

# Electronic Medical Records Assessment Handbook

Developed By: eHealth & Information Management Systems: Nigeria

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\* = VERY IMPORTANT STEP

## Clinic Overview

<p><b>Clinic Overview</b></p> <p>Clinic Name: _____</p> <p>Clinic Location: _____</p> <p>Type of Services:</p> <p style="margin-left: 20px;">                     Pharmacy <input type="checkbox"/>      Midwifery/Labor <input type="checkbox"/>      Medical Consulting <input type="checkbox"/>                      Family Planning <input type="checkbox"/>      HIV/AIDS Consulting <input type="checkbox"/>      Lab <input type="checkbox"/>                      Other: _____                 </p> <p>Clinical History: _____</p>	
<p><b>Staff Estimates</b></p> <p>Doctors: _____</p> <p>Nurses: _____</p> <p>Consultants: _____</p> <p>Midwives: _____</p> <p>Record Keepers: _____</p> <p>Administrators: _____</p> <p>Other: _____</p> <p>Total : _____</p>	<p><b>Patient Overview</b></p> <p>Total # of patients per day:</p> <p style="margin-left: 40px;">                     Mon: _____                      Tue: _____                      Wed: _____                      Thur: _____                      Fri: _____                      Sat: _____                      Sun: _____                 </p> <p>Total # of Patients / week: _____</p> <p>Total # of patients / year: _____</p> <p>Types of patients:</p> <p style="margin-left: 20px;">                     % Women: _____                      % Children: _____                      % Men: _____                      % HIV Positive: _____                 </p>

### Clinic Overview

<b>Facility</b>	<b>Equipment</b>
# of Rooms: _____	Ultrasound: <input type="checkbox"/>
# of Rooms w/lights: _____	Blood Bank Refrigeration: <input type="checkbox"/>
Hrs/day of light: _____	Instrument Sterilization: <input type="checkbox"/>
Generator Use: Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Technology/Equipment: _____
Always when electricity is off: <input type="checkbox"/>	_____
Sometimes during day: <input type="checkbox"/>	<b>Types of Referrals</b>
Always at night: <input type="checkbox"/>	Emergency Care <input type="checkbox"/>
Sometimes at night: <input type="checkbox"/>	Diagnosis <input type="checkbox"/>
Never: <input type="checkbox"/>	Labs <input type="checkbox"/>
Funding:	Other _____
\$ NGOs:	_____
\$ Government:	_____
\$ Patients:	_____

## Information Needs Assessment

### What Information is Needed?

<p><b>Job Title:</b> _____</p> <p>Information:</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p> <p>7.</p> <p>8.</p> <p>9.</p> <p>10.</p>	<p>Have Access to Info?</p> <p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/></p> <p>5. <input type="checkbox"/></p> <p>6. <input type="checkbox"/></p> <p>7. <input type="checkbox"/></p> <p>8. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p> <p>10. <input type="checkbox"/></p>	<p>If Yes, From Where?</p>	<p>Time to Find Info:</p>
<p><b>Job Title:</b> _____</p> <p>Information:</p> <p>1.</p> <p>2.</p> <p>3.</p> <p>4.</p> <p>5.</p> <p>6.</p> <p>7.</p> <p>8.</p> <p>9.</p> <p>10.</p>	<p>Have Access to Info?</p> <p>1. <input type="checkbox"/></p> <p>2. <input type="checkbox"/></p> <p>3. <input type="checkbox"/></p> <p>4. <input type="checkbox"/></p> <p>5. <input type="checkbox"/></p> <p>6. <input type="checkbox"/></p> <p>7. <input type="checkbox"/></p> <p>8. <input type="checkbox"/></p> <p>9. <input type="checkbox"/></p> <p>10. <input type="checkbox"/></p>	<p>If Yes, From Where?</p>	<p>Time to Find Info:</p>

