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by B B

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Health Records

Patients' record is essential in every medical facility. Doctors use information recorded for patients that includes their previous treatments and diagnosis to treat the present condition the patient has. Previous information is significant as it helps the doctor treat the patient with grounded knowledge about the patient's information. The physician's office I visited used both electronic system and papers, papers were used to record personal information while electronic record was used to patient diagnoses and dosage prescription. Technology advancement to patients records have also improved and it is the responsibility of medical facility to use systems to store patients' records because they are safe and uses less space. Quality of data is considered high when data fits the intended purpose that was collected for, such as decision making and operational (Wager et al., 2017). A high-quality patients' data is a data that is accurate, available, complete and precise to allow easy use by the doctor. To evaluate the quality of data in patients' record at the physician's office I used the Weiskopf and Weng framework which was researched to assess quality of data specifically. Data quality is measured during the entire process of data management. Data accuracy was correct in the electronic health record but misspelled names and typographic errors in discharge summaries were available in paper.

Accessibility of data was available in both electronic and paper record system; however, on the paper record information was accessible to one person at a time. The physician record system ensured that data collected was accessible whenever needed. For instance, relevant data recorded in paper was added to the system later. Recorded papers were stored in files to allow safe storage and protection. Nonetheless, the physician missed several words when transferring patient's data from paper to electronic system thus creating a problem in data precision which is very important in patient's data. Data should be close to the actual weight or standard of a particular measurement (Kruse et al., 2017). For instance, the dosage that a patient was given should be recorded with precision and not to be rounded off. Moreover, patient's data becomes obsolete after some time because diagnosis a patient has been admitted for is not the same as the previous one therefore making information to be more and of no use. The physician sells the papers for renewal to companies that renew papers hence does not care who will access the information. Again, more patient data is captured electronically than on paper. 80% of patients' data is captured electronically while 20% is captured on papers. The reason for the big gap is because electronic system has fewer limitations than paper. Electronic health record is considered by many people instantaneously to be utilizing a host of information technology tools. Also, using electronic health record allows patients to routinely review their records and keep their health records which encompass their clinical documentation about their diagnosis in the physician websites. Information recorded electronically includes patient's personal information such as name and age, diagnosis information such as the symptoms, medical test and medicine prescription. On the other hand, information recorded manually includes information such as name, age, email address, location and complain.

Method of information capture affect the quality of information. Information captured electronically must be documented and authenticated while recorded on paper must be legible. Information recorded on paper is always limited in terms of availability and accessibility because only one person can use the paper at a time. Besides, paper recording make it hard for updating information because one has to update information manually, hence being slow and reducing the quality of data because of the delays. Paper recording makes it difficult for patients to access their information, only physicians had the opportunity to view patient's information and

responsible for care, documentation and authorization of release of the information. For that reason, paper records have less security thus patients and physicians have risks of losing their data. Access of this information is protected by use of identification cards, doors and tedious sign out procedures for legal users (Silva et al., 2015). When an unauthorized user had the ability of getting access to the recorded paper, one may not know if the information was accessed and which information was viewed. Recording patient's data electronically will increase quality of data because information collected is stored and will never change how it was stored unless being updated by the authorized person. Electronically recorded information allows patients to view their diagnoses information and only authorized people can view the information. The information recorded should meet accrediting and regulatory requirements thus improvement on quality.

The data quality was not fully to my expectation because of the use of paper recording. The partly use of recording patient's information on paper resulted in a tedious work to the physician as well as the risks of losing patients personal information. The information recorded when lost can be taken to unauthorized people creating risks to patients. However, more important information was recorded electronically such as personal information, diagnoses, laboratory test and results and progress notes. Relevant results should be easily accessible, updated and available thus improves data quality.

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