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ARCHIVING BUSINESS AND HEALTH RECORDS IN PRACTICE

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ABSTRACT

The health institution is formed on one side of the medical records and documents, on the other hand, business documentary material. All this material is required at the time of use to work in a manner which will allow: accessibility, integrity and usability. Access to documents is ensured by the classification integrity by combining the lots and storage in suitable climatic conditions, which is responsible for the proper storage medium also provides usability.

Key Words: Long-term storage, Archiving.

INTRODUCTION

The University Psychiatric Hospital Ljubljana since its inception in 1981 kept medical records, business records preserved part of it is used much less (approximately 50 years). Knowledge of archiving and long-term preservation of documents employed at the state level, even a few years ago were not skilled. The Document operators are treated, each in their own way. Above all documentary material it does not provide the accessibility, as it collects each maker on their premises. This was the reason of redundancy and time-consuming procedures. The present work is geared toward medical documentation and legal vacuum with regard to its treatment.

Health records once the period around 3000 BC, the Egyptians began to lead the oldest form of health records. written documentation. The content of medical records were drawings and symbols called hieroglyphics, representing information on diseases, treatments and procedures used in operations in ancient Egypt. These records represent the first form of medical records [1]. In ancient Greece, physicians in his writings describing symptoms and treatments. Medicine is modeled after astrology summarized accurate records of phenomena. On European soil, the development of the records in the Middle Ages in the area of health records brought mainly records of names and surnames of patients and records of payment for treatment or prescriptions. In the fourteenth and fifteenth centuries saw the doctor's bills developed and include advice on nutrition and effective methods of treatment of diseases, as well as notes autopsies. The expansion of science means the maximum value of accurate health records, which are the sixteenth century has proceeded as book cases; Casebook, along the lines of the legal profession. Since 1750, doctors began to create medical records in hospital records as systematic and objective medical practice. Famous authors Casebooks Forman and Napier considered the predecessor of modern medical records [2]. While the first medical records about an individual may testify only about the signs of the disease, based on observation of the patient's complexion and urine, the development of medicine brought the possibility of blood tests. Keeping medical documentation in the late nineteenth century meant a doctor the possibility of analyzing data about an individual. The need for systematic data collection is dictated by hospitals to keep medical records; even if the operators did not have the standards of patient information must be collected [3]. Individual doctors are data write in their own way, which was verifiable and comparison of results difficult. In the early twentieth century was recorded in the hospital expansion of education, which has increased the need for standardizing medical records. In parallel with education in health care bloom well as research for which the medical record often primary matter. Medical records have therefore developed according to the need of the operator. The purpose of medical documentation is therefore in the history of mankind, as well as in the history of the file

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itself is changing. Health documentation is a much wider concept than the older concept of medical documentation as the latter writes only a doctor. Legal otherwise acting physician as the sole person responsible for health records, but in practice in many institutions is only one of the creators of the records, because the only documentation effectively manage health administrator or in the private sector nurses.

THE HISTORY OF HEALTH LEGISLATION

The oldest laws in the field of healthcare incurred already in the legislation of the Austro-Hungarian monarchy. The first bill to be: Small Business Act (Die Gewerbeordnung) of 20 December 1859 and the Sanitary Law (Das Reichssanitätsgesetz), dated 30 April 1870th

Andrija Štampar as one of the founders of public health in the field of Yugoslavia after 1923 Slovenia began to organize hygiene organizations. From the initial bacteriological "Stanic" have been developed and epidemiological institutes from these institutes of hygiene and health centers with counseling and dispensaries. With the establishment of bourgeois dictatorship and the Kingdom of Yugoslavia in 1929 they arose as ban administration, which has meant a boom health laws that have been specifically interpreted by the implementing regulations.

