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HEALTH INFORMATION MANAGEMENT BY RECORD OFFICERS: A STUDY OF MILITARY HOSPITALS IN LAGOS METROPOLIS

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ABSTRACT

The study seeks to generate information on the patients' records management by Record Officers in military hospitals in Nigeria. The objective of the study was to identify the types of patients' records created and maintained by military hospitals, the procedure adopted for the management of the records, retention and disposal of unwanted records and challenges associated with the patients' records management in the military hospitals of 68 Nigerian Army Reference Hospital Yaba; Nigerian Navy Reference Hospital Ojo; Military Hospital Ikoyi and 445 Nigerian Air force Hospital Ikeja. Qualitative research methodology was used for the study; data was collected through interview. The findings of the study revealed the types of patients' records created and procedure adopted for the management of the records which include case files/folders, report book and X-ray film. The findings also revealed that lack of ICT facilities, absent of finding aids, inadequate space and storage facilities as the challenges associated with the management of patients' records in the hospitals studied. Recommendations were provided in order to overcome such challenges which include Provision of ERM software to replace traditional method of managing records, provision of storage facilities and space.

Keywords: Patient, *Records, Management, Hospital, Nigeria*

Introduction

The history of records creation and management can be traced back to the ancient civilizations, such as the Mesopotamia, Chinese, Egypt, Greeks etc. During the ancient civilizations, people produced and maintained records of their culture, knowledge as well as their daily business transactions and administrative activities (Lawal, 2001). Records are considered important because they are described as the memory of organizations, and raw materials for decision making and basis for legal dispensability. Records also serve as evidence of structure, functions, policies, procedures, operation and internal external transaction of organizations (Shehu, 2010). The military as an institution is very essential to every nation because it provides security and defense in times of political crises or war, actively facilitates disaster rescue as well as peace keeping operations. In order for the military to deliver its functions to the

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society, the health care of its personnel and their families need to be attended to at all times. This explains why hospitals are established in the military institutions. In the process of carrying out their duties, military hospitals, create, receive and utilize records and management of those records is necessary. In Nigeria, military health care system came into existence in 1893 under the control and leadership of colonial masters as a military hospital (Kayode 2003).

Military hospitals catered for the health and medical needs of the British army personnel that served in the different parts of the region. Military hospitals are mostly located in the military barracks to allow patients get easier and quicker access to medical care. In Nigeria military hospitals according to Defense Health Maintenance Limited (2009) are categorized into:

a. General/Specialist hospital
b. Medical center
c. Reference hospital.

The medical center provides services to patients with minor illness, delivering babies and providing overnight services. The general/specialist hospitals, on the other hand, provide major services and special care to patients with severe illness and diseases such as diabetes kidney infections and so on. While the reference hospital is bigger and more sophisticated, patients are referred to such hospitals for complex treatment which are not available in other hospitals. Referrals are made to such hospitals because they provide for victims of war/ mission who need special care (Igonor, 2009).

Review of Related Literature :

Concept of Records

The concept of 'record' has been defined by different scholars depending on how they perceive and understand it. Record according to Auyo (2010) is "an item or collection of data". It can also be a tangible object or digital information: for example birth certificates, x-rays, office document etc. International Standard Organization ISO (2001) defines record as "information created and maintained as evidence of information by an organization or person in the pursuance of legal obligation or in the transaction of business". Similarly, International Council on Archives (2010) defined record as recorded information produced or received in the institution conduct or compilation of an institutional or individual activity and that comprises content and structure. In this regard, military as an institution produced and received records in the cause of its day to day activity.

Health Records

Health records, medical records, patient records synonymously refer to the same in this study. Generally, medical records refer to the permanent documentation of a patient's illness or injury made by legal or planning purposes (Nnadozie, 2006). He further stated that this record present an orderly written report of the patient's complaints, the diagnostic findings, treatment and the end result that forms a clinical picture and when completed, it contains sufficient data written for a series of events to justify the diagnosis and warrant treatment. According to Akanji (1990) health records, are those writings which state the social and health status of an individual when he gets in contact with the hospital. Health records are very significant to both health care institutions and the patients as they hold important information about the patient's health and that of his/her family. Medical records are the documentation of the medical histories of patients. They include information such as demographics; personal circumstances of the

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patient, such as the name, birth date; civil status etc. They also list diseases, sickness and growth land marks of the patients, as well as his/her allergies and references (Romaine, 2008).

According to Moyle (1976) in Igonor (2009) The information contained in medical records allows health care providers to provide continuity of care to individual patients. It also serves as a basis for planning patient care; documenting communication between the health care providers and any other health professional contributing to the patient's care; assisting in protecting the legal interest of the patient and the health care, and documenting the care and services provided to the patient. In addition, medical records may serve as a document to educate medical students/resident physicians; to provide data for internal hospital auditing and quality assurance; and to provide data for medical research. To attain these, managing health records is necessary. According to American Medical Transcriptionist Association (2011), medical records include:

a. Patient history and physical examination
b. Consultation report
c. SOAP note report (subjective, objective, assessment and plan notes) to mention but few.