<p><b>Job Title:</b> _____                  Information:                  1.                  2.                  3.                  4.                  5.                  6.                  7.                  8.                  9.                  10.</p>	<p>Have Access to Info?                  1. <input type="checkbox"/>                  2. <input type="checkbox"/>                  3. <input type="checkbox"/>                  4. <input type="checkbox"/>                  5. <input type="checkbox"/>                  6. <input type="checkbox"/>                  7. <input type="checkbox"/>                  8. <input type="checkbox"/>                  9. <input type="checkbox"/>                  10. <input type="checkbox"/></p>	<p>If Yes, From Where?</p>	<p>Time to Find Info:</p>
<p><b>Job Title:</b> _____                  Information:                  1.                  2.                  3.                  4.                  5.                  6.                  7.                  8.                  9.                  10.</p>	<p>Have Access to Info?                  1. <input type="checkbox"/>                  2. <input type="checkbox"/>                  3. <input type="checkbox"/>                  4. <input type="checkbox"/>                  5. <input type="checkbox"/>                  6. <input type="checkbox"/>                  7. <input type="checkbox"/>                  8. <input type="checkbox"/>                  9. <input type="checkbox"/>                  10. <input type="checkbox"/></p>	<p>If Yes, From Where?</p>	<p>Time to Find Info:</p>

## **Visual Representation of Information Flow**

- \* Map out how Information Flows throughout the clinic.
- \* Example: Follow a patients Form and see how it is used throughout their visit

## Evaluation Assessment

**Pre-Implementation**

**Post-Implementation**

**Recording**

1. How much time is being spent for record keeping
  - a. Health Care Workers:
    - i. Total time per day \_\_\_\_\_ (hrs)
    - ii. Time per patient \_\_\_\_\_ (hrs)
  - b. Record Keepers:
    - i. Avg per day \_\_\_\_\_ (hrs)
2. How many times is a patients data logged per visit: \_\_\_\_\_
  - a. Location 1: \_\_\_\_\_
  - b. Location 2: \_\_\_\_\_
  - c. Location 3: \_\_\_\_\_
  - d. Location 4: \_\_\_\_\_
  - e. Location 5: \_\_\_\_\_

**Reports**

Report Name	When Done	Time to Compile	# Questions not Answered

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**Information**

- 3. How much time is spent seeking patient information (other than filling out forms)
  - a. Family Planning: \_\_\_\_\_
  - b. Antenatal: \_\_\_\_\_
  - c. Labor: \_\_\_\_\_
- 4. How often is the information on the form used after it is written? (#/visit)
  - a. Family Planning: \_\_\_\_\_
  - b. Antenatal: \_\_\_\_\_
  - c. Labor: \_\_\_\_\_
- 5. How often does the staff ask questions that are not on the form? (#/visit)
  - a. Family Planning: \_\_\_\_\_
  - b. Antenatal: \_\_\_\_\_
  - c. Labor: \_\_\_\_\_
- 6. What questions are they asking?
  
- 7. How long does it take to find a woman's form if she has her ID card? \_\_\_\_\_
- 8. How long does it take to find a woman's form if she does not have her ID card? \_\_\_\_\_
- 9. How do they find a patients form if she does not have an ID card  
\_\_\_\_\_
- 10. How long is the patient visit cycle? \_\_\_\_\_ (hrs)
- 11. How many woman come to the clinic with missing forms \_\_\_\_\_ (#/month)

## Staff Evaluation Sheet (1 pg/staff)

<b>General:</b>	
Name: _____	Age: _____
Gender:    Male <input type="checkbox"/>	Female <input type="checkbox"/>
History:	
_____	
_____	
_____	
<b>Education:</b>	
Highest Level of Education:	Primary School <input type="checkbox"/> Secondary School <input type="checkbox"/> University <input type="checkbox"/>
Other: _____	
Name of University: _____	
Degree Attained: _____	
<b>Technology Level:</b>	
Technology Experience: No experience with any technology	1 <input type="checkbox"/>
Own and use a cell phone regularly	2 <input type="checkbox"/>
Use a computer at Internet café regularly	3 <input type="checkbox"/>
Own your own personal computer and use regularly	4 <input type="checkbox"/>
Technology Ownership:    Cell Phone: <input type="checkbox"/> Computer <input type="checkbox"/> Other <input type="checkbox"/> _____	
<b>Career Information:</b>	
Position:    Pharmacist <input type="checkbox"/>	Midwife <input type="checkbox"/>
Nurse <input type="checkbox"/>	Administration <input type="checkbox"/>
Other: _____	Doctor <input type="checkbox"/> Consultant <input type="checkbox"/>
Record Keeper <input type="checkbox"/>	
Time employed at clinic: _____ # Hours work per week: _____	
Job description/duties:	
_____	
_____	
_____	
Who do you report to: _____	

Who reports to you:

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Observational Notes:



## **Facility Layout**

\* Visual Representation of the Building Layout with names of buildings (include location of generator, lights, computers, etc)

\* If applicable, label the buildings in the order that patients go to them