HOSPITAL RECORD MANAGEMENT: A SURVEY OF IN/OUT PATIENT RECORDS MANAGEMENT IN GENERAL HOSPITAL S IN NIGER STATE

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ABSTRACT

This research work was contrived to determine the methods employed in the creation, storage, retrieval and disposal of in/out patient records in general hospitals in Niger state. To achieve these objectives, the survey research technique was employed. In view of that, the questionnaire, interview and personal observation were methods used in gathering required data while the quota sampling method was also used to arrive at the hospitals studied. The data gathered were analyzed using statistical method using frequencies of occurrence and their percentages. The research findings revealed that traditional (manual) method of operation is still used in the creation, storage and retrieval of records. Despite the fact that over 15,000 records have been generated by each hospital, there was neither any information about how many of such records have gone obsolete nor were they organized in any useful form for further use. The findings also revealed that there is no internal archives where outdated records could be stored. It was further discovered that record managers were neither adequately trained nor remunerated to perform effectively. Finally, the automation of records services, establishment of internal archives and adequate training and remuneration of record managers, among others were recommended.

INTRODUCTION

The concept of record management evolved even before the introduction of writing/paper and printing technology. However, with the invention of writing, paper and printing technology, knowledge on paper has become so diversed that at a time it led not only to knowledge explosion but also inadequacies of how the records produced could be managed in such a way that they could be stored, retrieved and disseminated with minimum effort and efficiency. This is more so where a beneficiary of the information is a patient waiting to be attended to by a medical doctor.

The concern of these researchers is enforced by the fact that in some cases, patients that visit hospitals for treatment have to wait for their cards over a long period before they could be traced from the cabinets. This makes the patients to suffer undue

hardship and create a negative impression about the entire system in his/her mind. There is no doubt that each of the hospitals studied generate a lot of new records on daily basis while yet, other records go obsolete for lack of use for a long period of time. This is not to say that these old records, though may be useless to the owner, are also useless to the authorities that created them. This may be due to reasons that may be unfolded in the course of the study.

Meanwhile, the extent to which hospitals studied have managed their records, both current and retrospective (non-current) about patients, the lapses inherent therein and the way forward in achieving efficiency are the main reasons for undertaking this research.

OBJECTIVES OF THE RESEARCH

i. To determine the forms which the records are created.

ii. To establish the volume of records created since inception by the hospitals.

iii. To determine the methods used in storing and retrieving records.

iv. To determine the volume of outdated records and methods of their disposition.

v. To highlight the problems or obstacles that exist in the management of in/out patients records in hospitals.

PURPOSE OF THE RESEARCH

a. To bring into limelight how in/out patient records are managed by hospitals in Niger state,

b. To produce a document that will serve as a guide in the management of in/out patient records in hospitals not only in Niger state but the nation as a whole.

c. To provide the basis for research in this and other related areas of record management.

d. To contribute immensely to the literature of library and information science.

SCOPE AND LIMITATION

This research was essentially devoted to the management of in/out patients records in public /general hospitals in Niger state.

STATEMENT OF THE PROBLEM

Hospitals in/out patient records are vital documents which are supposed to be traced within seconds of submission of patient reference hand cards. The filing of these cards need to be done with great care and enthusiasm to avoid problem of location as a result of. misfiling. Patients' frustration in waiting for their cards to be retrieved give room for suspicion of ineffectiveness and lack of care by those in charge. Afterall, Izah (2001) once opined that mishelved book (or any other item) is just like a missing book since the user cannot locate" and use it at the time he wants. Same view goes for in/out patient records in hospitals in addition to the fact that treatment may be delayed if found later and may result into lack of continuity of the patient's health history if completely unlocated.

A closer observation in the management of these records in Niger state

hospitals shows that many were not in the cabinets where they were supposed to be filed and therefore could not be traced easily when there is need. The question to be asked is what could be responsible for this ineptitude?

It is therefore, in the bit to highlight problems inherent in the creation, filing and retrieving of these records that this study is carried out. This is with a view that the finding will draw the attention of the authorities in solving or reducing the problems to the bearest minimum.