Records Management

Records management is a field of management responsible for the systematic control, maintenance, use, reproduction and disposition of records. According to Chinyemba (2005) records management is the capturing and maintaining of accurate, complete, reliable and usable documentation of activities of an organization in order to meet legal, evidential accountability and social/cultural requirements. In this regard, Louisiana State Archives Records management Handbook (2002) defined records management as the systematic application of management techniques to the creation, utilization, maintenance, retention, preservation and disposal of records for the purpose of reducing costs and improving of records keeping. Similarly, ISO (2001) defined records management as the field of management responsible for the efficient and systematic control of the creation, receipt, maintenance, use and disposition of records including the processes for capturing and maintaining evidence and of information about business activities and transactions in the form of records.

The above definitions indicate that records management has universal acceptable definition, nevertheless, records management is vital to organizations because a well-designed records management system helps to protect an organization legally, helps organizations to demonstrate compliance with regulatory obligation and increase organization efficiency by promoting the disposition of out of date items that are not records.

Records Life Cycle

To clearly understand the idea of records management we have to take a close look at the concept of records management life cycle. To Erlandsson (1997), the life cycle of records begins when records are firstly organized, maintained and actively used by creators. The life cycle of records reflect the opinion that all records irrespective of form and purpose, pass through certain well defined phases. In this regard, Gill (1993) described record life cycle as a movement of records in a logical steps from creation, through its usage, retention active files, and to its transfer to in-active files storage and finally disposal. Medical record like all other records also passes through various stages that is; creation, organization, utilization, storage, retention and disposal. In hospitals, the moment a patient goes to the hospital, a record known as patient case file/folder is created to him/her at initial stage, this record is systematically arranged based on

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the procedure used by the hospital record officers. The folder/file is therefore stored for future use by medical record officers, and if a patient stops using the folder for some time or the patient dies the folder is being transferred to archive or disposed as the case may be.

Management of Patient Records

Bennett (2000) identified management of patient records as the planning, controlling, directing, training, promotion and other managerial activities related to the creation, maintenance, use and disposition of the medical records to achieve adequate and proper documentation of a healthcare organization's policies and transactions. In a nutshell, management of health records entails proper planning, controlling, generating, organizing, storing and preserving medical records for future references. Bennett (2000) observed that if properly preserved and processed, medical records are capable of providing comprehensive information on the health status of a given community in respect of birth or death, illness pregnancies immunization sanitary conditions, etc. Management of health records is essential because the physician and other medical team cannot work effectively without a good health record. That is why management of health records is an important instrument for medical practice.

Types and Forms of Patient Records

Nnadozie (2006) highlights two types of medical records which include the nationwide system which deals with primary all aspects of vital registration data as well as censuses. The other, by his classification, is the limited medical records system in hospitals and health institutions. Gunter and Terry (2005) identified two major forms of medical records to include traditional/paper based and electronic medical records. A paper based medical record is a systematic collection of patient's personal information and health history which is documented or written paper form. Electronic medical record also termed as electronic health or electronic patient records refer to as a systematic collection of electronic health information about individual patients or population. Similarly, Wari (1993) identified two types of medical records that may be found in a medical practice: paper and paperless. Paper records are medical records that are stored in file folders. Paperless records are computerized records or records stored in digital format and are often referred to as electronic medical records (EMRs) or electronic health records (EHRs).

Statement of the Problem

The military as an institution is very essential to every nation because it provides security and defense in times of crises or war, actively facilitates disaster rescue as well as peace keeping operations. In order for the military to deliver its functions to the society, the healthcare of its personnel and families need to be attended to at all times. This explains why hospitals are established in the military institution to cater for health needs of the military personnel and their families. In the cause of, and vital to the day to day business of the military hospitals, the creation, receipt, maintenance and use of patient records has become very imperative.

Accordingly, the management of patient records is very important to the successful operation of any healthcare delivery institution particularly military health care services. Lack of proper handling of records constitutes a problem to the organizations. Records management indicators in Nigeria tend to suggest public and private organizations in the country are rated very low in respect of effective management of their official records (Chuma & Cizoba, 2006). The paucity of empirical knowledge about

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the state of management of patient records in military health institutions in Nigeria is considered a problem worthy of empirical study. Thus, the study investigates the management of patients' records in military hospitals in Lagos metropolis.

