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Letter to the Editor

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Working with patients' health records in a tertiary healthcare facility in Nigeria: A Physician's experience

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Dear Editor,

Health records professionals are trained to analyze and protect vital medical information to provide quality healthcare[1]. The most important records they are saddled with are patient health records. This entails information on patient bio-data on accessing the facility as well as the day to day compiled information on the patient. Health records officer therefore serve as a window to hospital clients and health workers within the hospital. This important role is one major key to successful and smooth running of the health system.

As physicians, the greatest challenge we are faced with is the patient's perception and expectations from our health system. Any patient who comes to the health facility anticipates prompt care with no bottlenecks in regards to when he/she is treated. However, this is not usually the case. All health workers including health records officers and physicians are meant to play important roles in ensuring this level of care. The health records officer, especially, plays a key role in this regards being the window into the health institution, as the saying goes "First impression lasts long".

In my setting, the practice at outpatient clinics is to initially ask the patients or their relatives to make payment and come back to supply the details used to fill the bio-data and other patient's health record details. This initial encounter could be fraught with lots of delay and bottlenecks. More so, there has been several complaints by patients of the way they were treated negatively by health records officer. This could possibly be due to overwhelming workload and/or individual attitude. Noteworthy to say is that a good number of health records officers possess good human/public relations. Ensuring timeliness and appropriate communication should be a cornerstone of every health worker's approach to patient care. This is apt because as said earlier, health records unit in the outpatient clinic is their first impression of the health facility. Likewise, the state of mind of these individual patients should also be considered while relating with them. One approach to minimize this is by embracing electronic process of data management that inculcates electronic payment. The department of health records can as well considers pasting required details of information on a board close to the respective units.

For returning patients to outpatient clinics, patient health records are obtained through a

retrieval system which capitalizes on proper assembly, coding and filing from previous appointments and inpatient discharge. In most cases, this is essentially a successful process in my setting. On few occasions however, patients encounter challenges and their health records folders got missing in transit. This occurs mostly following discharge of such patients. The process of retrieval of patient's record from the wards needs a systematic review. I have been told by an experienced health records officer that the duration of sorting, analysis, coding and re-shelving discharged records takes between 48 to 72 hours. Therefore, concerned patients cannot be seen at a clinic appointment within that period. This requires a systematic appraisal. Though one would assume a properly treated and discharged patient should stay home for a while before clinic follow-up, there exigencies that may require short term duration.

Patients coming into the hospital through emergencies require prompt attention to ensure quick intervention and minimizing complications. For most departments in my centre the health records units have been decentralized to minimize time wasted and the hectic process of sorting at a central records unit. This has positively impacted services and patients coming into the hospital for the first time. However, this service is only available in most units during core working hours. This implies that at hours between 4pm and 7am from Mondays to Fridays and on weekends and public holidays, health records services will be available on few points and patients still go through the hectic process of going to the few central units. This tends to make the hospital unfriendly and takes a toll on patients and their relatives. Adequate staffing and provision of sleep in facility may minimize this challenge.

Decentralizing patient health records remains a means of ensuring improved efficiency for the health records unit[2]. I envisage it will improve access to patient's health records on point-of-care. It will equally improve logistics with the unit and improve the relationship between health records officers and other health workers. This will also create a platform for a seamless computerization of patient health records when the time ripens. Likewise, to achieve a computerized records system, there is a need to improve on structuring of clinical forms and formats. On this note, all user-departments would have to work together with the department of health records in the review of these forms and formats. In addition, what we write should be more readable to assist health records officers in their coding and analysis. All these steps will allow for clarity of recorded information, completeness and proper auditing of health records.

For inpatient in some cases, there are issues with regards to discharged patients to be followed up at the outpatient clinic. The usual practice is for a designated officer to pick the discharged records from the wards. The record is then made to pass through several units before it get back to the shelf in the central records library. The records department sometimes is unable to account for the records either due to non-recovery from the wards as a result of undue retention by physicians; inappropriate filing by the records officer in the central location or it gets misplaced in transit. A suggested means of minimizing this challenge is to strengthen the appointment system. This will include reemphasizing the importance of appointment list to the consultant in charge of cases.

In regards to research, health record officers in my hospital play a cardinal role in protecting health records as well ensure ethical principles are adhered to. This contributes to improvement in evidenced-based care and advancement in medical knowledge.

In summary, patient health records is cardinal to ensuring proper care and follow-up of patients. To achieve this, there is a need for regular on-the-job training for health records officers and continuous effort to improve service rendered by this very important unit of health care delivery. On our part as physicians, we need to reduce the rate of undue retention of patients' records as well, work on legibility for clarity. Most importantly, when the hospital management embraces electronic health records, healthcare services will be enhanced[3].

Thank you.

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