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THE IMPORTANCE OF ELECTRONIC MEDICAL RECORDS FOR PATIENTS IN HEALTH FACILITIES

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Abstract:

The aim of the study is to know the medical records of patients in health facilities, the importance of having medical records for patients in health facilities, the type of information required in the medical records of patients in health facilities, the mechanism for requesting the medical record by the treating physician in medical clinics, knowing the mechanism for keeping the medical record by the medical records department. A questionnaire was conducted via Google Drive, the questionnaire was distributed via the social media network (where 800 questionnaires were distributed) to mobile groups, and responses to 700 questionnaires were obtained via email.

Keywords: *Importance, Electronic medical, records, patients, health facilities*

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INTRODUCTION:

An electronic medical register is a medical record in digital format. In health informatics, electronic medical records are one and the same shape as electronic health records, but in general usage, these terms are used interchangeably. [(1)] The terms medical record, health record, and medical table are used somewhat interchangeably to characterize systematic documentation of a patient's medical history and care over time within the jurisdiction of a health care provider. The medical record contains a variety of types of "notes" entered by health care professionals over time, recording monitoring and administration of medications and curing, orders for the administration of medications and treatments, test results, x-rays, reports, etc. Maintaining complete and accurate medical records is a requirement for health care providers, and is typically enforced as a prerequisite for licensure or certification. [(2)]. The terms are used in written (paper notes), physical (image films), and digital records that exist for each individual patient, and for each set of information contained within them. Medical records have traditionally been collected and maintained by healthcare providers, but advances in online data storage have led to the development of personal health records (PHRs) maintained by patients themselves, often on third-party websites. This concept is supported by the US National Health Administration and the American Health Information Management Association [(3)(4)(5)]. In 2009, Congress licensed and funded legislation known as the Health Information Technology for Economic and Clinical Health Act to incentivize the conversion of paper medical records to electronic charts. While many hospitals and doctors' offices have successfully used the concept since then, e-health companies' systems have not always been compatible with each other, and countless patients undergo repeated procedures - or fail to receive them altogether - because essential parts of Their medical history are missing [(6)(7)]. Because many people consider the information contained in medical records to be sensitive private information covered by the potential for privacy, several ethical and legal issues are responsible for its protection, such as third-party access and appropriate storage and disposition. Medical records are generally the property of the health care provider, and in most jurisdictions, the actual record is considered the property of the patient who can obtain copies of it upon request [(8)]. The information in the medical record permits healthcare supply to determine a patient's medical history and provide informed care. The medical record is a central repository for planning patient care and documenting communication between the patient and the health care providers and professionals who participate in his or her care. An increasing purpose of the medical record is to ensure documentation of compliance with institutional, professional, or governmental regulations. A traditional medical record for inpatient care may contain admission notes, in-service notes, progress notes (SOAP notes), preoperative notes, surgical reports, postoperative notes, procedure notes, delivery notes, and postpartum notes payment notes. Personal health records unit many of the above features with portability, allowing the patient to share medical records across providers and healthcare systems [(9)]. A personal medical record identifies a patient and contains information regarding the patient's case history with a particular provider. A health record and any kind of electronically stored file of traditional paper files consist of the correct identification of the patient. Additional information varies depending on the patient's personal medical history [(10)].

2-MATERIAL AND METHODS:

This study started in (the holy city of Mecca in Saudi Arabia), began writing the research and then recording the questionnaire in March 2023, and the study ended with data collection in July 2023. The researcher used the descriptive analytical approach that uses a quantitative or qualitative description of the social phenomenon (The importance of electronic medical records for patients in health facilities) ,this kind of study is characterized by analysis, reason, objectivity, and reality, as it is concerned with individuals and societies, as it studies the variables and their effects on the health of the individual, society, and consumer, the spread of diseases and their relationship to demographic variables such as age, gender, nationality, and marital status. Status, occupation [(11)], And use the

Excel 2010 Office suite histogram to arrange the results using: Frequency tables Percentages [12]. A questionnaire is a remarkable and helpful tool for collecting a huge amount of data, however, researchers were not able to personally interview participants on the online survey, due to social distancing regulations at the time to prevent infection between participants and researchers and vice versa (not coronavirus participation completely disappearing from society). He only answered the questionnaire electronically, because the questionnaire consisted of eleven questions, five were open, and six questions were closed. The online approach has also been used to generate valid samples in similar studies in Saudi Arabia and elsewhere [13]

