WHO-FIC-IFHRO JOINT COLLABORATION

STANDARDS FOR HEALTH RECORDS

Lorraine Nicholson1 and Sue Walker2

1. President of IFHRO 2007-2010 & Independent Health Records Consultant, UK
2. Director, National Centre for Health Information Research and Training, Australia

The WHO-FIC-IFHRO Joint Collaboration (JC) aims to improve the quality of healthcare globally by encouraging and promoting high standards of Health Information Management (HIM) education and practice and by the promotion and use of standards for record-keeping by clinicians. The JC recognises the importance of high quality, accurate and comprehensive health records for the safe and effective delivery of healthcare and also to support medico-legal processes.

Accurate and comprehensive record keeping is an essential part of a clinician’s professional accountability for the services they provide and is essential for the delivery of high quality services and for the management of patients/clients. A health record consists of all relevant information related to the provision of healthcare services and is, in many countries, a legal document which provides a formal record of care provided. The failure of clinicians to maintain accurate health records may be deemed to be negligence. The health record includes but is not limited to: written or typed documents, computer files, audio tape, e-mails, faxes, video tapes, photographs, images and health records held on other electronic media.

Patient/client data and information must be recorded, stored and transmitted with care, taking into consideration the requirement to maintain confidentiality and security at all times. All identifiable information about a patient’s health status, diagnosis, prognosis and treatment and all other personal information must be maintained in accordance with the privacy legislation applicable to the setting in which the data is obtained. Confidential information should only be disclosed if the patient/client gives their explicit consent to disclosure or if release of patient data is expressly provided for in law. Patient information can be disclosed to other healthcare professionals for legitimate purposes i.e. continued delivery of healthcare if those healthcare professionals are involved in the management of the patient/client.

Healthcare organisations should ensure that appropriate procedures are in place for the safe storage and retrieval of all health records. These procedures should protect the records from loss, physical damage e.g. by water, fire or vermin, theft, unauthorised access or disclosure, and tampering. The processes should also be compliant with local/national requirements for retention and disposal and permanent preservation when appropriate.

Individual patients/clients may have the right to receive information about themselves, recorded in any of their health records. This information should be given in an easily understandable format e.g. written or verbal, which is appropriate to their culture. Release of information should follow a documented procedure according to national or local hospital policy.
Health records provide valuable information that can be used to:

- Provide evidence of informed consent to treatment and/or disclosure
- Facilitate clinical decision making
- Improve healthcare services including safety and quality of care by means of clear communication of intervention/treatment rationales
- Facilitate a consistent approach to teamwork, particularly in the context of multidisciplinary health records
- Ensure continuity of healthcare delivery and management between different service providers
- Support other associated activities such as teaching, research, audit, quality assurance programmes and outcomes monitoring
- Demonstrate that healthcare professionals have selected and provided the highest quality healthcare appropriate to the needs of their patients/clients
- Provide evidence in the event of litigation
- Provide a vital source of statistical and managerial information for the day to day management and future planning of healthcare services and the delivery of those services

The WHO-FIC-IFHRO Joint Collaboration encourages its member organisations/associations to provide guidance and support to their employees/members in respect of health record keeping, storage, retrieval and permanent preservation (where appropriate) of health records in compliance with relevant national legislation, retention and disposal schedules and standards.