REVIEW OF LITERATURE

Parmar and Buhta (1989) defined record as a group of related fields of information treated as a unit for organizational purposes. More recently, Stewart and Molesco (2007) defined record as a piece .of information created by or received by an organization or business establishment that gives evidence of a business decision or transaction should be preserved. Provision of necessary information about a patient which is the basic requirement of the creation of in/out patient records is in the words of Popoola (2000) the fifth factor of production and is the most vital tool today (because) it is needed daily in the process of planning, decision making and control. One major characteristics of all hospitals in Niger state and every where is the creation of large amount of records about patients that suffer from various ailments.

Record management, according to Abioye (2002) is the planning and control of the use of a set of resources to achieve one or more objectives. This presupposes that there should be adequate planning and strict control of records so that they could be traced without difficulty and within a specific time.

The above idea was supported by Enwerere (1992) when he opined that record management should enable people to find their way through a flood of information and assist decision makers to arrive at just and correct decisions. To achieve this objective, Enwerere further observed that records should pass through three stages of management in their lifecycle. In his view, the first stage is the current stage in which records are managed in the offices that created them. The semi-current stage, he argued is that in which records are managed in the record centres while at the non-current stage, records are managed in the archives.

Adikwu (2001) who studied the lifecycle of managing records agreed with the above procedure. He also identified three stages of record management. These, in his view are current records which are newly created; semi-current records; and archival records which could also be referred to as non-current or outdated records.

While the authors cited above agreed with the above stages in the life cycle of records for several organizations, these researchers are of the view that their idea may not however, conform in entirety with the aims and objectives with which hospital in/out patient records are created. This is due to the fact that, under normal circumstances and in an ideal situation, same registration card is expected to be used by the same patient throughout his/her life so as to have his/her health historical data in one place.

In view of the above analysis, in/out patient record in hospitals could go for only two stages. These are current, when created and used and non-current/ outdated when the patient dies. Undoubtedly, other hospital records such as those of finance and drugs etc could go round the three stages.

METHODOLOGY

The survey research method was used in conducting this research. This is because Osuala (1993) contended that the method has the advantage of studying both large and small population by selecting and studying samples chosen from the population Aina (2002) in addition to this, said the method has the advantage of having a relatively low cost associated with gathering the data and that the researcher can get the results in a fairly short period.

Niger State has various types of health institutions. These include General hospitals, rural hospitals, and dispensaries scattered all over the stale. It is however, the belief of these researchers that large amount of records are generated at bigger hospitals. These are based on the geo-political zones, A, B and C. In view of that, the biggest hospital in each of the zones was selected for this study. These hospitals are the General hospitals, Minna, (MGH) Bida (BGH) and Kontagora (KGH) (zone B, A and C). They are felt to be representative enough since smaller ones are supervised by them. Thus, quota sampling technique was used. Aina (2002) opined that quota sampling attempts to create a representative sample by specifying quotas, or targets, of particular types of people that need to be included to represent the population.

The population of the respondents covered by this study is thirty (30). It was observed that the management of in/out patient records in these hospitals was apart from the main record room decentralized. Thus, the heads and the entire staff of the records offices were served with questionnaires while interview was held with the heads of each unit in addition to the observation of some records.

All questionnaires returned were analysed using descriptive statistics.

ANALYSIS OF DATA

INTRODUCTION

Under this caption is the presentation, analysis and interpretation of data gathered for this research. The presentation is in tables with columns for responses, respondent, total and percentages. Below each table is the interpretation of its contents.

Table 1: Response rate.

Respondents	No. of questionnaires	No. of questionnaires Returned	Percentage (%)
MGH	10	10	100
BGH	10	8	60
KGH	10	6	60
TOTAL	**30**	**24**	**80**

From the above table, it could be deduced that thirty (30) questionnaires were administered while twenty four, representing 80% were returned and found usable.