3- RESULTS:

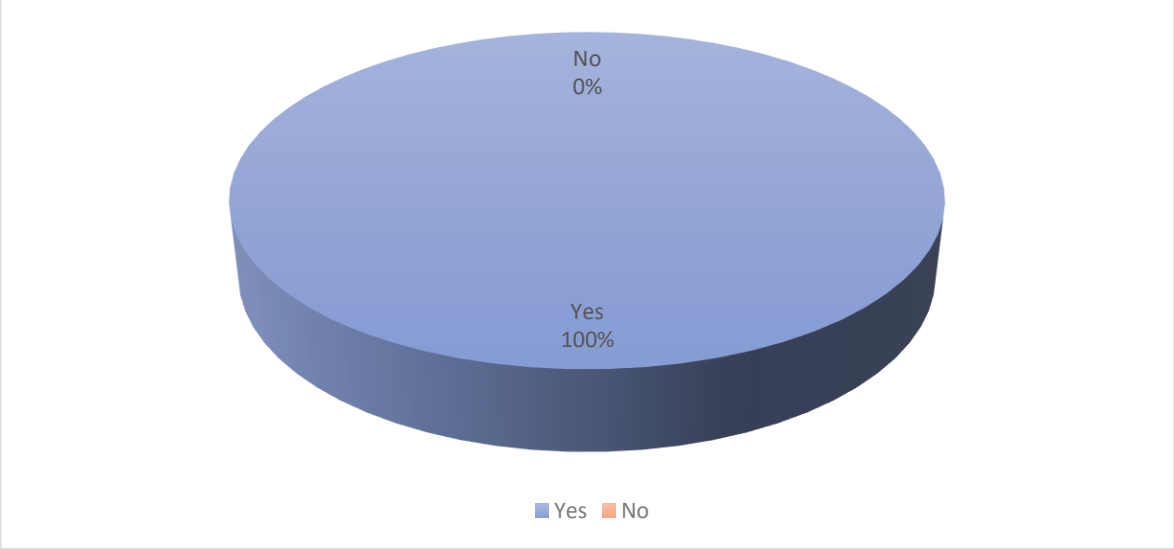
For those who agreed to participate in the research questionnaire, the approval rate was 96.4%, and the rejection rate was 3.6%. As for the age of the participants in the questionnaire, the percentage of their ages was as follows: from the ages of 16-25 years, it was 12.9%, from the ages of 26-35 years, it was 24%, from 36-45%, which was 37%, from the ages of 46-55 years, it was 25.9%. As for the gender of the participants, the percentage of males was 63%, and the percentage of females was 37%. As for the gender of the participants, the percentage of Saudis was 92.6%, and non-Saudis 7.4%, and as for their professions, they were as follows: government employee 78%, student 7.4%, and careerist 0. %, private sector employee 11.1%, self-employed 3.5%. As for their educational status, it was as follows: Primary 0%, intermediate 0%, secondary 14.8%, university 51.9%, diploma 11.1%, master's 17.1%, doctorate 5.1%. When moving to the research questions: The first question is about: Is it important to have electronic patient medical records in the health facility? Yes, 100%, and no 0%. The second question is: Are medical records necessary to follow up on patients' conditions? Yes, 100%, and no 0%. The third question is: Do you update patients' medical records every 6 months while maintaining previous information? Yes, 96.6%, no 3.4%. The fourth question: Is there confidentiality of patient information in medical records? Yes, 100%, and no 0%. The fifth question: What is the nature of the health information contained in medical records? The answers were as follows: I do not know, medical history, treatment methods, recording everything related to patients, the person's name and family history of illness, information related to medical histories, statistics, case follow-up, case analysis, and disease prevention. All information that helps in serving the patient, enhancing the health condition, the clinics that the patient visited, the date of review in the clinics, the treatments provided or scheduled for the patient, the dates of visits in the clinics, personal information, medical history,, statistical information, medical history, age, gender, height. , weight, etc., personal information and vital signs, information that records health status, medical history, and prescribed treatments, the patient's disease record, all private information, in terms of health and psychological status, age, hereditary diseases, nationality, diabetes and blood pressure, patient data. The sixth question: Who are the people authorized to view patients' medical records? The answers were as follows: medical records technician, nursing, physician, specialist nurse-physician, physician, medical record employee, clinic nurse, treating physician, physician only, physicians, and staff. Medical personnel, specialists in departments only and not administrators, medical and technical staff in the hospital, and the patient's family in some cases. The seventh question: Is the presence of patients' medical records considered a quality standard in the health facility? Yes, 100%, and no 0%. The eighth question: What are the methods for keeping medical records for patients? (Choose the following)? Saving electronically 29.6%, saving on paper 0%, saving with backups 14.8%, all of the above 55.6%, others 0%. The ninth question: How important is it to have patients' medical histories in medical records? Very important, mandatory, patient follow-up, necessary, disease follow-up, protection and protection for families and children from hereditary diseases and very useful in the case of marriage, childbirth, and transmission of diseases, it helps in diagnosing the disease, to know about hereditary diseases, very important as it helps in diagnosing the condition and taking precautions. Knowing the patient's history helps reduce the risks of medications or disease and helps the doctor give the appropriate treatment, to track the patient's condition and link it to his health condition, it is important to determine the treatment plan, to enable the doctor to provide the service better, the presence of the patient's medical history in medical records within the facility helps in the accuracy of diagnosis and speed of treatment. It describes a person's condition when exposed to any health infection. Important in treatment. The tenth question: What is the importance of coding medical records for patients in clinics in the health facility? It is very important. Very important

