure quality of service, uniformity and better outcome, then the technology that will drive the change and improve the standards and service should be embraced.

Recommendations

It is therefore recommended that:

1. the standards of a typical health records should be based on the types of services to be rendered and the size of the hospital and this should inform the number of sections the department should have.
2. It is also recommended that the deployment of Electronic Medical Record (EMR) should be a major consideration for standards of a typical health records department.

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Authors Contribution:

ASO conceived of the study, initiated its design, participated in literature search, article selection and review, data analysis and coordination and drafted the manuscript. OSK, ARA and TTA participated in the design, literature search, article selection and review, data analysis and coordination and reviewed the final manuscript.