Research Questions

The study was guided by four research questions and they are as follows:

i. What are the types of records created and maintained as well as their format in military hospitals in Lagos metropolis?
ii. What are the criteria for retention and disposal of unwanted patients' records?
iii. What storage facilities are available in the military hospitals studied?
iv. What are the challenges associated with the management of patients' records in military hospitals in Lagos metropolis?

Objectives of the Study

The objectives of the study are to:

i. identify the types of records created and maintained as well as their format in military hospitals in Lagos metropolis;
ii. examine the criteria for retention and disposal of unwanted patients' records;
iii. identify the storage facilities available in the military hospitals; and
iv. identify the challenges associated with management of patients' records in the military hospitals.

Methodology

Qualitative research design was used in carrying out this study. Interview was used as research instrument for data collection. The target population of the study was Record Officers of the military hospitals of Lagos metropolis. Due to restrictive nature of the military, typical case sampling was used to select one record officer from each hospital as participant of the study making a total of four (4) participants. Typical case sampling according to Springer (2010) is a procedure in which the researcher seeks cases that are typical of the phenomenon under study. A descriptive analysis technique was used to analyze the data collected

Table1: Information about the Hospitals

Name of Hospital	Year Established
68 Nigerian Army Reference Hospital, Yaba	1968
Nigerian Navy Reference Hospital, Ojo	1986
Military Hospital, Ikoyi	1983
445 Nigerian Air Force Hospital, Ikeja	2000

Table 2: Information about the Participants

Name of Hospital	Participants	Educational Qualification	Working Experience
68 Nigerian Army Reference Hospital, Yaba	Records Officer	Postgraduate Diploma Records Management	12 years
Nigerian Navy Reference Hospital, Ojo	Record Officer	Postgraduate Diploma Records Management	13 years

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Military Hospital, Ikoyi	Record Officer	Diploma in Public Administration	5 years
445 Nigerian Air Force Hospital, Ikeja	Record Officer	Higher National Diploma Public Administration	6 years

Findings and Discussion

Types and Format of Patients' Records

Data on the management of records in the military hospitals in Lagos metropolis were solicited through interview. Data collected from the health record officers regarding the health records created and received by the military hospitals indicated that records such as patient case file/folder, report book are records created by health record officers. In addition, all the 4 participant interviewed revealed that they create and manage records on paper format. This indicated that despite the advent of ICTs military hospitals in Nigeria do not use such technologies in creating and managing their records.

Retention and Disposal of Unwanted Patients' Records

Medical records like other records need to be kept for a certain period of time, most healthcare institutions and agencies emphasized the need to retain medical records for a longer period in case of litigations, claims and in defense of a physician should a patient bring claim regarding care and treatment (San Bernardino County Medical Society 1998). In view of this, participants were interviewed regarding retention and disposal of unwanted patients' records. Data obtained from the interview conducted, all the (4) participants revealed that unwanted patients records that are no longer in use from time to time are removed from the records. The record Officer of Nigerian Navy Reference Hospital Ojo, explained that unwanted records are transferred to remote store which is more like an archive. Similarly, Record Officer of Military Hospital Ikoyi, and 445 Nigerian Air force Hospital Ikeja identified that patient records are retained for at least 10 to 15 years after last contact before destruction. The researcher observed that the hospitals lack criteria for retention and disposal, and record managers dictate when and how records should be retained or disposed. The researcher also observed that all the hospitals do not have records retention policy which state period or length of retention of records. The implication of not having a policy or law, regarding what, when, why and how records should be retained or disposed of, results to missing of patients' case file/folder, and sometimes complete loss of the patient's case file.

Storage Facilities

Result of the interview regarding the types of storage facilities used in keeping records, all the participants revealed that the most common devices used as storage facility are steel cabinets, wooden shelves and metal shelves. The researcher has observed that the storage facilities were grossly inadequate. As a result, some files were seen either placed on top of the cabinets or kept on the floor which constitute security risk for the records. This finding may not be surprising because storage facilities such as cupboards, wooden shelf, metal shelf and drawers are commonly found in most of the organizations in Nigeria. Abioye and Habila (2004) noted that records which are not properly stored will be at the mercy of agents of records destruction such as rats, termites, fungi, molds, heat, humidity and even destructive agents like theft and damage. They conclude that if a record is worth keeping, then such record must be adequately stored and protected.

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Challenges Associated with the Management of Patients' Records

The findings of this study show that there were some factors negating effective health information service provision at the hospitals studied. The participants of this study highlighted that lack of adequate and in some cases unqualified staff with the knowledge, ability and zeal to work as record officers, lack of modern ICTs facilities in the record rooms which is equally a problem of record management, absence of finding aids such as catalogue and check list to facilitate access to patients' records as the major challenges facing management of patients' records in the hospitals. Problems such as misfiling, poor documentation etc. can be minimized if records are generated, utilized and maintained electronically. In line with this, Shaun (2010) stated that "Electronic Medical Records can manage and store immense information and can be retrieved whenever required". Another challenge as revealed by the participants is lack of adequate space and storage facilities to store patients' case files/folders and absence of document (policy) stating records management.

