MANAGEMENT OF PATIENTS' RECORDS IN UNIVERSITY OF ABUJA CLINK

Aliyu Ahmad[1], Maryam yunusa[1], Bilkisu Lawal[2], Ishaq M. Muhammad[1], and Kou Bala Mohammed[3]

[1]Kashim Ibrahim Library, Ahmadu Bello University, Zaria
[2] Umar Musa Yar'Adua University, Katsina,
[3]Department of Library and Information Science, Hmadu Bello University, Zaria.

Abstract

The paper investigates management of patients' records in University of Abuja Clinic with emphasis laid on improving the management of patents' records to conform to digital age practice. To undertake the research, qualitative research methods and survey design was adopted. The instrument used for data collection was interview. A total of 10 respondents were interviewed who were selected randomly. From the findings, problems associated with the traditional manual records' management in the University of Abuja clinic were enumerated. It was concluded that the best remedy is to resolve to the use of electronic device to address the challenges of sorting, updating records, retrieval, storage and loss of records. Recommendations proffered are on partial automation or complete computerization of the entire management cycle of medical records in University of Abuja Clinic.

Introduction

Information is an important resource for service providers in accessing, planning, managing and utilizing safety pre-hospital care to the patient. Information is significant in all aspects of our lives that we cannot afford to mismanage especially for purposes of health.

"Information and records management are the bedrock of business activity. Information management underpins the key activities of planning, analyzing, action and, above all, learning and development. Therefore, if there is no information, management of all activity is crippled in its planning and decision-making processes. It also implies that information is the factor input in achieving organizational decision-making and high quality service delivery. It is needed in order to develop, deliver and assess the effectiveness of organizational policies, make choices between alternative causes of action. It provides the basis for transparency and accountability, protects individual rights and enforces legal obligations" (Popoola, 2000).

According to Ngoepe, (2004) "sound records management is the heart of good public management because government services are dependent on access to information which always requires accountability and transparency for proper governance." An organized medical record serves the purpose of its creation as well as patients who leverage on it and key into proper diagnosis of a returning patient. It is therefore not exaggeration that the high cases of most of the medical negligence claim rest with the quality of the medical records. Record maintenance is the only way for the doctor to prove that the treatment is carried out properly. Medical records are often the only source of the truth and are likely to be far more reliable than memory (Thomas, 2009).

The management and preservation of the hospital records in Nigerian context present a very gloomy picture. Despite the intensive efforts at national

and international level, the fundamental health care needs of the population of the developing countries are still unmet largely because of the lack of basic health data. Lack of basic health data renders difficulties in formulating and applying a rational formula for the allocation of limited resources that are available for patient care and disease prevention. (Gagnon *et al.*, 2010).

Records are information, irrespective of the form or medium created, received or maintained by an individual agency, establishment, institution or organization in pursuance of its obligations or in carrying out business operations. According to Williams (2013) records are those materials made or received by institutions in pursuance of legal obligation or in conduct of functions and preserved as evidence.

Patient Record

Patients record consists of name of patient, address, age, sex, occupation, disease, modes of diagnosis and recommendations made after by the concerned doctor in course of undergoing treatment. It helps patients to acquire the right and apt treatment. Moreover, it acts as a tool for the doctor who is looking after the patient.

The development of Patients' record as researched by Mersey Care (NHS Trust, 2003) started eighteenth century when in 1752 A.D., Benjamin Franklin set up an incorporated hospital in Philadelphia in United State of America presently known as Pennsylvania Hospital. He introduced a unique patient's record by preparing file of special cases on which patients' name, admission date, discharge date, etc. were written. In the same way, another hospital was opened in Boston in 1821 A.D. where a typical method of keeping relevant data was initiated. Separate files were opened for different individual patients in order to keep records. This process proved to be more helpful in finding the necessary data regarding patients. Besides this, it helped in acquiring important facts easily to take care of patients and conduct proper research. (www.healthnet.org.np/reports/bpkIcos/mrecord.html).

