Management of Electronic Records for Service Delivery at the University College Hospital, Ibadan, Nigeria

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EXECUTIVE SUMMARY

Healthcare providers have, over the years, struggled with the management of patient records. The struggle became exaggerated as information became increasingly large and convoluted. The contemporary healthcare environment is characterised by information overload; without the proper organisation of information resources, access to valuation resources can become an albatross, if not properly managed. Health information is the data associated with the medical ailment of a patient's history, containing symptoms, diagnoses, procedures, and results. Quick access to this vital information may be a life-and-death decision that must not be taken for granted. This chapter aims to investigate how electronic records are managed in a contemporary method as adopted by the University College Hospital (UCH).

INTRODUCTION AND BACKGROUND OF THE STUDY

Effective medical record is an enabler of prompt service delivery in a health institution because it contains a critical description of the patient's medical history which includes management and treatment comprising medical procedures and complications a person has experienced. Therefore, it's an essential tool in the management of the patient. Implementation of electronic medical records increases the ease of access to health records, meanwhile handwritten medical records may be poorly legible and constitute problem readability which can lead to medical errors (Luthuli and Kalusopa, 2017).

The notion of Electronic Records management has attracted the attention of wide variety of scholars for instance Corbett, Deardorff & Kovar-Gough (2014) distinguished between Electronic Health Records (EHR) which is a patient's digital medical records which is available via network that can enable information access from different location, on the other hand, Electronic Management Record (EMR) is an electronic and local record within a particular health institution to enable access to patient's information online. The health sector is an information demanding industry in which exact, trustworthy and appropriate information constitutes an essential resource for the establishment and monitoring of service provisions at all stages of health care delivery whether primary, secondary or tertiary level (Oweghoro, 2015).

The implementation of electronic health records (EHR) is of immense advantage in any hospital environment for enabling patient care, stimulating clinical practice, as well as improving patients and service providers' communication and risk error reduction. Besides, caregivers testified to extraordinary levels of satisfaction and general reliability of the system by embracing Electronic Health Records. Regardless of the benefits, the application of EHR system is happening at a slow pace to become fully incorporated in into different levels of clinical management (Seri, Nurussobah and Ahmad, 2018).

Electronic Health Records have positive influence in health care delivery, it has a significant effect on data quality by recording patient information, this automated storage of patient information enables prompt and timely access to information which could assist in speedy health care provision which is capable of improving treatment outcome by reducing errors and having access to patient health history to promptitude of decision. (Hamade, 2017: 9). As a result of the importance of electronic records in health facilities, it is also imperative for health care providers to expand the application of this technology by incorporating new and enhanced EHR features because computer software program entails persistent monitoring and maintenances, interrupting the use of these facilities could upset and hamper workflow in health care delivery. Therefore, the accessibility of technical support is vital for the uninterrupted use of this modern facility (Hamade, 2017: 9).