To distinguish cases in each clinic, to maintain the confidentiality of information, is mandatory, Important, very important, I don't know, for convenience, it is important to facilitate work and communication between doctors, to get it quickly, Confidentiality of the information, I do not know that. Coding medical records in clinics helps save effort on doctors and assistants, which leads to alleviating

suffering for the patient, ease of dealing with the patient, Confidentiality of information

I don't know. The eleventh question: What is the mechanism used by the treating physician to request medical records for patients in clinics in the health facility? I do not know, I do not know, fill out the file request form, make a request to request a medical record file for a specific case, electronic search by system, and submit an electronic request to access the information to be extracted. I don't know, With an ID number, electronically, Research the patient's medical history, Request via any methods available in the facility, via appointment number or file, Once the patient arrives, the record is uploaded to the doctor, I don't know, When the auditor arrives, he is recorded by the reception in Raqeem and the arrival is recorded by the nurse, and then the doctor to review the file. Requesting the patient's medical record automatically via computer, save. (Figure No.1)

Figure N0.1: Opinions and attitudes of questionnaire participants about the importance of having medical records for patients in health facilities



4-DISCUSSION:

The current study finds that, the importance of having medical records for patients in health facilities, in terms of following up on patients' health conditions in all medical clinics.

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REFERENCES:

1- A State Policy Approach: Promoting Health Information Technology in California." California Legislative Analyst Office. February 2007. Archived from the original on 25-03-2019.
2- Personal Health Records" (PDF). CMS. April 2011. Archived from the original (PDF) on 05/03/2012. Accessed on 14/04/2012.
3- American Health Information Management Association". Ahima.org. March 22, 2012. Archived from the original on 14-07-2019. Accessed on 14-04-2012.
4- Frequently Asked Questions". MyPHR.com. Archived from the original on 12/10/2018. Viewed on 14/04/2012.
5- National Institute for Health". Nih.gov. Archived from the original on 20-10-2020. Accessed on 14-04-2012.
6- HITECH Act Enforcement Interim Final Rule". Hhs.gov. Archived from the original on 03/01/2020. Accessed on 25/09/2018
7- Paper Trails: Living and Dying with Fragmented Medical Records". undark.org. Archived from the original on 15/10/2019. Accessed on 25/09/2018
8- Health Information Privacy". Hhs.gov. Archived from the original on 12/06/2015. Accessed on 04/14/2012.
9- Medical Records". McKinley Health Center. Archived from the original on 10-08-2016. Accessed on 14-04-2012.

10- A Sample Health Record". Nlm.nih.gov. Archived from the original (PDF) on 05/07/2016. Viewed on 14/04/2012.

11-Alserahy, Hassan Awad, et al (2008), The thinking and scientific research, Scientific Publishing Center, King Abdul-Aziz University in Jeddah, the first edition

12-Al Zoghbi, Muhammad and AlTalvah, Abas (2000), Statistical system understanding and analysis of statistical data, first edition, Jordon- Amman.

13-Kadasah, N.A.; Chirwa, G.C.; et al. Knowledge, Attitude, and Practice Toward COVID-19 Among the Public in the Kingdom of Saudi Arabia: A Cross-Sectional Study. Front. Public Health 2020, 8, 217.