Vol 6 | Issue 2 | 2016 | 74-78.

e-ISSN 2248 – 9142
print-ISSN 2248 – 9134

International Journal of
Current Pharmaceutical & Clinical Research

www.ijcpcr.com

DOCUMENTATION AND ARCHIVING IN THE HEALTH DEMANDS AMENDMENT

Milena Marinič*

The University Psychiatric Hospital Ljubljana, Studenec 48, 1260 Ljubljana- Polje, Slovenia, Europa.

ABSTRACT

In Slovenia, the health system within the public administration, the most disordered documenting facts and findings. This disorder is due to the absence of legislation governing this area. Hence the need for change. Good records show a careful health treatment, fact-finding and ordered the operator of medical information. Archiving of medical data require the management of documents and forms, which consist of health records. In the first place, the operator must determine the forms, which consist of health records, because only a single document could represent a basis for comparison with each other and scientific research. Using action research were in the period from September to December 2015 to find all the forms by health professionals in their work and recorded. We have created a register of forms and documents, and reduce redundancy. During the research we recorded over 500 forms. The conclusion of the study: Redundancy documents, inappropriate content and structure, inter-comparability, outdated forms. Operators of medical information for quality data processing themselves within the existing legislation can create rules for filing and archiving. The employers for their employees prepare reminders, clinical pathways, protocols that keep workers in a situation to take the path of quality health treatment. Even forms lead to the writing staff of the relevant facts. Forms should therefore be updated to keep up with modern trends and accepted professional guidelines. However, in order forms serve as legal certainty, they should be those already fulfilled, even in safe custody; Be you within medical documentation or another safe place.

Key words: Preservation, Documentation, Document security.

INTRODUCTION

Health records witness the findings of the health of workers, planned and carried out health treatment on approvals and an explanatory duty, as well as on adverse effects and outcomes of health treatment. The facts, therefore, form part of health records as an important legal document under which justice and judicial experts concluded historical facts and actual status. Health documentation is not among the private papers of individuals and private letters and are not located on private premises owner's data, but the operator of the collection of health data. According to its content, records health records represent the confession of the patient. That is a constitutional right to secrecy of correspondence, in particular, that these records are not used against itself. *Directive 95/64 / EC* of the Privacy Act of Sweden poured into domestic law more specifically from the Slovenian legislation. The operator has a duty imposed by law annually on the basis of the requirements to inform individuals about the handling of health data. The need for a holistic approach to health documentation also notes the Information Commissioner of the Republic of Slovenia, requiring records of documents within the health files, which reduces the possibility of abuse. The traceability process hearing only stems from the integrity health records, which is legally very important collection. It contains all legally relevant facts as a basis for judicial review of the conduct of health staff and the development of diseases such as damage to health.

Corresponding Author :- **Milena Marinič** Email:- milena.marinic@psih-klinika.si

Greater legal value of records ensures their chronological and substantive accuracy of the records. The great importance of accurate records is also confirmed by the ECHR in the grounds of the decision in the case McGlinchey and others v. The United Kingdom.

Changes in health status, causes and consequences are transparent in the records of the health documentation. They serve mainly to clarify the adequacy of the treatment, which can be an indicator of the cause of death, which confirms the interpretation of the judicial decisions of the Supreme Court of Alabama, in the case of *Ex parte Northwest Alabama Mental Health Center. Skip, Newman*. An expert in making decisions in addition to the doctor's records of great help to the detailed records of nurses within the health records. From domestic case law is clear that health records are important legal document in court and redress procedures. For judicial review are in addition to accurate health records to remain relevant and precise chronological arrangement of keeping the history of health and disease, as is apparent from the grounds of the decision of the Higher Court in Ljubljana where *I Cp 2835/2009.*

THE SWEDISH LEGISLATION

The Swedish legislation Sweden has privacy in health care organized as part of the law for public health care, dental care and rehabilitation facilities. Protecting the privacy of the ban on disclosure of oral and written information to individuals, families, insurance companies and authorities. Aware of the need for secure data processing worry from the moment the health professional accepts these data, the privacy divided into internal and external.

Indoor privacy is an important pillar of receiving data privacy onwards. In this case the obligation to comply with the statutory rules of conduct for all those involved in health care, dental care and rehabilitation services and are familiar with the personal and health data. The operator is obliged to ensure accessibility to health information only to those who participate in medical treatment. Nevertheless, health records may not represent the broad field of access. Therefore, Sweden view data in medical records is very limited; It is forbidden to read the health warnings due to the acquisition of practice or out of curiosity. Assuming the possible exceptions and eligible insights into the health records, it is necessary to establish a record of insights persons in such reading does not cooperate. Such rules of conduct apply to data in paper or electronic form.

