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Health Records Retention and Disposal in Nigerian Hospitals: Survey of Policies, Practices and Procedures

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Abstract

This study examines health records management in Nigerian hospitals with the objective to determining the existence of health record retention and disposal policies and practice and the effect on health records management in Nigeria. A descriptive research design was adopted, and data were collected using a questionnaire administered on the heads of departments of health information in each of the hospitals through direct contacts and emails. A total of twenty hospitals were surveyed across the country out of which eighteen responded. Respondents answered questions on health record management, retention and disposal policies, and these include the responsibility of health information professionals in policy administration, retention periods and its determining factors, as well as other information on disposal and destruction practices. The study reveals that there is no national policy on maintenance, retention, disposal and practice of patients' health records in Nigerian hospital, resulting to poor management of patients' health records retention and disposal in hospitals.

Keywords: Retention, Disposal, Health Records, Health Information, Medical Records, Patient Health Records, Health Records Management, Health Records Dormancy.

Introduction

Health care is an information intensive industry in which accurate, reliable and timely information constitutes a critical resource for the planning and monitoring of service provisions at all levels of health care delivery be it primary, secondary or tertiary level.

Health information like other records are like organisms which are born, live some life spans and become dormant at some age forming what is widely referred to as the "records life cycle.". In patient care, this cycle begins when a patient's record is initiated and ends when such record becomes dormant. A patient health record can be assumed to be dormant when such records have not been accessed for any purpose in ten years. Effective patient records management is one element of information governance, that can be described as a set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information at an enterprise level, supporting an organisation's immediate and future regulatory, legal, risk, environmental and operational requirements.

Health record management is a specialised field of records management. It is a good practice for every healthcare organisation to have a records management policy in place to suit her operating environment. Patient health information serves as corporate memory to care providers necessary for efficient and effective health care and research. Failure to retain necessary patient information and to be able to produce that information on demand can subject a healthcare organisation to litigation and some rather harsh penalties. As such, it is important for hospitals to develop a comprehensive data retention and disposal plan as part of its record management policy.

A patient's health record serves many diverse

purposes in the daily operations of a healthcare organisation. For instance, the health records assist care providers to: review previous and current care-related activities and to communicate with one another; examine the cause and nature of the patient's illness; have a credible basis to plan, execute and document the patient's course of treatment and monitor responses which help in making correct prognosis; provide a credible source of health information for statistical, research, administrative and educational purposes; provide a reliable and statutory source of evidence in legal proceedings; and establish a credible basis for the health care billing process and generation of financial reports.

Health information management (HIM) professionals are expected to play important roles as experts, in the creation, maintenance, retention and disposal of health records. This they guided by rules, regulations or schedules developed by each hospital management to guide the maintenance, retention and disposal of health records. However, these rules, regulations or schedules must be guided by established national policy on health records management. National policies are general in nature serving as guide for hospital's management in developing their rules, regulations and schedules for patient's health records' retention and disposal. The rules, regulations and schedules are determined by both internal and external factors such as status of limitation, nature and operational functions of each hospital, environmental factors such as type of health care, level of research, storage facilities and space available, and level of information and communication technology available to the hospital. These require the availability of a patient's health record for varying periods of time. Despite the importance of record retention and the availability of health record documentation, no research has been done to evaluate the status of health record retention and disposal practices in Nigerian hospitals. This study was designed to assess record retention and disposal practices in Nigerian hospitals.

According to the Ipswich Hospital records management policy (2012), records management refers to:

> *a systematic and planned approach to the management of records within the organisation, from the moment the need for a record to be created is identified, through its creation and maintenance to its ultimate disposal ensures that the organisation has ready access to reliable information. An organisation needs to maintain that information in a manner that effectively serves its own business needs, those of Government and of the citizen, and to dispose of the information efficiently when it is no longer required.*

It is in this context that Tavakoli and Jahanbakhsh (2013) opined that medical records must be maintained by a facility to support patient care; meet legal and regulatory requirements; achieve accreditation; allow research, education, and reimbursement; and support facility administration.

In Nigeria today, health institutions still operate the paper-based medical record system. The nearest to what can be described as computer-based medical record system is the "acclaimed" hybrid medical record system where one or two operations are computerised. This was established in two separate studies by Oweghoro (2012, 2013) where it was found that only 10% of the teaching hospitals are partially computerised while 90% still operate paper-based system of health record in South West Nigeria.

