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ROLES AND RESPONSIBILITIES OF MEDICAL RECORDS STAFF IN HEALTHCARE SETTINGS

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Abstract

Medical records staff play an important role in healthcare operations. The objectives of this essay were: to identify the roles and responsibilities of professional medical records staff; to describe various qualifications required for employment in a medical records department; to explain the use of, and need for, medical records in a variety of healthcare settings; and to describe the increasingly important field of electronic health records. The essay found that there are many roles and responsibilities that medical records professionals are, or can be, involved in. This blend of tasks undertaken has a significant impact on the efficiency and effectiveness of patient care and treatment. There is also a significant need for staff, and staff in a position of authority, to have the knowledge and skills required to carry out their roles safely, accurately, and consistently. (Nwosu, 2024)

Accurate, legible, and organized medical records are essential components of patient care. It is crucial that all healthcare professionals take an interest in the electronic or paper medical records which they generate. In order to be effective, they must be trained and retrained on how to comply with their medical records responsibilities. Compliance with a variety of medical records-related legislation is required. Many documents are retained, and destruction of medical records must be monitored and executed using secure and ethical yet cost-effective methods. The healthcare system predominantly operates to encompass the provision of care and treatment for individuals, and to prevent ill health on a community level. These roles are carried out with the use of legible, accurate, and complete medical records. Failure to utilize such a documented paper or photographic-based tool can result in litigation, inadequate resources, and/or a substandard level of knowledge of healthcare professionals. Ultimately, this paper-based essay will identify and define the required levels of competence of medical records professionals, the techniques used to assess such competencies, and some strategies which can be used to teach and maintain the necessary levels of medical records knowledge and skill that the working healthcare professional needs. (Wager et al., 2021)

1.2 **Keywords**

Medical records, healthcare staff, data integrity, compliance, electronic health record, documentation, coach, quality assurance, supervisor, technical skills, coding, reception, patient care, personal health records, privacy.

The medical records staff member has the important job of keeping records in compliance with standards, federal and state guidelines, and applicable regulations. Medical records staff are frequently involved in the following duties: ensuring the proper documentation is in the chart, e.g., consents, H&Ps, progress notes, lab reports, consultations; entry of reports into the computer system; coordinating the removal of charts to and from the offsite storage facility; interpreting doctor orders for the support staff; posting test results; ensuring the scanners are working so that paperwork can be scanned into the medical chart; working with the Compliance Office when a patient submits a request to see their personal health record.

More and more healthcare settings are moving from paper documentation to electronic health records. Medical records staff will be involved in converting the patients' existing paper record into electronic format. Medical records staff are typically supervised under a department manager or quality assurance supervisor. They are typically expected to know things like Excel. They should have basic computer skills, in addition to good communication and coaching skills. Medical records staff that are trained in medical coding are likely to report to a business office staff member, rather than a hospital or clinic medical records staff member.

1.3 1. Introduction

Vital patient records are integral to healthcare facilities and personnel. The maintenance of patient and treatment records by medical records staff is a crucial and comprehensive process that encompasses correct, complete, and secure handling of relevant health information. This information informs the course of care and supports the competency of physicians. In addition to assured patient care, record quality and precision have an impact on reducing medical errors and directing the clinical decisions of specialists. Health records have always played an important role in patient care. However, the medical records industry has undergone significant changes in recent years as a result of rapid technological and patient administrative developments. (He et al., 2021)

Patients' electronic health records were first recognized for clinical information towards the latter part of the twentieth century, when data was digitized. More recently, patient medical records have faced the transfer of files to digital formats available in electronic health record systems. Patient records are seen as the property of the healthcare systems that develop them and are protected by laws. The government is managing an increasingly complex regulatory environment and is taking steps to both protect the confidentiality of patients' digital records and to ensure that health facilities comply with laws in the event of a data breach. Alongside technical developments and administrative regulations, medical records staff must be trained for proper handling of various aspects of patient files to ensure adequate patient care and the proper organization and maintenance of institutional patient data. In processing patient files, the primary duties of health facility records specialists, such as running hospitals, clinics, and outpatient clinics, are coding, processing, and transcribing reports from healthcare providers to ensure communication among insurance carriers, regulatory bodies, and case managers, and to support student care. Care is taken to give permission to manage and access patient documents. (Bani et al.2020)