Table 2: Format of records

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	Cards	10	8	6	24	100
b	Folders	10	8	6	24	100
c	Registers	10	8	6	24	100
d	Computers	-	-	-	-	-
e	Others specify	-	-	-	-	-

From table 2, it is evident that all General hospitals studied (100%) use cards, folders and registers for the registration of patients that deserve treatment in their respective hospitals. When interviewed however, the staff admitted that while the cards are used for outpatients, both the cards and folders are used for in-patients. The registers, according to them serve as reference points if the cards and folders could not be traced. On the other hand, all the hospitals studied agreed that computers are not used in the registration process of patients.

Table 3: Registration procedure

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
A	By surname of patient followed by other names	8	—	6	14	58.3
B	By first name of patient followed by surname	10	—	—	10	41.7
C	By serial Nos. e.g. 1 ,2,3, etc	10	8	6	24	100
D	By year or date of registration	—	—	—	—	—
E	Others (specify)	—	—	—	—	—

Table 3 is a reflection of the fact that all hospitals studied (100%) use serial numbers in registering patients. This is followed by 58.3% who used the surname of patients in registering them while 41.7% of the respondents register patients by their first names. A close observation by these researchers revealed a mix up of the use of the names of patients and serial numbers in the registration process. While interviewed about the complexity of this process, the record administrators indicated that each card issued out in the name of the patient is assigned some serial numbers to avoid conflict which may arise if there are same names by different patients e.g. several people bear Mohammed Mohammed or Aisha Mohammed and Abubakar Mohammed etc.

Table 4: Filing process

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	By surname	—	8	6	14	58.3
b	By first name	—	—	—	—	—
c	By serial numbers	10	—	—	10	41.7
d	Date of registration	—	—	—	—	—
e	Others (specify)	—	—	—	—	—
	Total	**10**	**8**	**6**	**24**	**100**

The table above reveals that majority (58.3%) of hospitals in Niger state their in/out patients records by the surname of patients while only 41.7% perform same function by the use of serial numbers.

Table 5: Size of records created since inception

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	1-5,000	—	—	—	—	—
b	5,001-10,000	—	—	1	1	4.2
c	10,001-15,000	3	2	2	7	29.2
d	15,001 and above	7	6	3	16	66.6
e	No idea	—	—	—	—	—
	Total	**10**	**8**	**6**	**24**	**100**

From table 5, majority 66.6% of the respondents said that records (in patients) created since the inception of the hospitals are well over 15,000 while 29 and 4.2% said the total number of records created might be 15,000 and 10, respectively.

Table 6: Size of outdated records

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	1 -2000	—	—	—	—	—
b	2001-4000	—	—	—	—	—
c	4001-6000	—	—	—	—	—
d	6001 and above	—	—	—	—	—
e	No idea	10	8	6	24	100
	Total	**10**	**8**	**6**	**24**	**100**

The above table reveals that the records administrators in Niger state hospitals have no idea of the size of the records that have gone obsolete (no longer in use). This is indicated by 100% of the respondents.

Table 7: Management of outdated records

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	Arranged in cabinets for future use	2	1	—	3	12.5
b	Tied away in cartons/cabinets	8	7	6	21	87.5
c	Computerized	—	—	—	—	—
d	Recycled for future use	—	—	—	—	—
e	Sold/burnt away for lack of space	—	—	—	—	—
f	Others (specify)	—	—	—	—	—
	Total	**10**	**8**	**6**	**24**	**100**

The highest number of respondents from the above table (87.5%) said that outdated records are tied away in cartons and cabinets. 12.5%, who constituted the minority said that such records are arranged in cabinets for further use. A close observation of these records by the researchers revealed that outdated records are tied together, some on the floor of record rooms without any form of arrangement. Others were in wooden pigeon holes in the offices.

Table 8: Missing/lost reference hand cards

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
A	Search all available records	10	6	6	22	91.7
B	Go through the inventory	-	2	-	2	8.3
C	Retrieve from computer -	-	-	-	-	
D	Any others (specify) -	-	-	-	-	
	Total	**10**	**8**	**6**	**24**	**100**

When the records administrators were asked how they could trace record of a patient who lost his/her reference card, the above table reveals that " majority of the respondents (91.7%) said that they search all the available records. A few of them (8.3%) said they will go through the inventory.