Most health care institutions today support a hybrid data environment, with medical records storage in both physical and electronic formats. In a busy hospital, these records often must be maintained and made to flow efficiently among all the specialized departments who are required to comply with regulations concerning privacy and security of medical records. At the same time, health records management equipment and processes should meet best-practice standards for cost-effectiveness, space utilization, optimum retrieval, ensured security, and meaningful use of technology.(www.ameshealthcarerecords.com/records/.)

Patient's Records Management

Patients Records Management is system that deals with a comprehensive assemblage of powerful, proprietary, tailored software solutions that is ideal for the health care records space.

Patients Records Management according to Judson and Harrison (2010) handles everything from entry-level, tracking to advanced imaging all with enhanced security and optimizes workflow. These flexible, easy-to-use patient record management systems solutions can:

1. Unify the entire spectrum of medical records for institutional needs
2. Make retrieval and viewing of patient (or staff) information easy and secure
3. Provide high-performance management of every record throughout its entire life cycle from admission through discharge, then from archival storage through mandated destruction

4. Ensure the right information is in the right hands at the right time
5. Supply real-time tracking information for all files at all times (no more missing or mishandled records)
6. Deliver easy-to-use, transparent reporting in a variety of formats.

Statement of the Problem

From various accounts and personal impression, it is clear that record management is vital to administration in any organization and indeed in the field of health sciences. It is therefore pertinent that managers operating in the health sector should be up to date in ethical concerns and professional skills that surround patients' record management.

Patients' records management in developing countries, and indeed Nigeria is yet to attain the level of attention and support that it has received in countries of the developed world which are both effective and efficient in healthcare services and delivery. Our health institutions inefficiencies could be blamed significantly on poor record keeping and filing system in clinics resulting to the healthcare sector failure. The manual handling of patient files cause undue delays in attending to patients. This has been a cause of concern to all. Ajewole (2001) stated that, the problem of records management is not with records and information per se but with those having interface and interactions with these two vital resources. The problems of records management can be summarized into inadequate knowledge of the life-cycles of records, inertia in implementing a form of system and information. He identified these problems in every phase of life-cycle of records. Accordingly, Longe (1988) reported that over the years, hospitals in Nigeria have consistently faced increasing complex organizational problems in areas such as resources maximization, staffing, procedural problems regarding planning, control and evaluation, information storage and retrieval and calls for prompt remedies. http://www.webpages.uidaho.edu/~mbolin/atulomah.htm

The manual system of record keeping and filing system in Nigerian clinics has over the years proved inefficient. There had been incident of misplaced documents inability to retrieve some patients' records, loss of records or files, alteration of information, etc, result in unnecessary delay of treatment which even sometime leads to the death of the patient.

Research Questions

This study is carried out to provide solutions to the following research questions:

1. What types of patient's records are kept and how are they arranged in University of Abuja Clinic?
2. What are the influences of records on patients' health?
3. What are the challenges of keeping patients records in University of Abuja Clinics?

Objectives of the Study

The following are the objectives of this study:-

1. To examine the types of patient's records kept and how they are arranged in University of Abuja Clinic.
2. To find out the influence of records on patients health.
3. To recommend possible solutions and ideas and to develop an operational Patient Information Management System that would help overcome the problems of records management in University of Abuja Clinic.

Methodology

The study adopted a qualitative method of research. A qualitative

research has been defined as "any kind of research that produces findings not arrived at by means of statistical procedures or other means of quantification" (Strauss & Corbin, 1990). According to Creswell (2003), a qualitative research takes place in the natural setting. He states that the qualitative researcher often goes to the site (office) of the participants to conduct the research. This enables the researcher to be more detailed about the individual or place and be highly involved in the actual experiences of the participants. According to Denzin and Lincoln (1994) qualitative methodologies include "interviewing; observing; artifacts, documents, and records; visual methods; personal experience methods; data management methods; computer-assisted analysis; and textual analysis".