1.4 2. Importance of Medical Records in Healthcare

The medical records department is an essential part of every healthcare institution. It is a storage area for medical record documentation, both paper and electronic. Medical records are used to record patient diagnoses, procedures, treatments, and drug regimens, among other things. The implications of inaccurate, incomplete, and poorly maintained medical documentation are widespread. Patient protection and quality of care are linked to proper record-keeping and maintenance. Interoperable electronic medical records protect patient health, improve quality of care, and add value to healthcare financing. Medical records facilitate interaction and continuity of care across all healthcare services. Effective communication and the obtaining of patient healthcare documentation are good indicators of care continuity. Healthcare documentation is critical to delivering and communicating patient information and coordinating a multi-disciplinary team's treatment. (Tanwar et al.2020)

Their primary use is to record a patient's medical management and treatment, and to provide insight into the patient's condition and identify future treatment plans. Complete records enhance decision-making and the patient care that follows from it. A patient's historical medical record is valuable for their current medical record in the clinical environment. All practitioners in a healthcare environment are legally accountable for ensuring that accurate and complete medical records are retained. Inadequate records leave a black hole in the patient's history and can lead to delayed or poor treatment. Healthcare providers' good record-keeping habits are critical to maintaining patients' trust. As a result, medical record organization and strength are an essential aspect of healthcare quality assurance. According to confidentiality legislation, all medical records must be considered confidential. A variety of legislative requirements and industry guidelines prescribe how medical records are generated, stored, and kept. Medical records are found at every level and are well protected in the healthcare system. Policy standards for document selection are regarded as a significant factor in quality care.

1.5 3. Key Roles of Medical Records Staff

The primary functions of any health information management department are patient record management and data management. To ensure the performance of these two functions, medical records staff members have developed and have been assigned specific roles in managing medical records. In this study, we identified several key roles that medical records staff are expected to perform. The roles and their corresponding expectations are discussed in the following. (Wager et al., 2021)

Medical records filing and retrieval. This is the ability to file records promptly and accurately in the designated storage area, and retrieve and refile records, again promptly and accurately. Medical records staff should be familiar with the filing system in use and have experience maintaining it. Filing should be required for both loose filing on shelving, as well as on-room filing in storeroom or storage areas, to ensure the documentation is coded and filed in the correct storage allocated for easy and accurate subsequent retrieval. The organization of documents through filing allows for quick and accurate access to documents by authorized personnel, and efficient tracking of protected medical records throughout their required retention period. Protection of confidentiality and the maintenance of the information contained on protected records should be a priority, and maintaining the integrity of the filing system.

3.1. Maintaining and Organizing Patient Records

Care of patient records is the primary responsibility of quality patient care through organizing and maintaining accurate health records. Patients expect confidentiality and privacy in these records. The medical records staff ensure that legal, ethical, medical, and administrative record-keeping requirements are met in accrediting healthcare institutions' review records. Responsibilities of the medical records staff fall under the categories of maintaining and organizing patient records, release of patient information, research, monitoring health care services provided to patients, financial administration, and management of health information services. The effective maintenance and organization of patient records are necessary in ensuring the safety of the patient, quality control, continuity of medical care, documentation of the care provided, assistance in legal issues, education, research, and management/commercial analysis. Health records represent an essential part of patient care. Records are continually monitored, evaluated, and maintained as an integral part of patient care. All patient services rendered during a period of time require proper documentation. Every health record point is a potential source of research or teaching material of a statistical data set. Inpatient charges and recovery of the cost of work performed are derived from these records with the advent of third-party payments. Management makes decisions and business analyses based on data derived from the record content. Medical records ensure the patient that parsimony and confidentiality are practiced. Medical records include all types of written, individually identifiable, and pertinent patient information. The physical record housing the patient, the content of the health record, the components of the health record, and content confidentiality: release, maintenance, and disposition are included in the record. Any documented information that is used in the physician-patient relationship is included. Administrative, clinical, and related services provide patient care services using the information required and the outcomes. Data analysis and decision support management activities understand that documentation of the care provided serves as evidence of the services. Information fundamental to research, teaching, education, and training. (Huda2022) (Huda2022)

