Patient information management is part of healthcare quality
High-quality information underpins the delivery of high-quality evidence-based healthcare. The Health Records Service provides maintenance, confidentiality and security of all patient data (in both manual and electronic form) in accordance with legal requirements, standards, evidence-based practice and professional work practice.

How Health Records Staff Support Clinicians in Patient Safety

NHSScotland (NHSS) recognises the need for Health Records staff to have appropriate knowledge and skills to support frontline operational services. Health Records staff contribute to patient safety by:

- Maintaining a schedule of up-to-date patient records
- Participating in quality assurance and audits of health record quality
- Providing patient information records in a timely way for patient appointments
- Enhancing completeness of records including test results
- Enhancing access to clinical information held in records, following good practice guidelines.
Good Health Record Management and links with Patient Safety

Examples of types of records that Health Records Staff are responsible for:

- National routinely collected health statistics
- Admission records
- Test results
- Communication between healthcare professionals

Health Records Development Manager, NHS Greater Glasgow and Clyde

The NES Administrator's Guide to the Quality Strategy (version 1, December 2011) provides additional example contributions to safety including:

- “You know and do what is expected in helping control the spread of infection,”
- “Administrative staff make a significant contribution to ensuring patient safety at all stages of their journey in NHS. Part of this work is ensuring that they positively identify patients against the Health Board's Master Patient Index. If the information or records are wrong, there can be very serious consequences”.

Learning and Re-designing Administrative Services

There is a need for records management to be recognised as important in the delivery of high-quality evidence-based healthcare. NHS Boards, such as NHS Dumfries and Galloway, have carried out service improvement workshops to identify potential areas where processes should be streamlined in order to support service efficiency and national operations. The questions highlighted on the diagram below summarising an example workshop makes links to safety such as enhancing access to patient details and history to ensure that the healthcare professionals involved have the requisite patient information to deliver care safely.

Workshop - Health Records Service Improvement

- Why do we prepare records two weeks in advance of patient arrival?
- Is there a need to explore the preparation and holding process?
- Why do we check allergies from pre-operative record against case note folder (i.e. this is a clinical responsibility)
- Why do we enter an interim code for cases where additional information (e.g. results of pathology) are required and then mark SMR record as being complete?
Centralising Patient Information Records for Better Patient Care

The workshop focus groups were used to examine how health records staff were currently working and asked the question, “Are we working in the best way we can?” The general consensus from the NHS Dumfries and Galloway workshop consultations was that the admission and administration functions such as health records should be centralised. Good communications across healthcare teams, with other departments and with patients all contribute to patient safety.

“A centralised case note preparation, admission processing and bed management function was established as a direct result of the service improvement workshop. The service is now more patient centred as all administrative preparation is undertaken by a single group of staff who are aware of all planned activity for each patient. The team can take account of any possible conflicts when scheduling activity thereby enabling clinical staff to provide efficient and timely care. Furthermore, staff awareness of each step in the patient journey has led to improved communication with patients and carers.”

Patient Administration Manager, NHS Dumfries & Galloway

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1 Freedom of Information (Scotland) Act 2002, Code of Practice on Records Management
2 An Electronic Patient Record (EPR), also Electronic Personal Health Record (EPR) or Electronic Health Record (EHR) is an evolving concept defined as a systematic collection of electronic health information about individual patients.
Patient Centred Services Contributing to Patient Safety

NHS Greater Glasgow and Clyde operates a patient focussed booking service in a number of clinics and services, aiming to ensure timely appointments and enhance access to care by patients, contributing to patient safety:

“When arranging hospital appointments, we invite patients to arrange their appointment by telephone. During telephone conversations, patients and carers are able to advise of any special needs such as interpreter services, ambulance transport, alternative print format, e.g. large print, Braille etc. This has led to reduced missed appointments and reallocation of cancelled appointments to other patients on our waiting lists.”

Health Records Service Improvement Manager, NHS Greater Glasgow and Clyde.

Without high quality records and an efficient flow of information by Health Records Staff, the quality of patient care would be severely compromised. In some situations, poor quality records and inefficient records management could have serious implications for patient safety. The examples described in this patient safety education scenario illustrate what can be achieved when health records staff get together to learn about their management processes and plan ways to improve.

“The Scottish Government has set ambitious Health Service targets including the elimination of avoidable harm to patients. Education has an essential role to play which should not be overlooked just because it is difficult to quantify the impact of staff education on patient outcomes. Patient Safety education scenarios build on the established success of patient stories in using narrative and qualitative data as powerful levers for improvement. The scenarios in our portfolio demonstrate the impact of educational interventions on healthcare staff whilst caring for their patients.”

Professor Philip Cachia
Chair, NES Patient Safety Multi-disciplinary Group, Postgraduate Medical Dean

Useful links

www.knowledge.scot.nhs.uk/recordsmgt.aspx

For further information contact:
acs.project@nes.scot.nhs.uk