One of the oldest laws in the area of the Austrian medical health care law of 1870, which stipulated the organization of health care. Any legislative amendment was also introduced innovations in the field of documenting the findings of health, but also planned and carried out jobs. Such regulation of health services was maintained until 1930. In the years between 1918 and 1930 the hospital passing of the Austro-Hungarian monarchy in the jurisdiction of state administration, after 1930 the public hospitals under the administration of the Drava Province. The hospital for mental illness in Studenec (the current University Psychiatric Hospital Ljubljana), in addition to Ljubljana's general and women's hospitals since 1931 again fell under state administration. The transition of power from one hospital to another can be attributed to the absence of legislation on evidence.

HEALTH RECORDS TODAY

Health records created today from birth through to death of the person to whom it relates. The history of the disease also contains records of other family members. The records of the health status of individuals affect the good name and dignity of the individual and indirectly also to the dignity and reputation of his descendants, the closest members and close relatives. Health documentation records representing various health care professionals in paper or electronic form, images in digital form, photography, digital images fruit, computerized tests, as well as a letter or health records content. Under the current Act, Medical Practitioners Act as the sole person responsible for medical records, but in practice the medical records of governing and taking care of the storage of medical administrators and nurses. Chronological record health data represents exemplary guidance and legal certainty for the operator and patient because the only available and authentic documents and records may be evidentiary foundation for the exercise of individual rights. Health documentation about the individual, even within a single institution, run by various experts. The method of keeping, storage, accessibility and integration but is not legally defined, allowing excessive availability, disposal of individual files or entire documents. Legal undefined area is also storage, security and accessibility of health records after the death of the private health-care providers or creator records, both private doctors and experts.

DESCRIPTION OF DOCUMENTS

In the absence of legislation is only part of medical documentation at the level of a single country. These are the forms in which they manually keep medical records for the invitation and the forms which are subject of billing of medical services, as prescribed by the payer. In particular, in hospitals, in the application, and the newly generated substantially more forms. In doing so, each institution creates its own forms for current operations. The more organized societies (the latter is also the University Psychiatric Hospital Ljubljana) keep a list of codes of forms and change tracking. Nevertheless, he still generated some form of the past and is not included in base form. The biggest problem of the proliferation of different forms in different naming. All health institutions are recorded in addition to medical records, including procurement of medicines and food, and personal property, and others. Naming Convention and the retention period is also required forms to take over the patient's clothing and valuables. The latter is the first necessity of defining what falls within the concept of valuable items. Opinions within the institute are in fact different, or, as is one of the key housing of the valuables; but goes where for instance fur coat and a passport or bank card. The importance of keeping the database forms, mainly due to conversion tracking, as well as the determination of the storage period. Each form must therefore have at the time of entry equipped with a number that is already printed on it. In this way the classification of the document will never be missed, but will also immediately clear retention period.

DISPERSION OF HEALTH DOCUMENTATION AT THE LEVEL OF THE OPERATOR

Providers of health treatment carried out in different locations and in different activities. It is formed at each location and each activity for the same patient specific health documentation. When this comes to redundancy investigation, findings, documents; the loss of time and not the last budget money. Combining health records would facilitate the review of health-care treatment

of the investigations already carried out. To avoid redundancy of documents I haven`t University Psychiatric Hospital Ljubljana at establishing a central repository, proposed to combine all the health records for each patient. Upon acceptance of a patient at the hospital health professionals so archivist ask for health documentation antedate or a document rejecting the patient; all of which continue to be combined into a single health records. Combining documents the fact that this would require additional manpower, which is not available. Security documents medical records. Documents in the medical documentation are easy prey for any theft, since there is no single list of the contents of the documents. This collection therefore offers no legal certainty, no patients nor the contractor. It is also unclear about who was familiar with medical documents. In foreign case law in relation to Clark Boyd v. US notes that the medical documentation of the health card, which allows you to read medical records and electronic health record without printing. [4] The need for a holistic approach to health documentation also notes Information Commissioner RS when required documents within the health record documentation, which decreasing the possibility of abuse. The traceability process hearing only stems from the integrity medical records, which is legally very important collection. It contains all legally relevant facts as a basis for judicial review of the conduct of medical staff and the development of diseases such as damage to health. 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 health situation, causes and consequences of the most transparent in the health record documentation. [5] Therefore, in particular, they serve to clarify the appropriateness of treatment which may be an indication 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. [6] Skip, Newman. However, an expert in making decisions of great help in addition to doctor records 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, in addition to accurate health records, an important organization and management of precise chronological 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. [7] Treatment of all bearers of health data should therefore be carefully defined to ensure the integrity of documents and the privacy of the patient.