Observation has shown in Nigeria that lack of file space and volumes of information are just a couple of issues that create labour-intensive maintenance processes for retrieval of health records necessitating a record retention schedule. Historically, health record maintenance processes include various methods such as scanning to optical disk, use of microfilm or microfiche, and off-site storage of records. None of these is practised, resulting to records overload in most hospitals. Even with the evolution of new technologies and media storage techniques many hospitals do not have the capability to go backward and scan records to free up storage space. Consequently, health records continue to grow at uncontrollable rate creating the need for a clearly defined retention plan.

In their study, Davis and Melissa (2002) found that the duration of record retention differs for the various types of records kept (e.g, laboratory data, radiology reports and films, fetal monitor strips, birth certificates, master patient indexes) and for different

facilities (e.g. physicians' offices, hospitals). Tavakoli and Jahanbakhsh (2013) opined that it is important to know how long a health care facility must keep medical records. The length of time a record is kept by a facility is the record retention schedule. Even though health care professionals are frequently asked the question about how long to keep patients records unfortunately there is no universal answer to the question.

Tavakoli and Jahanbakhsh (2013) quoting Susan and Susan (2001) believed that "several factors need to be considered deciding about medical records retention time, including the number of inactive records, the rate of readmission of patients, financial estimation of space, staff and equipment, accessible and usable space, the status of limitation, research and education, especially in teaching hospitals, types of records (mental health records, heart diseases records, emergency records.), types of health care facilities (long-term facilities, short-term facilities, general or specialized hospitals." All these put together make the health record unique in retention and disposal management.

NHS (2011) stated that the destruction of records is an irreversible act, but the physical space required makes the retention of all records an impractical option. It is therefore essential that all records be reviewed to ensure that those records, which are required for medical, business or other legal purposes, are not inadvertently destroyed. This has become necessary in the management of patients' health records since it has been proved that a record declared inactive could become active in near future.

Methodology

The research was conducted as a cross-sectional descriptive study design with heads of health information management departments in teaching and specialist hospitals as target respondents. The choice of teaching and specialist hospitals for the study was informed by observations that levels of health records management at the general and health centres are either non-existent or at best very low in Nigeria hospitals. Data was collected using a self-designed questionnaire that aimed at finding out if there is a national policy on patients' health records management; or rules and regulations in the hospitals that guide the maintenance, retention, disposal practices on patients' health records in Nigerian hospital and effectiveness of such practice. Heath records management experts' viewpoints were obtained using the Delphi technique. While statistical analysis of data collected through the questionnaire was done with the aid of SPSS software to produce frequency tables.

Results

The survey was carried out in government teaching hospitals in the six geo-political zones in Nigeria. All the hospitals were involved in teaching; the specialist hospitals are mono-healthcare institutions while the federal medical centres also assume a teaching hospital status. A total of twenty (20) copies of the questionnaire were administered through direct contact and e-mail; and of these, eighteen (18) responded, eleven of which were teaching hospitals, five specialist hospital and two federal medical centres representing a response rate of 90%.

Policies on Health Records Management in Nigeria

Health records as a source of information on healthcare are a basic resource which plays a vital role in the management of patient care. Properly managed records will significantly contribute to efficiency in healthcare. Policy on health records management lays a suitable institutional framework that will support effective management of patient records and therefore seeks to facilitate standardisation in the application of procedures and practices in the management of records effectiveness of service delivery.

Hospitals in Nigeria, especially the government-owned institutions, still maintain their patient records in paper form, with 15 (83.3%), of the 18 hospitals operating paper-based health records. On whether they were aware of policies on retention and disposal of health records in Nigeria, 10 (55.6%) indicated that they were aware of policies on retention of health records in Nigeria.

When asked to indicate areas covered by these policies, 9 (50.0%) indicated maintenance, 4 (22.2%) said creation; 3 (16.7%) indicated retention; and 2 (11.1%) destruction.

Policy or Procedure on Retention and Disposal/Destruction of Health Records in Hospital

Respondents were requested to indicate if their hospitals had policies or procedure on retention and disposal of health records and the area covered by such policy or procedures. Table 1 shows the majority of the respondents eleven claimed that they had retention and disposal policies on periods records were active; six said it is on the medium records were kept and five indicated that their policy was on period record/information is retained, mode of retention, method of disposal, type of records and information to retain. Only four of the respondents said they documented record destructions.