Foreign privacy, unlike the Slovenian legislation the Swedish legislature wanted to create a useful law and identify all forms of transfer of health data. In particular, he prohibited the dissemination of that information in writing, by talking in public areas, including through social media on the Internet, such as blogs, facebook and others. Health data include information that directly describe the patient and his disease, treatment, and mental state, working capacity and family relationships, information in health records, in other notes in a fax message, e-mail, test results and other data they know the employees of the patient. In order to select contractors safe mode of transmission, the legislature has a way of transferring information also identified. Such a secure transfer method of using a pre-selected numbers for rapid intervention, whereas this option mistyped numbers excluded. Because of the possibility of sending the wrong message and intrusion into the electronic transmission is permitted only if the exchange of encrypted messages.

At the end of the high-quality medical treatment required quality records. To the creators of health files to create high-quality records are important well-designed forms. In the absence of regulation of this area come to redundancy forms, each department creates its own.

CALIFORNIA LAW

State of California has a privacy best defined by the Confidentiality of Medical Information Act (CIMA) and the Law on Health Policy. This Act provides for the protection of health history, health conditions, information about the treatment of diseases, including sexually transmitted diseases, rape and mental illness. Very precisely regulates the handling of sensitive data, including the signing of protecting the know ', sets out the principles of conduct for the use of professional cards and governing the documentation of death. As part of the health records, performing all health data, which may be the author inform anyone else. In our domestic law guidance on the documentation generated during and after death, handling and storage, we do not; on the basis of logical thinking it is an integral part of health documentation of the individual. In addition, California law provided even loss of health records and identifies solutions. It is a very good implementation act, which could lead to legal regulation in the RS. CIMA so in their daily work with health documentation provides basic guidelines. From the presented bill it is evident that the special protection of health data is important to adopt a special law for them. For processing health records are an important document Legal Medical Record Standards, which clearly indicate to the operator loading each page of documents containing personal data, prohibiting the copying of individual parts.
Good practice of protecting health records resulting from a legal act of the California Legal medical record standard. The said act considered health documentation as a hybrid record, since it is located in separate locations, as well as paper and partly electronically. The regulation provides inter alia that the 'health records to identify each page of a multipage document with full name and surname of the patient and the uniform number of the health card. Implementation of this provision prevents intentional or inadvertent replacement of parts of the health records of

different people. It is therefore not permitted from health records, to photocopy individual pages, or send by fax. It is important for the privacy of third parties, it is determined that the records of third parties in the health documentation of the individual considered as an integral part of health documentation and is subject to disclosure to the patient or court. The privacy of third parties in connection with the owners of health data is not protected. The regulation contains important operational provision which imposes a duty of the contractor on completion of health treatment to complete health records in one day. Completion of health records significant impact on the claims for compensation and the possibility to continue treatment for another. Access to health information is essential to define in operational terms, it is in everyday use. Even in this part of the Legal health record standard limits envisaged, namely through the Review Committee, quality management and documentation insights. The transparency of the processing of health data is a recording of requests for access or obtain photocopies of the information system. This rule should also follow each issue health records from the archive. Such records thus enabling transparent and immediate response to an individual request for the list of all those who were familiar with health data. That provision also regulates the traceability of insights, making each health professional access to the information system used only a single identification. Preservation of health records is very important but neglected area in the Slovenian legal system, it is specially well-governed legal- health record standard. In accordance with the terms of that provision, therefore, the original healt records from the facilities manager can not be removed, except by court order or where required by law. The doctor, therefore, at the service of the operator shall not dispose of any original health records. This must be the protection of privacy at all times kept in a room and under conditions which prevent loss, destruction, modification. Special attention is given to provision mental health documentation documentation are dependent on alcohol or people who abuse illicit drugs, child abuse, data on HIV-positive persons. Even more important for the security of documents in the health documentation, the obligation to keep the chronology of health documents, wherein Base is not allowed to delete anything, nor remove the documents. In order to avoid possible errors due to illegible font and therefore misinterpretation of the text regulation imposes obligations on the clarity and legibility of the recordings of the author of the record. In the case of electronically controlled health records it is due to provide clarity for the content of the printed records. Also, the threat of possible errors due to illegibility is a big reason for keeping health records, including prescriptions electronically. Comparison with that regulation indicates that Slovenian legislation on health documentation provides only that the doctor on the basis of Article 50 of ZZdrS required to keep documentation on the state of health and other records provided for by law. Neither said nor any other law but does not give detailed instructions for managing health records and privacy protection in it. Due to the legal vacuum leads to redundancy forms are also behind me incomparable. Therefore, it is first necessary registration forms.

