Availability of Patient Data in Acute and Chronic Conditions to Facilitate Quality Healthcare

Documentation of patients' health information is beneficial for many reasons such as providing good and continuous medical care to patients. Clinicians use this data to understand the overall conditions of their patients, take diagnostic decisions and start or alter a treatment plan (Sayles & Gordon, n.d.). The availability of health records is essential for dealing with either acute or chronic conditions.

In acute cases, the recorded personal details, medical history and family history of patients may contribute to reaching an accurate clinical diagnosis. Acute care is often given in emergency as the patient has an emergent health condition. Keeping an up to date and accurate health records of patients that contain in-patient and outpatient's data, in addition to the plan of care is extremely important in emergency cases. The recorded data contains all personal information of the patient including his address, physician name, date of birth, insurance data, family information and contact details. Family members may be contacted in cases of emergencies especially if the patient suffers from accidents or comas.

Once the patient is admitted to a primary setting, some preliminary data should be collected before his admission. These data contain the provisional diagnosis of his illness which will need subsequent medical care. Moreover, the admission records include financial information about the patient, medical history, previous medications, allergies of the patient ordered by physicians, diagnostic tests such as lab investigations and imaging. What's more, it is important in acute cases to document the clinical observation of the patient's case to follow up his/her response to the treatment plan and then make further clinical decisions.

Chronic diseases represent a great proportion of healthcare spending. Furthermore, these illnesses are principle causes of death. One measurement to improve the quality of health care provided to chronic patients is well-developed health records (R, 2017). The recorded data about the medical history of patients allow access to this information everywhere and anywhere, which aids clinicians to consider their treatment decisions based on obvious clinical data. Furthermore, the availability of this chronological records of patients' medical conditions is beneficial for educative and research purposes. Medical staffs can illustrate health documentation to improve their clinical sense and compare the efficacy of different medication on different medical conditions. As a result, optimal management of chronic cases can be achieved depending on an integral health record system.

An additional benefit of personal health records for chronic disease is patient engagement. Patients will be more involved in their treatment decisions and show higher levels of commitment and compliance (Epping-Jordan, 2004). Every patient has the right to access his health record and use it to be sure that he is the receiving a good medical care, give his feedback and may consult his health records if needed. Since chronic diseases usually need long-term treatment plans, well-recorded medical information is essential for the patient to understand his case and know about effective treatments that can improve his condition and decrease the tendency to suffer from more complications (S, R, A, M & D.W., 2014). Therefore, personal health records are crucial tools to support patient self-management and clinical engagement.

Reference:

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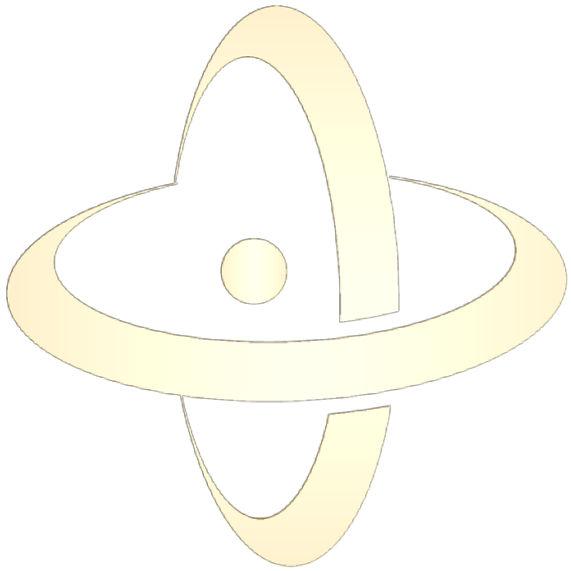

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