The importance of quality in health records

Health & Medicine

ASSIGN BUSTER

The Importance of Quality in Health Records A health record facilitates the recording of important clinical information for use by the relevant healthcare professionals as well as for improving the provision of public health care (NHS, 2013). Health records can be on either paper or electronic with the Electronic Health Records (EHRs) being favored in the modern world where they significantly improve the quality and safety of health care in the United States (Agency for Healthcare Research and Quality, 2013). As such, the federal government advocates for the use of the EHRs and invests heavily to this effect. Notably, there are strict laws that guarantee the confidentiality of the information processed in the health records. Moreover, quality matters in health records. Indeed, accurate and complete clinical documentation of health records define the quality of health records.

A quality audit of health records refers to the process of conducting internal or external reviews of all the tools, policies, procedures, and techniques used in healthcare institutions to ensure that the health records are up-to-date, accurate, efficient (Holmboe, n. y), liability-free, and compliant with the federal and the Department of Health standards. A quality audit seeks to improve clinical documentation with an aim of promoting better delivery of health care as well as ensuring efficiency and accuracy in documentation. Moreover, it establishes the medical areas that need improvements and corrections (Sharma & Mahajan, 1999).

The conduct of a quality audit follows various steps. It can adopt an explicit or an implicit approach. However, the explicit approach is highly recommended (Holmboe, n. y). An understanding of the audit process is fundamental in assessing the quality of medical records. Notably, quality audits focus on and evaluate the procedural and diagnosis code selection

adopted by a health practitioner. Firstly, the reviewer determines the educational and evaluation purpose of the audit. He then chooses and defines the quality measures in application. Additionally, he describes the audit process with well-defined inclusion and exclusion criteria. Then, he establishes the areas of weakness, presents the audit findings, and establishes the areas of improvement and corrections in collection and processing health records. Most assuredly, the steps in the audit process determine the quality of the audit (Holmboe, n. y).

The quality of documents in healthcare is very important. Various methods assure quality in documents. They include the requirement for authorization to the use and exchange of health information with an aim of promoting patient safety and confidentiality as well as improving efficiency. Furthermore, the advocacy of giving the correct information boosts the quality of health documents. In addition, professionalism involvement t in the process of collecting and procession health information guarantees the quality of documents in health care (Zender, 2012). This ensures compliance to set health standards and minimizes errors. More so, avoiding adverse drug events that lead to incomplete linking information also fosters the quality of health documents. At the same time, avoiding duplication of records adds merit to the health documents. Moreover, ensuring patient identity integrity helps in ensuring completeness, accuracy, and quality of an individual's health documents (Zender, 2012). More so, the licensing of medical practitioners equally leads to quality health documents.

Quality principles in health records are a fundamental aspect in healthcare. Indeed, the quality principles in health records ensures that the patient gets the best and accurate care as well as promoting the availability and use of

correct and understandable information. In addition, the quality principles ensure that best and efficient decisions result from the information on the health records. Moreover, the quality principles guarantee consent and authorization to health records as well as protecting the privacy and the confidentiality of the health information. Ultimately, quality principles in health records increases efficiency and minimize human error in collecting and processing health information.

References

Agency for Healthcare Research and Quality. (2013). New Childrens Electronic Health Record Format Announced. Retrieved from: http://www. ahrq. gov/news/newsroom/press-releases/2013/childehrpr. html

American College of Cardiology. (2013). Personal Health Record Principles. Retrieved from: http://www. cardiosource. org/en/Advocacy/Issues/Health-Information-Technology/ACC-Policies-and-Activities/Personal-Health-Record-Principles. aspx

Holmboe, E (n. y). Practice Audit, Medical Record Review, and Chart-Stimulated Recall. Retrieved from: http://mededconnect. com/samplechapters/9780323047098/Sample%20Chapter. pdf

NHS (2013). Health records. Retrieved from: http://www. nhs. uk/NHSEngland/thenhs/records/healthrecords/Pages/overview. aspx

Office of the Health Services Commissioner. (2001). Extracted from the Health Records Act 2001. Retrieved from: http://www. health. vic. gov. au/hsc/downloads/hppextract. pdf

Sharma, Y., & Mahajan, P. (1999). Role of Medical Audit in health Care Evaluation. Retrieved from: http://www. jkscience. org/archive/Volume14/Role%20of%20Medical%20audit. pdf

Zender, A. (2012). Ensuring Data Integrity. Retrieved from: http://library. ahima. org/xpedio/groups/public/documents/ahima/bok1_049675. pdf