REGISTRATION FORMS

The University Psychiatric Hospital Ljubljana I am therefore September 2015, was given the task to record all the forms to be used. In the period from September to December 2015, I therefore together with my colleagues sought forms and documents that are in their work various health professionals.

I registered 516 forms, 58 alien forms, 104 instructions 37 instructions for patients. It was in 5 cases for notebooks, which are created by the nurses and they were written by hand, in 50 cases the author of the form is no longer known, therefore it will be necessary to create a new form. In 10 cases, it is the same content but different formats. In these forms, we will propose a unifying content. Forms and other documents I brought to the table - a register in which is recorded in the register of address form, which is not expected to change, the acceptance date of the last version, the organizational regulations is registered in the register of the administrator of the document. The Register also contains the badges of all versions of a document. In this way, I created a central register of forms, documentation of quality management and legally important documents. In register allows to search by title of the document and immediate access to the badge which identifies the appropriate document.

The survey forms and recording is especially important for document management and forms used, as well as to unify and to reduce the number. One of the main purposes of the registration document is the legal aspect, because we will run through the register also records the time of the validity period of each version of the document. Such a register of documents will in the future serve all healthcare professionals who wish to change to a specific form, as they will from the register available data, the individual who created the document and when, and the contents of the document. The study went further. For amendments to the assistant of the Legal Service prepared a standard form which will be the future promoters passing amendments to the forms or other documents.

TABLE OF CONTENTS

Forms are also creating content of health records. Upon the establishment of health records it is essential to create a list of contents. The content of health records must include the first list of documents which must be entered every document that consists of a collection called health records (Annex 1). The first five places on the list is reserved for:

1) a statement on the provision of health information,
2) the appointment of a proxy health,

3) a statement in advance of the will expressed
4) other statements will
5) the court decision on legal capacity of the patient and his representative, if they exist.

All these documents are the legal basis exercise of patient rights must therefore be complied with at all hospital admissions, health records pursue a clearly visible place and to be transparent. The first five documents has therefore always be stored in such a way that when scrolling through health records above and therefore first visible.

The fact that the document was entered and numbered in the top right corner of increasing document security against theft. For the patient's legal security as well as safety for operators of health treatment are forms declaration of intention of major importance. Only on the basis of the existence of a written statement given to the patient's will power to say with certainty retroactively.

Such a list the content of health records is designed manually and electronically-controlled health records. Modern forms of processing and sharing of health data processing for traceability to ensure greater security of individuals' privacy. We must not overlook the fact that the transmission of health data electronically significantly faster. As a result, even more important safeguards against unauthorized intervention; So also send protected documents - on the basis of an electronic signature.

ELECTRONIC EXCHANGE FINDINGS

Electronic exchange of findings contribute significantly to the speed of treatment, pollution of the environment with the paper, since the information thus received may only attach the health documentation. In this way void printing on paper, shorten the access time, reduce the financial cost of data transfer by courier, at the same time reduces the volume of the single file named health records. Such a document will be an entry in the electronic health records may be useful for many doctors. All this reduces costs and redundancy investigations. Finally, such a mode of transport sensitive data enhances security, because the data does not tolerate paramedical staff, nor traveling by unsecured e-mail channels. Such health information based on its electronic signature can only be opened by your doctor. In addition to all the direct intake of prenatal health records accounted dilemma of how to archive. Such records are part of electronic health records at the end of hospitalization also be printed and bound into a unified bundle.

PREPARATION FOR ARCHIVING

After each release is to be in the health documentation to verify documents according to the list and by covenant in the assembly. For each health treatment from admission until discharge occurs one set of health records. All radiographs nurse toward the signature handed to the patient in storage. By signing the form it is then an integral part of the paper-based health records. An integral part of health documentation as well as all requests and forms which recorded acquainted with health records. Individual sets of health records form the entire health records of each patient, in cases where the patient may be repeatedly treated in a hospital. Therefore, every health administrator when recorded remission of the patient is required to regulate the entire health documentation. It should ensure that the health documentation of all fixtures and the last set, which he wrote last she arranged for long-term storage, in accordance with content and tied records. Only in this way have health documentation handed over archivist. Due to the traceability of changes in health documentation is necessary archivists signature or record of repayment through a barcode on taking up health records in the archive.