3.2. Ensuring Data Accuracy and Integrity

Regardless of the confidentiality measures and procedures of a healthcare facility, the accuracy and integrity of patients' data are still at great risk of misuse, damage, loss, or alteration. It is observed that electronic health data can be intentionally destroyed or compromised by viral attacks, hackers, or other unwarranted persons with access to unauthorized information. For these reasons, it is essential for medical records staff participating in the institution's security compliance program to protect data accuracy and integrity. Medical records staff should ensure the accuracy and integrity of computerized systems, programs, and data being created and implemented. Medical records staff should also participate in computer usage security measures by following the code of ethics that requires the protection of computer systems from unwarranted individuals who seek to destroy or use these systems without permission. They should collaborate with vendors and their liaisons to resolve system interface vendor problems and participate in developing and revising system interface software and programs whenever required. Finally, it is important to recognize the importance of building system training for the appropriate medical records staff and health team members in order to promote its overall efficiency in the provision of patient care. (Wu et al., 2022) (Wu et al., 2022)

3.3. Compliance with Legal and Regulatory Requirements

The hospital staff, including the medical records practitioners within those healthcare settings, should be made familiar with their scope and limitations. They must be educated about the existence, relevance, and implications of legal and ethical guidelines since those address the concept of confidentiality and privacy. In broader terms, compliance can also eventually lead to a reduction in the legal risks that healthcare institutions are facing. To this end, it is recommended to establish a multidisciplinary committee that is tasked with, among other things, the continuous monitoring and updating of the establishment's activities and operations to include new or amended laws or regulations. Additionally, the hospital should have in place a mechanism allowing all stakeholders to voice concerns while staying personally protected. Meetings in the form of at least three occasions—education, consultation, and structured discussion—are to be held regularly, and the output is disseminated throughout the hospital. In this manner, general awareness and adequate multidisciplinary communication are achieved. (Vos et al.2020)

1.6 4. Use of Electronic Health Records (EHRs)

Electronic Health Records (EHRs) are helping shape a new era in the record-keeping of medicine. Prior to EHRs, records were almost exclusively managed on paper. This was a time-consuming and frustrating process for practitioners, as it was hard to retrieve data as fast as needed. The integration of EHRs has transformed the process, making it easier to input data in real time and then quickly access it for further analytical purposes. EHRs have also redefined the role of medical records staff. They have taken on a variety of additional responsibilities or adapted to the new technological changes in the case of those who were part of the original transition period. In addition to providing higher-quality data for analytical purposes, EHRs give staff the capabilities to transfer data instantly to various locations, something that was once almost unthinkable. One of the more important points of care capabilities of EHR is the easy access to data at any time. Given that patients are increasingly mobile and people are living longer, this is critical because acute care often is delivered at a location that does not have access to a person's primary records. In a life-threatening situation, a health services provider will ask about the patient's medical history and certain medications via a treatment summary, which may be accessed from the electronic health record or the healthcare of the individual involved. This eliminates the reduced access to medical records during that particular time of treatment when health services providers conform to a paper-based records system. EHRs aren't just beneficial for the patients. Once the medical staff has been properly trained in the use of the EHR systems, they are able to navigate through the records with ease, resulting in a more productive workflow. The recent shift to EHRs has forced employees to keep their skills up to date, which in turn has made these employees an invaluable part of the healthcare system. While the transition to EHRs has had a mostly positive impact on the healthcare system, it has also posed significant new challenges. Individual employees must be trained on these new systems in order for them to function at full capacity; therefore, initial staff training costs have increased. Additionally, patients may have privacy concerns related to the maintenance of their electronic records. The electronic health record is improving the report-based prescribing and dispensing of medication; the brief description is entered into the medical practitioners' software at their practices for it to be automatically inserted into the clinical information systems of their connected healthcare providers. This decreases the risk of misinterpretation because all the information is now sent to the relevant treating healthcare provider within 24 hours. The