EMERGENCY LEGISLATION AND IMPLEM ENTING REGULATIONS

Processing and storage of documents prescribed by various special laws, such as implementing legislation appears Regulation on administrative operations, which clearly defines all stages of processing, as well as long-term storage via a classification plan. The problem with the processing of health documentation is generated because the Regulation as an implementing rule for its enforceability needs a basis in law, no health law but of the administrative operations of such implementing regulation does not state that would be enforceable in the processing of medical records; while for the business part of the archives of the archives of a health institution unquestionably true. Detailed instructions for keeping health records do not provide any legal regulation. This is reflected in the absence of contents list and description of the different documents within a collection.

TIME OF RETENTION OF SPECIFIC DOCUM ENTS

The lack of regulation and the emergence of various forms in different institutions may lead to confusion as to the retention time of the document. Mental Health Act was introduced 26 forms for which there is no defined retention period and location. All of these documents is not part of the health records and their storage is expected to be less than that accorded to health records. In addition, the health care documents arising on the acquisition of the patient's clothing, valuables and money. Because of their different denominations have these documents in various institutions including different retention period.

PREPARATION OF DOCUMENTS FOR LONG-TERM STORAGE

Individuals are health records once after the completion of health treatment in addition to other preparations also bound bundle of documents with the state cord and ensure the integrity of the file one reading. Such preparation, but only partially guaranteed integrity. I want to emphasize that a concern to prepare for long-term preservation of documents assume any creator documents. This concern and duty of every artist must provide the operator. It is also the task of the operator to set a deadline within which it must be documentary material handed over to the central archive.

DECISION

The decision concludes that no single set how long it is necessary to protect a specific type of health records and when - if ever - to destroy it. Also, legal provisions how to protect data from third parties in the health documentation of the individual is not. Undefined content and the absence of a list of the contents of health documentation represents the unregulated area. It is therefore considered quod non est and ACTIS, non est and mundo (Lat.) Or "That which is not in the scriptures, this is not the world". Defined documents which are an

integral part of health documentation constitutes a legal problem due to non-uniform designations at the national level. Handling of documentary material must be uniform in future legislation at national level along the lines of the Anglo-Saxon legal system. Despite the age of computerization is the increasing importance of health records for the exercise of individual rights remains essential legal protection manually kept records, because health records are still largely kept manually. The selected manually-controlled health records, in addition to all the presents archival documents. Unlike health records at the level of business documents such simple merger yet. My desire is supported by the leadership of the institute is to make all completed cases - both health records and business records creator mailbox central archives, this documentary material will be placed in the appropriate collection, and it set the retention period depending on the entry. In this way, the business documentary material available to the beneficiaries, we will avoid unnecessary losses and innumerable copy. An even better way would be the transformation of these materials into an electronic format, which would be the easiest to current issues applicable. Along with efforts for a better, easier and more secure processing of documents to observe the time I was at the behest of parent established in 2009, central archive of the University Psychiatric Hospital Ljubljana also slow movements in terms of classifying documents. Classification of documents I introduced in 2010 and note movements already in the mindset of some employees, because we have good experience in the documents received from the outside, you can easily fit into the proper law of the case, if they are equipped with our entry. Also employed is pleased to participate in the selection process and the elimination of business documents, as they sit the annual opportunity. Also positive changes speak for themselves, so the movements slow but effective.

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CONFLICT OF INTEREST:

The authors declare that they have no conflict of interest.

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