A BOUND COLLECTION

Hospital health records after each discharge from hospital is bonded to form a whole, several individual wholes being composed of a single health records for one patient. The safest way of storage of documents, thermal binding of the book. This method is not the best when later that health records be copied, because such connections can dissipate. The best way, which would allow subsequent copying should sew in a book.

HEALTH ARCHIVE

For proper handling of health records archives is an important fact to whom it is granted custody. The archive health records know how best to behave Health Organization and the health care professional, it is *de lege ferenda* need to regulate a legal basis for the storage of health records within the institution that created it, so the introduction of special archives. Such an ideal and cost effective solution is the establishment of the National Health Archive in the competence of operators who will combine all the health records of health care for private and public law.

Conclusion of the similarity of the recommendations of the EU to the operator's health files can only health worker, leads to the conclusion that the operator archive health records can only health institution. Terms archiving for an individual operator constitute excessive costs, making it a logical grouping of hospitals depending on the specialty with a view to the common archiving of documents. The cost of preservation would be partly covered from the budget for preservation of cultural heritage, while the second part of the participation of operators in relation to the proportion of the documentation that they wish to be kept there. Such production and storage of health data in a special law would mean the best, cheapest and most secure storage of health data, even after the death of the person. If it were a health archive in the maximum operator specific branches of activity, which is also training new staff, it would also mean a rational

storage and at the same time ful fill the conditions in respect of record keeping on the recommendation of the EU by trained health care professional. Health documentation to the health archive took over after the termination of the activities of the private contractor, which will be accessible to other selected contractor as well as the court and an individual. All health records relevant to the research and the history of the nation, it would be as archives healthcare area gathered in one place. Storage and handling of this documentation should be regulated under a special law on health documentation. Such an archive would be documentation such as archives secretion only ten years after the death of an individual, or a hundred and thirty years after his birth. Create archives in each hospital separately means nowadays too high financial and human cost.

CONCLUSION

The importance of documents in health care, it is difficult to determine the concept. The paper documentary material to the Slovenian health care today represents a large amount of mainly poorly regulated materials and huge financial cost. Converting paper-based health records into digital form to represent the operator an even greater financial burden due to digitization and the method of storage. Traps for privacy in digital health documentation no longer the subject of this debate, as long as the applicable legislation in this area is not clearly defined, but applies *nulla poena sine lege*. Protection of personal privacy after death is largely in the archives disorderly.

Ownership of health data only notional and the patient does not give an overview of the management of health records, allowing internal abuse and uncontrolled access and processing of sensitive personal data. Above all, indifference content and processing of paper health records, allowing uncontrolled manual data processing.

The latter confirms the need to create an archive that would allow the processing of paper and hand-guided health data exclusively to the beneficiaries, and all other health professionals could benefit from the operational work simply an electronic version of the documents, with the purpose of ensuring traceability and insights treatment. In particular, it is necessary to regulate the fast and secure transmission path findings because today certificates traveling via fax, e mail or courier. In doing so, they often get the wrong address, they become acquainted with them by any unauthorized person.

ACKNOWLEDGEMENT: None

CONFLICT OF INTEREST:
The authors declare that they have no conflict of interest.

REFERENCES

1. FLIS, Vojko. Medical records and patients' rights. In medicine and law. 1996, 1997, 1998 / editor Jelka Reberešk Grišek and Vojko Flis. Maribor: Maribor General Hospital. 1999.
2. Case U.S. Supreme Court, Boyd v. United States, No.: 116 U.S. 616 (1886).
3. Case ESČP McGlinchey and others v. The United Kingdom 2003.
4. Case Supreme Court of Alabama, No.: 1090629 − Ex parte Northwest Alabama Mental Health Center in Skip Newman Skip Newman, 25. 2. 2011.
5. Case Higher Court in Ljubljana No. I Cp 2835/2009. The standard of proof.
6. Confidentiality of Medical Information Act (CIMA).
7. Legal Medical Record Standards Policy No. 9420.
8. Medical Practitioners Act (ZZdrS-UPB3), 2006 .Official Gazette of RS, no. 72/06.