Population of the Study

Population in research is simply the totality of the collection of individuals, objects, or measurement (Yakeen, 2006). These are the aggregate of all observations of interest to the researcher Abdulkareem et al (2006). The population includes clients, professionals, paraprofessional and the non-professionals staff of the University of Abuja Clinic,

Sample and Sampling Techniques

Sampling in a research work is a device employed in the selection of representative members, objects or elements from a given population. As clearly defined by Aina, (2007), the study sample is the selection of some part from the study's population of interest.

Probability sampling techniques is used for the selection of the sample; probability sampling is a form of sampling in which each member of the population has equal chance of being selected in the sample Abubakar (2013). While drawing the sample of this study, stratified sampling is used as a form of probability sampling technique in the selection of the sample. This is because according to Kabir (2007) in stratified sampling, the entire population is sub divided into smaller homogenous groups to get an accurate representation. Each sub-group has unique characteristics. From each sub-group random selection is carried out. Stratified sampling ensures that every subgroup is represented in the same proportion.

However, for this study, the researcher carefully selected eight (8) from the clients/patients met in the clinic and two (2) from the clinic staff as representative so that the outcome resulting from data obtained will be accurate, reliable and adequate for this research.

Instruments Used for Data Collection

The instrument to be used in collecting data for this research is interview which is discussed below;

Interview: In this method, there will be interactions between the researcher, clients/patients and the Staff. Interviews will be conducted with the medical superintendent and some potential employees to find out what difficulties they encountered with the existing system. This fact finding method will also be useful for getting information based on the research questions. Each research questions formed a theme and formed the focus of the interview.

Result and Discussions

Data collected were analyzed following the narrative procedure and assessing the implications.

Types and how patient's records are arranged in University of Abuja Clinic

From the responses the current record management system at the University of Abuja Clinic is a manual system, where all patients' records and information are being collected with papers and pens and kept in paper file folders or box files. This system exhibits

some strengths and weaknesses. The strength of this system is; patient's records are kept in box files which are then stored in office file cabinets, the system is also easy to use because it does not require any training of the user as asserted by one of the respondent;

> *"Alright, eeh... base on the question on the current management system, honestly for now, it is not easy to retrieve in the sense that whenever you come at least you must exercise patience and wait in order for the process to be easier. You must give out your ID card for them to look for your file before waiting for the doctor in which if for instance we are going to use the modern system that is being used in other places now it will be easier for them to retrieve and easy to do, see your doctor very easily and quickly."*

Another respondent noted that;

> *"Well! In terms of recent record keeping system as in the way they keep the file, I think they are trying cause most at times like I once went to the clinic and then mistakenly took somebody's file that the name was close to mine and they took it as mine and in the process of retrieving my file. But so far so good I think they have been trying to retrieve my file without wasting time. I am a kind of satisfied with the system."*

Likewise, another respondent (asst chief medical records officer) also noted that the clinic uses the manual system in managing their patients record which has to do out-patients and in-patients even though he is contented with the system but even at that it requires upgrade to meet the present paradigm shift to technology which gave an answer to research question two that the types of patients records managed are both out-patients and in-patients:

> *"Ooookey! I will like to be very brief, as a professional in this field of record management, the patients record are arranged in a straight numerical order i.e. according to the hospital number. These records have to do with out-patients and in-patients and I find it easy because I've been using for years. It is safe, flexible, and easy to access but it's becoming outdated anyway."*

Another respondent's view was:

> *"In this clinic, what we do majorly is to use what we have at hand which is using paper and pen because it is what we can afford and that is what we have. On types of records kept eeh... is just manual health record practice and hybrid health record practice".*

Influence of record on patients

Record have numerous influence on patients as it saves lives and also help inform on the previous health status of the patients. This is pointed out by one of the respondents:

> *"it has negative influence most especially if its been kept manually as regards cases of emergency in which it requires immediate responses, but before they look for the file, the patient might have gone through a lot of pains but if kept electronically, it will help eliminate the slow nature of the manual record".*

On the other hand, another respondent said that:

"it helps in providing necessary and important data in connection with the past"

Challenges faced in managing patients' records

Weaknesses of the current system also include; time to retrieve the required records especially when the files are many, updating of patients records is cumbersome files are easily lost or misplaced in cabinets, lack of data security, manual calculation are vulnerable to errors and big storage space is wasted where file cabinets sit. Among the weaknesses of the current system as noted by one of the respondents that:

"Inability to be able to retrieve long consult patients' records is a major problem. In fact our staffs tight their faces when it comes to searching for old files of somebody because it is tedious. Let me also say that because the clinic Administration currently uses health record files for storing patient's information, drug suppliers, and staffs" records on payment respectively, the system of information storage is susceptible to security problems such as illegal modification and update of records."