Conclusion

The main purpose of the study is to investigate the management of patients' records in the military hospitals in Lagos metropolis, the study revealed that all the hospitals studied create and maintained various types of records for both in- and out- patients. The study also revealed that patient records are retained for specific period of time before been transferred to archives. The study also revealed the type of storage facilities available in the Lagos metropolis military hospitals and also the challenges. The findings of the study revealed a number of challenges in the management of patients' records in the hospitals studied. As a casual observer and later a patient of the 445 Nigerian Air force hospital Ikeja, the researcher has come to appreciate the worth of patient record in health care delivery in the hospital. However, the study indicates among other things weaknesses and inadequate facilities in the generation and management of patients' records in the hospital studied.

Recommendations

Based on the findings, the following recommendations are made:

i. The findings indicate that inadequate and qualified health records officers in the military hospitals, therefore it is recommended that adequate and qualified record officers should be recruited and also priority should be given to their training and re-training by the hospitals.
ii. Patients' records should be computerized. In other words the records should be created and maintained electronically. Electronic Medical Records (EMR) software can be used to replace the traditional method of managing health information records. Therefore, it is recommended that ICTs facilities should be used in the management of patient records.
iii. Concerned body or authorities should set up a record management committee which will draw up a written record management policy and to ensure full implementation of the policy.

REFERENCES

Abioye, A. A. & Habila, R. J. (2004). Records management practices in Colleges of Education in Nigeria: a study of Federal college of Education, Yola and College of Education Jalingo. *Gateway Library Journal,* 7(2).

Akanji, D. O. (1990). Development of medical/health records in Nigeria: The journey so far**.** *Nigerian Health Records Association Journal,* 4(1).

ISSN: 1596 - 1595
Journal homepage: https://www.mbjlisonline.org/

Auyo, M.A. (2010). Records management: Principles, techniques and significance. A paper presented at a workshop on academic records management held on 31st March-1stApril 2010. Kano: Bayero University

Bennett, R.L. (2002). The practical guide to the genetic family history. New York: John Wiley and Sons.

Chinyemba, A. & Ngulube, P. (2005). Managing records at higher educational institutions: A case study of University of KwaZulu-Natal, Pietermaitzburg Campus". *South African Journal of Information Management,* 7(1).

Chuma, O. N. & Chizoba, D. N. (2006). Management of medical records in selected public and private health institutions in Owerri". *Gateway Library Journal,* 9 (2): 40-53

Erlandsson, A. (1997). *Electronics Records Management: A Literature Review.* Paris: Francis- Bourgeois.

Gill, S. L. (1993). *File Management and Information Retrieval System*: *A Manual for Managers and Technicians.* 3rded. Englewood, Colorado: Libraries Unlimited.

Gunter,T.D. & Terry, N.P. (2005). *The emergence of National Electronic health record architecture in the United States and Australia: cost and question*s. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1550638/

International Council of Archives (ICA). Retrieved from http://www.archives.ca/ica/p-er

International Organization Standard (ISO). 15489 (2001). Retrieved from http://en.wikipedia.org/wiki/Records_management

Lawal, O. O. (2002). Modern librarianship in Nigeria. Calabar: University Press.

Louisiana State Archives and Records Management Handbook (2002). Available at: http//:www. louisiana. gov/portals/archives/pdf-handbook. Retrieved on 20/07/2010

Nnadozie, C.M. & Nnadozie, C. D. (2006). Management of medical records in selected public and private health institutions in Owerri, Nigeria. *Gateway Library Journal,* 9(2).

Romain, L. (2008) Important reasons for having medical records. Retrieved from http://ezinearticles.com.

San Bernardino County Medical Society (1998). Medical records: Retention, storage and destruction. Bulletin June 1998 issues of safe practice, a newsletter of the SCIPE Companies.

Shaun, K. (2010). The importance of electronic health records. Retrieved from https://beardocs.baylor.edu/xmlui/bitstream/handle/2104/8388/Shaun_Kuoni_h onorsthesis.pdf?sequence=1.

Shehu, U. M, (2010). " The management of students' academic records in universities in North Western Nigeria: Implications for access and effective utilization". Unpublished MLS Thesis. Kano: Bayero University.

Springer, K. (2010). *Educational Research: a contextual approach*. USA John Wiley and Sons Inc.

The Louisiana State Archives and Records Management Handbook (2002). Retrieved from http://www.sos.la.gov/HistoricalResources/PublishedDocuments/RecordMgmt Handbook.pdf

Wari-Tobi, T.A (1993). Medical records administration: A base for hospital efficiency. *Nigerian Health Records Association Journal,* 7(2).