Respondents were of the opinion, table 2, that the Hospital Management, Federal Ministry of Health and the Health Records Officers Registration Board of Nigeria (HRORBN) should be responsible for

Table 1: Policy/Procedure on Retention and Disposal of Health Records in Hospitals (N=18)

S/N	Variables	Covered N %	Not Covered
1.	Period for which record/information should be regarded as active	11 61.1	7
2.	Period record/information is retained	5 27.8	13
3.	Mode of retention of records and information	5 27.8	13
4.	Type of records and information to retain	5 27.8	13
5.	Mode of destruction of records	5 27.8	13
6.	Medium in which the records will be kept (e.g., paper, microfilm, electronic, etc.).	6 33.3	12
7.	Person to be responsible for deciding what to keep and destroy	4 22.2	14
8.	method of disposal (e.g., shredding or incinerating)	5 27.8	-
9.	documentation of the destruction of health records	4 22.2	-

Documentation of Policies/Procedures on Retention and Disposal/Destruction of Health Records in Hospitals

Where there are policies and procedures on retention and disposal/destruction of health records in hospital,s the study sought to know who made such policies and if such policies are documented. Nine respondents claimed that policies were made by the respective hospital management boards of the hospitals. Only 6 respondents indicated that these policies and procedures were documented, while two respondents indicated such policies/procedures were made by heads of departments.

Responsibility for making Polices

The policy of each health care institution is an important factor that needs to be considered in retaining and disposing the records. American Health Information Management Association (AHIMA) had standards in line with State Law Data Protection Act as a matter of professional practice, establishing the retention standards of 10 years after the most recent encounter (adult health records); and age of majority plus statute of limitations in case of minor health records. Views of respondents were therefore sought on who should have the responsibility of making policies and procedures on retention and disposal/destruction of health records in hospitals.

making policies on retention and disposal of health records.

Table 2: Opinion on who should make Polices on Retention and Disposal of Health Records.

SN	Variables	SA	AG	DA	SD
1.	Federal Ministry of Health	6	1	0	1
2.	State Ministry of Health	1	4	0	2
3.	Local Government Council	0	1	2	3
4.	Hospital Management	2	9	0	2
5.	HRORBN	5	1	1	1
6.	HIMAN	2	1	1	3
7.	Head of Department	0	1	3	2

Purging for Inactive Health Records from the File and Purging Intervals

Respondents were asked to indicate if shelves holding health records were purged for inactive records to create space for new records. Respondents claimed that they purge files for inactive patient records; however, and only 7 (38.9%) did this between 10-15 years, and another 7 respondents said though they purge for inactive records, but have no specific period for doing this purging inactive records while 3 (16.7%) said they do so annually.

Medium of Retaining Health Records before Disposal /Destruction by Hospital

Respondents were asked the medium on which health records were retained before disposal. Majority, 12 (66.7%), indicated that they retained their records in paper form before records were disposed and destroyed 1(5.60) respondent each indicated that they retain records in images, optical disc, CD-ROM and microfilm and microfiche.

Period of Patients' Health Record Retention

Retention policies in health institution should clearly state what records should be kept for what periods and how they should be disposed off. According to Stanger and Olson (2007), written retention policies should state the length of time the records will be kept. On retention period of health records before destruction, table 3 shows that respondents indicated varying periods over which records were retained before destruction; 8 respondents claimed there are no specific period of retention; and while 6 indicated between 11-15 years of retention (see table 3).

Table 3: Years of Retention of Health Records before Destruction

Year	N	%
No specific period	8	44.40
0 – 5	-	0.00
6 – 10	2	11.10
11 – 15	6	33.30
16 – 20	1	5.60
21 – 25	1	5.60
Total	**18**	**100**

Factors that Determine Retention Period

When requested to state factors that determined period of retention, from table 4, it could be seen that 16 (88.9%) respondents indicated filing space as the major factor; 10 respondents indicated the size (volume) of records; while 8 indicated that retention depended on how often the patients' records were accessed.

Table 4: Factors that Determine Retention Period of Health Records in Respondents' Hospitals

SN	Variables	SA	AG	DA	SD
1.	File space	11	5	-	-
2.	Period of research	-	3	5	2
3.	Status of limitation	4	3	2	1
4.	How often the records are accessed	5	3	3	
5.	The cost total retention requirement	2	2	5	1
6.	The size of the record	2	8		1
7.	off-site storage	-	2	7	1
8.	Activities or functions that require routine access to the record (e.g., quality reviews, release of information)	-	8	2	
9.	Discharge date	-	4	5	1

Respondents were asked to indicate the minimum recommended period of certain specified records were kept before they were disposed or destroyed. From table 5, it can be seen that majority of the respondents 10 (55.6%) indicated that records of disease and operative index, register of births and deaths and master-patient index are kept permanently. However, 7 (38.9%) indicated that there are no minimum period specified records to be kept before disposal/destruction.