Another respondent was met standing in the queues and was questioned on what she was waiting for and she promptly responded;

"I am waiting for my patient record to be found and I have been waiting for at least ten minutes and to be honest with you they need to improve on the way they manage their records because this is not the first time this is happening. If there's an emergency, that's how somebody will die because some people may be having just headache and because of delay in treating it, the person may die which is not good at all?"

Another respondent reported that:

"Well, wasting of time, really they wasted my time in the cause of retrieving my file but if I can remember very well, there was a time I went to the clinic and they retrieved my file and then they gave me my ID card on time after which I sat for a while that was the section that actually took time before the doctor comes in."

Using a file and paper system is also not secure in the Clinic as when there may be fire outbreak or any form of attack which can lead to the loss of the information forever as responded by a respondent and he says:

"To me, the current system you know... is not secure at all in the sense that it is only written and anything can happen for instance when the file is lost or if the file is burnt definitely your records are totally out but if they use the computerized system in which it is stored in the system it can be retrieved somehow cause there will always be a back up. You can easily access your information, know your status through the modern system eehm... eehm...you know modern system networking something that will make it easy for you to retrieve."

Shelves and cabinet consumes space and with time invites pests and rodents making the papers at risk. When the space for the shelves and cabinets are exhausted, the only option is to move some files to the archiving room which will consume energy and time to

determine which file will be archived as said:

> *"Permit me to say that there is no much problem in terms of security, speed, flexibility except for storage. We need space to be able to organise this files very well. Another problem is misfiling of patients records which are applicable to any health care set up and time wasting in retrieving the patients records."*

Summary of the Finding

The present manual system of collection and keeping / storing records, documents, and all other related patients' information in the University of Abuja Clinic is inefficient and below standard, hence, the need for the development of a computer application system in Nigerian clinics.

However, the study has revealed the problems associated with the manual method of record keeping such as difficulties in sorting, retrieving and updating records, lack of security of records, loss of relevant information and so on. The program developed for this project is used to handle the proper storage of all records and related information in a clinic, the patients' treatment reports, date of treatments, doctors in charge and other relevant information will be entered into the system. The application of computer in our health sector is meant to improve on or overcome the lapses of manual method of record management in Nigerian clinics.

Implication of the Findings

In the tradition of record management, the researcher advances possible recommendations as strategies to overcome the challenges of keeping patients' records in the University of Abuja Clinic, Abuja.

Registration

Before a patient can received a treatment from doctors, he needs to be registered by the file administrator in the clinic, and if the patient has ever received treatment from the clinic, then attendants are responsible for his retrieving file where details of that particular person is kept.

In registration process, every patient has to open a file in the administrative department where the files are kept for subsequent retrieving whenever the patient visits or has an appointment in the clinic.

The findings also show that the types or techniques of patient's record kept in University of Abuja Clinic are both out-patients and in-patients. They seem to be satisfied with it because they've been using it for years which imply that they are very conversant with it even though it causes delay. The implication of this is that there is urgent need for an upgrade or improvement to help curb the situation.

The study also sought to understand the influence that patient's records being managed at the clinic has on their patients. The responses gotten gave an insight that records help in providing necessary and important data in connection with the past. The slow nature of record retrieval sometimes discourages the patients from attending and find their way to the road side pharmacist for medication while some go for self-medication.

Findings also reveal that though the manual system is easy to store and manage but it has a lot of challenges such as; Inability to retrieve patients' records, being susceptible to security problems such as illegal modification and update of records, sometimes time wastage, lack of space to be able to organize this files properly and also misfiling of patients records.