electronic health record provides for a secure and confidential national system, which allows an individual to have a health professional act on their behalf. Updating and maintaining an EHR system presents an ongoing challenge. To be useful, the system needs to be supplied with accurate, up-to-date information. If not updated regularly, the information may be less than helpful, even inaccurate. Systems need to be maintained and upgraded, and outdated systems need to be replaced, all at great cost. Nonetheless, it is likely that these challenges will be continually improved upon, and that EHRs will soon be accepted as a routine part of maintaining medical records. (Floyd et al.2021)

1.7 5. Training and Education for Medical Records Staff

Training and Education in Employment

The staffing challenges in today's healthcare settings and the necessity to transform business processes from paper-based to electronic medical recordkeeping and other eHealth/HIT projects mandate sound employee training and orientation programs. These programs must be tailored to meet the specific electronic systems and processes the organization has in place. Just as important as having a well-designed training plan is having skilled instructors who are competent in medical record management methods and procedures. Those working in medical records who have education and training in the field can be an asset and a bridge between the front-line caregivers, staff, and managers.

Training Programs Training program information is available from various associations that offer a range of training opportunities for those in the field or those aspiring to be in the field. There are also colleges and universities that offer training and education in this discipline, and many community colleges have a two-year associate degree program for medical record technicians. In those particular instances, there are Board examinations that can be taken for certification as Registered Health Information Technicians. The test is given every April/May and August/September.

Certification Certification for Health Information Technician programs is available through various organizations. This certification is essentially an exam for "certified associate." In order to be eligible for the HIM certification exam, certain qualifications need to be met. The entire certification process typically takes two to three years: one or two years of education and one to two years of experience. Having been educated at a school that is either accredited or has pre-accreditation status provides a significant advantage. A Certified Medical Technician becomes certified through a membership organization; generally, one would join to learn about qualifications for the examination. HIM professionals are often recognized when they have the Registered Health Information Administrator (RHIA) credential. Additional credentials are available through the association.

Those who have knowledge of medical records management systems and standards can contribute greatly to the implementation and ongoing management of technology-based systems in healthcare and health-related settings. Those educated in quality medical recordkeeping standards and practices will be uniquely skilled in helping their organizations to meet the challenges and reap the benefits that come with health information technology and electronic medical record systems. Successful medical records staff will need to be trained in current electronic medical record

systems. The ability to keep up to date with data management, security, and regulatory issues is crucial. (Charow et al.2021)

1.8 6. Conclusion

In conclusion, the work of medical records staff in maintaining accurate and up-to-date patient information in private practice settings is crucial to the accurate care and referral of patients. The entire process is governed by the legal aspects, providing a safeguard for the practice of medicine and the patient against harm or abuse. As history and technology progress, medical offices and healthcare organizations also evolve in their methods with the shifting times; from written accounts to electronic databases. The skilled staff necessary to safeguard the lives and rights of patients will likely always be necessary, although the intelligence, training, and education for the skill is ever-changing and continuously developing. (Ahmad et al.2021)

In conclusion, the medical records department is an important asset in healthcare settings. Effective management and use of the clinical information contained in electronic health records is considered vital to efforts to improve the quality of care, enhancing patient safety, managing care delivery processes, and improving care delivery efficiency. To this end, medical records staff are not only responsible for patient confidentiality and compliance with federal and state laws, but also with the standards and accuracy of records and appropriate release of information. Staff should be trained and encouraged to remain current in the laws and developments in trending topics regarding patient care and the laws influencing the management of their records, i.e., electronic health records usage, appropriate measures for accounting paper records, and regulations regarding substance abuse and its treatment. (Bani et al.2020)

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