Table 9: Disposal of records

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
A	1-2 years of non-use	—	—	—	—	—
B	2-3 years of non-use	—	—	—	—	—
r	3-4 years of non-use	—	—	—	—	—
D	5 and above years of non-use	10	8	6	24	100
E	Any other (specify)	—	—	—	—	—
	Total	**10**	**8**	**6**	**24**	**100**

The in/out patients record administrators were asked about the stage at which they consider such records outdated. They unanimously said such records are disposed after five years of non-use by the patients.

Table 10: Availability of an archive within the hospitals and utilization of past records

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	yes	-	-	-	-	-
b	no	10	8	6	24	100
	Total	**10**	**8**	**6**	**24**	**100**

In answer to a question on whether there are internal archives within the hospital premises where outdated records are kept and il such records are utilized by Doctors, all the respondents said no as indicated in the table above.

Table 11: Training of the records officers

		Respondents				
	Responses	MGH	BGH	KGH	Total	%
a	Yes	3	2	2	7	29.2
b	no	7	6	4	17	70.8
	Total	**10** -	**8**	**6**	**24**	**100**

The respondents were asked if they have been trained as record officers. The above table reveals that the majority (70.8%) have not been adequately trained for the job while only 29.2% who are in the minority claimed that they have been trained for the job.

Table 12: Staff motivation

	Respondents				
Responses	MGH	BGH	KGH	Total	%
Well paid package	—	—	—	—	—
Prompt promotion	7	6	5	18	75
Conducive working environment	—	—	—	—	—
Staff development	3	2	1	6	25
Adequate staff welfare	—	—	—	—	—
Others (specify) prompt payment of salary	10	8	6	24	100

When the staff of the records unit of the hospitals were asked about the forms of motivation they receive from their employer, all (100%) of the respondents indicated that they receive their monthly salary promptly. This is followed by 75% of the staff who also said they get their promotion as and when due while 25% of them said staff development motivates them in performing their functions. Unfortunately however, they were all silent about adequacy of their paid package, conducive working environment and adequate staff welfare. These are other important areas where government need to look into to motivate staff the more.

Table 13: Adequacy of staff

	Respondents				
Responses	MGH	BGH	KGH	Total	%
Yes	-	-	-	-	—
No	10	8	6	24	100
Total	**10**	**8**	**6**	**24**	**100**

When asked whether the records units of General hospitals are adequately staffed, all, 100% said no.

Table 14: Way forward

	Respondents				
Responses	MGH	BGH	KGH	Total	%
Well paid package	10	8	6	24	100
Prompt promotion	10	8	6	24	100
Adequate training and retraining of staff	10	8	6	24	100
Creation of an archive for non-current records	5	5	4	14	58.3
Application of computers	10	8	6	24	100
Adequate number of staff	10	8	6	24	100
Others (specify)	—	—	—	—	—

In view of the earlier opinions expressed by the staff of the record units of the General hospitals in Niger stale, they were asked of the ways in which service could be provided more effectively, efficiently and conveniently. The above table shows that all the respondents (100%) agreed that they should be provided with a well paid package, adequate training and retraining, adequate staff, continue with prompt payment of salaries and application of computers to records management. In addition to the above, 58.3% supported the idea of creating an archive within the hospitals for non-current records for future reference purposes.

DISCUSSIONS

The traditional method of operation is still being emphasized in the creation, storage, retrieval and dissemination of records in all the hospitals studied. This is reflected in table 2 which revealed that computers which could be used in conjunction with other electronic devices to provide reliable and prompt service are yet to be employed in the management of in/out patient records in Niger state. This attitude creates a lot of difficulties in the management of these records. This is despite the fact that Enwerere (1992) who made a study on records management in Nigeria observed that many management staff (of government and organizations) are aware of these difficulties and of the view that such difficulties could be overcome by computers and modern technology (if) employed in information management.