Table 5: Recommended Minimum Period Keeping Records before Disposal/Destruction

S/N	Variables	None	5 years	10years	Age of maturity	Permanently
1.	GOPD records	7	2	6	1	2
2.	Accident and Emergency records	7	2	6	1	2
3.	Patient health records (adults) Out-patients	7	3	5	1	2
4.	Patient health records (adults) In-patients	7	0	7	1	3
5.	Patient health records (minors)	7	0	0	3	8
6.	Diagnostic images (such as x-ray film)	7	1	3	1	6
7.	Disease and Operative index	7	0	0	0	11
8.	Master patient index	7	1	0	0	10
9.	Physician index	7	0	0	1	10
10.	Register of births	7	0	0	0	11
11.	Register of deaths	7	0	1	0	10
12.	Register of surgical procedures	7	1	0	1	9
13.	Radiology reports	8	2	1	0	7
14.	Admission and Discharge Registers	7	0	1	1	9
15.	Other (specify)	10	1	1	0	6

Method Adopted for Destroying inactive Health Records

When asked what methods hospitals used in the destruction of inactive health records, majority of the respondents 11 or (61.11%) claimed to adopt burning; 8 (44.4%) indicated paper pulping, paper pulverizing or throw the records into garbage dump.

Discussion of Findings

The study examined the retention, disposal and destruction practices of patients' health records in Nigerian teaching hospitals, and the policies and procedures guiding such practices. The paper-based patient health record practice is still a common place. No teaching hospital operates a fully computerised health information management system and the thought of electronic health records practice in the near future might be a mirage. What is regarded as electronic medical records could only be taken as partial computerization of a few sections of the department. This collaborated Oweghoro's findings that 90% hospitals in the South West Nigeria still operate paper-based system of medical record.

The federal and state governments or their agencies, the ministries of heath, do not have established policies and procedures that guide the management of health record practices in hospitals. Policies and procedures for retention, disposal and destruction of health records are made for hospitals by their respective management boards. Few of the hospitals have their policies made by the heads of the health information management department. The result of this is that there is no standard guideline on policy and procedure for the retention, disposal and destruction of patient health record practices in the country. This absence of a standard health Information management practice had led to the hospitals operating varying approaches to health records management practice, resulting to no standard policies and procedures for the retention, disposal and destruction of patient health record in Nigeria. This practice is not in line with Ameican Health Information Management association (AHIMA's) recommendation that there be standards and state law as a matter of professional practice, established retention standards. Added to this is Stanger and Olson (2007) findings that hospitals and other health care providers establish written records retention and destruction policy to ensure that records are maintained for the appropriate time.

The hospitals surveyed retain patient health records in paper form and has no specific period for which patient health records are retained. Retention is mostly guided by filing space; and the disposal of patient health records is mainly a function of access while destruction is done mainly through burning patient health records. No hospital claimed to maintain patient health records permanently in their original format or retain them in some medium before disposal or destruction. Only one hospital claimed to put her records on micro-film. The hospitals do not have retention period for specific health records before they are disposed, exception to this is the patient index card. This finding is not in line with World Health Organisation policy of 2002, revised and updated in 2006 on policy that when developing a retention policy, it is important to remember that medical records should be kept by the hospital as long as required under the statute of limitations (retention for legal requirements) or the country's record retention regulation

Conclusion

The study examined policies, practices and procedures for the retention, disposal and destruction of patients' health records in hospitals in Nigerian. Findings show that the level of health records management in Nigerian hospitals is generally low compared to modern day practices in the developed countries. Patient records are still maintained in paper form. There are no policy or standard guidelines on retention, disposal and destruction of health records in Nigeria hospitals; this can be attributed to the fact that neither the state nor the federal government had put one in place. Majority of the hospitals do not have guidelines on retention, disposal and destruction of health records. Few hospitals adopt their own strategy in managing their health records; the result is that patient health records are not properly managed. Consequently, there is no standardised approach to retention, disposal and destruction of patients' health records in Nigerian hospitals.

One would expect that the Federal Ministry of Health, through the Health Records Officers Registration Board of Nigeria, the regulatory agency for health records management, would formulate policies and procedures for the retention, disposal and destruction of patients' health records in the country.

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