Conclusion

Based on the findings the research concluded that files made of paper are used for managing in patient and out patients in the clinic. Furthermore the study concluded that employees are able to access patients' records and avail them for use. The study concluded that filed were stored on the shelves. Nonetheless the study also concluded that value and purpose of the record was a key requirement before files were destroyed. Moreover the researcher concludes that the files were secure and the privacy of patients' information was maintained.

Recommendations

Based on this research work, the following recommendations are made:

a. The clinic should employ a partial automation system or computerization system for quick retrieval which help enhance fast response to save the time and lives of their patients.
b. Experts should be employed and put in place so as to discourage the patients especially the students of the institution from going into self medication.
c. The hospital should construct a modern medical record where electronic and manual record management function symbiotically to help staff working in the section improve their effectiveness and efficiency as they perform their day to day activities.

References

Ajewole, B. (2001). Records and information resource management in the public service: A theoretical and practical framework. Lagos. *The Administrative Staff College of Nigeria* (ASCON):24-28.

Creswell W.J (2003). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 2nd Ed. Thousand Oaks, CA: Sage Publications.

Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In N. K. Denzin & Y. S. Guba (Eds.), *Handbook of qualitative research*, CA: Sage Publications.

Gagnon, M.P., Pluye P., Desmartis, M., Car, J., Pagliari, C., Labrecque, M., Frémont, P., Gagnon, J., Njoya, M. and Légaré, F. (2010).A systematic review of interventions promoting clinical information retrieval technology (CIRT) adoption by healthcare professionals. *Int J Med Inform*; 79: 669-80.

http://ori.hhs.gov/education /products/n_illinois_u/datamanagement/datopic.html.

http://www.liasa.org.za/conferences/conference2004/papers/LIASA_Conference_2004_Ngoepe.pdf (Accessed 10 December, 2015)

http://www.nas.gov.uk/recordKeeping/recordsManagement.asp

Judson, K. & Harrison, C. (2010). "Chapter 6: Medical Records and Informed Consent". Law & Ethics for Medical Careers (5th ed.). New York: McGraw-Hill Higher Education.

Longe, R. S.(1988).*Fundamentals of educational planning*. Akure; Fagbamigbe Publishers, p 45.

Mersey Care NHS Trust, (2003). Policy and Procedure For Records: Retention & Disposal" *(PDF)*... Retrieved 15|01|2016 from

National Archives of Scotland (NAS), retrieve from http://www.nas.gov.uk/recordKeeping/recordsManagement.asp

Ngoepe, M. S. (2004). Accountability, transparency and good governance: the National Archives and Records Service of South Africa's role in helping Government to better service delivery to the South Africans. Paper presented at the Seventh LIASA Annual National Conference, Polokwane, September-October.

Olatokun W. M & Igbinedion L. J. (2009) The Adoption of Automatic Teller Machines in Nigeria: An Application of the Theory of Diffusion of Innovation. *Issues in Informing Science and Information Technology*. 6 (377)

Popoola, S. O. (2000).A cost model approach to records management system in the Oyo State Civil Service, Nigeria. A Ph. D Thesis, University of Ibadan, Ibadan

Pre-Hospital Emergency Care Council (2010). What the PHECC: An Introduction to Pre-Hospital Emergency Care. TSMJ 14 (1) 2012. Retrieved from www.phecc.ie

Strauss, A., & Corbin, J. (1990).*Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage Publications, Inc. retrieved on 11/02/2017 from http://scholar.lib.vt.edu/ejournals/JTE/v9n1/hoepfl.html

Thomas, J. (2009) Medical records and issues in negligence. Indian: J Urol publications. 25(3): 384–388. doi: 10.4103/0970-1591.56208

Williams, C. (2013). Records and archives: concepts, roles and definitions. UK: Chandos Publishing. P.53–67

Wilson, D. (2002) *Managing Information*: IT for Business Process, Butterworth-Heinemann. www.infed.org/thinkers/argyris.htmfor an overview of Argyris's work.

www.webpages.uidaho.edu/~mbolin/atulomah.htm