The study reveals a variance of methods of records creation. In an ideal situation all the hospitals in Niger state should first register patients by their surnames followed by other names. Since there are other elements of differentiation, such as the date of registration, age, religion, etc. Registration under the surname should be preferred for convenience of filling. Anglo American Cataloguing Rules (AACR) (1998) in support of the above assertion, provides that a person's name containing a surname or consisting only of a surname should be entered under that surname.

From the history of existence of the hospitals studied, and based on the large population of the localities they were expected to serve and have been serving, these

authors agreed with the view of majority of the respondents in table 5 that records created since inception should be over 15,000. This is because all the hospitals have existed since the colonial era in Nigeria. Some of the emirates which they were initially established to serve are now made up of 5-8 local government areas.

As pointed out in table 7, outdated records are actually tied together without any form of organization. Certainly, records in this state could be very difficult to retrieve for reference after sometime lapse. This is why information contained in table 8 is a pointer to the fact that when a reference hand card is missing or lost, that might be the end for tracing a patient's record and subsequently his/her health history in the hospital.

Table 10 is a revelation of the fact that all the respondents saw no need for establishing an archive within the hospitals. When confronted on the importance of such a facility, especially to serve as a reference point for Doctors and issuance of death certificates however long, they were still of the view that with modern science and technology, methods of treatment changes often. But from the observation of these researchers, modern or up-to-date scientific and technological equipment and methods are yet to be fully imbibed by the hospitals in the management of these records.

Despite the fact that the records staff claimed to be paid promptly on monthly basis as shown in table 12, they seemed to avoid the questions on well paid package, conducive working environment and adequate staff welfare. That is an indication that they are not satisfied with all these conditions of

service. These, in addition to lack of adequate staff development, are major determinants which could weigh down a staff in putting off his best in accordance with his/her ability in a place of work.

The unavailability of adequate or enough qualified staff to perform the basic tasks of records management, as contained in table 13 may also result into leaving certain functions not being performed properly or not being performed at all. There is no gain saying that adequate number of required staff makes performance of various tasks to be efficient and effective.

CONCLUSIONS

The creation, storage and retrieval of in/out patient records in hospitals are manually done as against modern methods of performing this task using computers and related electronic gadgets.

Despite the fact that several thousands of records have been created by hospitals in Niger state, the records managers do not have adequate knowledge or keep record of how many that have been outdated.

The majority of record managers, despite the numerous advantages that accrue to the establishment of an internal archive, are against such an idea.

Majority of record managers are neither adequately trained for the job nor sufficiently remunerated to boost their morale in performing their functions as expected.

There are insufficient numbers of staff to manage the records properly.

RECOMMENDATION

Record managers should be given the desired training, especially in the area application of computers to the management of records to save the time and achiev desired efficiency in the performance of their functions. Computers should also b provided in the records units to practicalize the training acquired by record managers.

In relation to the above, the vacuum existing in the remuneration of the sta should be filled up, especially by an enhanced salary and allowances, conducive working environment etc.

Hospitals should equally employ adequate and capable manpower in th management of in/out patient records.

All in/out patient records should be entered under the surname, followed b other names of the patients for convenience of filling and retrieval of records easily.

Librarians should be employed to manage such records as they specialize i making entries of authors of materials and also interpret such laws that govern th conduct of such activity as contained in AACR.

Having weighed the tremendous contributions which an internal archive w serve in General hospitals in Niger state these researchers highly recommend that a archive should be established within each hospital for stocking outdated records t serve as reference point for medical doctors. This will facilitate the avoidance mistakes of the past and improve upon past achievements in the area of treatment patients. This proposition was also supported by Nwosu (1995) in Georgeotutru (199 when he opined that the mistakes of the past are repeated because people do not stud records of past events.

Records that qualify to be deposited in the hospitals archive should have th names of patients deleted. This is because Abioye (2002) is of the view that searc regulations (in the archive) may give expression to the need to protect personal privac and safeguard national interest. In view of that, such records should therefore b classified by the type of ailments e.g Diabetics, which will now serve as the headin under which each record should be filed and • retrieved.

To achieve the above objective, there is need to keep track of how man records that go obsolete on regular basis so that there could be an account of th strength of the internal archive.

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