

Impact of Health Education in Perception of Patients regarding Storage of Health Records among Patients attending Tertiary Care Hospital, Bareilly District, Uttar Pradesh

¹VK Tiwari, ²Abhishek Kumar, ³Ashok Agarwal, ⁴Hari S Joshi, ⁵Deepak Upadhyay, ⁶Pooja Bansal

ABSTRACT

Objective: To know the patients' attitude regarding preserving records: pre- and postcounseling.

Materials and methods: A questionnaire was administered to all the subjects, and data were assessed by applying statistical test. The health education awareness is regularly carried out in outpatient department (OPD) and inpatient department (IPD) by various audiovisual aids.

Setting: A cross-sectional study was conducted among the patients from OPD and IPD of the Department of Pulmonary Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India.

Results: Out of 998 patients studied, 421 (42.2%) of them were preserving record and 577 (57.8%) did not. After counseling both groups who were preserving and not preserving the records, a remarkable change was observed, i.e., 800 (80.2%) patients from OPD and IPD started preserving their records in a positive way and were bringing at the time of consultation.

Conclusion: With the sustained and regular health education/motivation, the patients realized the importance of record keeping.

Keywords: Counseling, Health awareness, Health education, Health motivation, Health records.

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^{1,3}Professor, ^{2,6}Resident, ⁴Professor and Head ⁵Assistant Professor

^{1,2}Department of Pulmonary Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

³Department of Pediatrics, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

^{4,5}Department of Community Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

⁶Department of Forensic Medicine, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India

Corresponding Author: VK Tiwari, Professor, Department of Pulmonary Medicine, Rohilkhand Medical College and Hospital Bareilly, Uttar Pradesh, India, E-mail: vijeshtiwari@gmail.com

INTRODUCTION

The health record is a vital and relevant document made by a health care practitioner at the time of or subsequent to a consultation and/or examination or the application of health management. A health record/reports like X-ray, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound, angiography, pulmonary function test, bronchoscopy, echocardiography, microbiological culture/susceptibility reports and other records, such as admission/discharge notes, medical certificate records, referral letters, prescriptions, etc., contain information about the health of an individual.

The importance of record keeping by the patients has been observed to be the vital throughout the life of the patient. The records should be preserved well as far as possible so that these can be utilized when the need arises, especially for the evaluation and comparative assessment of the patient's health condition. Many people, especially those who are illiterate, ignorant, and unaware of the importance of keeping health records, find it irrelevant with regard to the diagnosis, treatment, and prognosis. The follow-up assessment and outcome is not possible or difficult in these patients.

Most of the patients reporting at outpatient department (OPD) and inpatient department (IPD) do not preserve their records. It creates difficulty for consultants to make proper diagnosis and assessment for their prognosis and outcome. That is why, many times the patients do not find relief and sometimes it results in serious outcome. This is mostly observed in the cases of tuberculosis and other lung diseases, like pneumonia, chronic obstructive lung diseases, interstitial lung disease, malignancy, etc.

Hence, the present study has been planned to assess the perception of patients regarding record keeping and provide them health education regarding importance of storage of treatment-related documents. The studies related with personal keeping of the records by the patients have not been conducted till date, but few studies do have related data regarding storage of documents by hospital.¹⁻⁴ With this study, we want to highlight that proper storage of documents is the most basic and crucial step in order to provide a better diagnostic treatment and prognostic aid in tuberculosis and other pulmonary diseases.

MATERIALS AND METHODS

A prospective longitudinal study was conducted among the patients attending OPD/IPD in Pulmonary Medicine Department, Rohilkhand Medical College and Hospital, Bareilly, Uttar Pradesh, India, from July 1, 2014 to January 31, 2016. All the patients coming to OPD during the first year of study and gave consent were included in the study. Both new and old patients participated. One individual was enrolled only once in the study during his/her first visit to OPD regardless of their further course, i.e., hospital or home-based treatment.

Inclusion Criteria

- Patients aged 18 years or above
- Only clinically stable patients, and
- Patients suffering from chronic diseases like chronic obstructive lung disease, interstitial lung disease, malignancy, tuberculosis, etc.

Exclusion Criteria

- Patients not giving consent for study and
- Patients who died during the study period.

A questionnaire was administered to all the patients to assess demographic details, their perception about medical record keeping on first visit as well as follow-up regarding details of maintenance of medical records. Primary data regarding the perception and practices of the patients in storing health records and demographic details were taken while enrolling patients first time in the study and health education was imparted regarding the importance of medical record keeping. Sources of health education were: Individual/group motivation, videos/skit programs, pamphlets, leaflets, folders, instructed files, brochures, display boards, posters, and banners.

First follow-up was done after 1 month of enrollment in the study and practices of storage of health records were assessed. During the first follow-up, the patients were reeducated again regardless of their practices of record keeping. Second follow-up was done after 3 months of enrollment; the impact of health education and counselling was viewed by assessing their practices regarding record keeping. While assessing the practices, important medical documents like radiological investigations (X-rays, ultrasonography, CT scan, and MRI), pathological investigations, other investigations like echocardiogram, electrocardiogram, and previous prescriptions were included in medical records.

OBSERVATIONS AND RESULTS

The present study was carried out as a prospective study to assess the patient's knowledge about carrying

the documents at the time of hospital visits, to assess the methods of keeping important documents, their perception regarding importance of document, and to assess impact of health education in proper storage of health records.

During the study period for first inclusion of patients, a total of 1,028 patients were enrolled in the study. However, only 998 patients came for complete follow-up, i.e., two follow-up visits and were included in the final analysis of results. These patients were also evaluated based on the demographic profile.

Of 998 patients, 631 (63.2%) patients were males, 664 (66.5%) belonged to age group of 36 to 65 years, and 766 (76.8%) were from rural background. Majority patients were illiterate – 658 (65%), married – 852 (85.4%), labor by occupation – 458 (45.9%), and from nuclear family – 598 (59.9%). In addition, 502 (50.3%) patients were given IPD-based medical care and rest, 496 (49.7 %) patients, were given home-based treatment and OPD-based follow-up (Table 1).

Out of a total of 998 patients, only 42.2% had their previous records preserved and good practices of maintaining health record. After providing proper counseling and health education to both groups, who were preserving and not preserving the records, in the first month of follow-up, there was an increase in record keeping by patients from 42.2 to 78.2% and on second follow-up (on third month) it reached 80.2%. While test for difference is done in proportions, change in practices among patients for keeping the records and carrying at the time of consultation was found to be significant ($p < 0.001$). Therefore, there was significant increase in practice of record keeping after health education.

There was significant increase in record keeping practices in both sex, both rural and urban residents, in both IPD and OPD patients, and both nuclear and joint family background. But, only significant increase in record keeping was seen in married persons in comparison to unmarried persons (Table 1). It shows that proper health education increases record keeping practice in all persons regardless of their gender, age, education, occupation, family type and treatment pattern type. Therefore, health education targeting the general population will help in improving the good habit of record keeping regardless of basic demographic characteristics.

Table 2 shows questions and response of patients who did not store records. Among all, the most common reason for not storing records was that 221 (38.3%) thought that storage was not necessary as the disease was cured, course completed, or became asymptomatic, 161 (27.9%) were ignorant about record keeping, 125 (21.7%) did not care or thought that it was not necessary, and 70 (12.1%) had lost or destroyed records by someone

Table 1: Demographic profile of the patients enrolled in the study

Demographic characteristics	Number of patients (n = 998)	Patients with previous practices of maintenance of health record (n = 421)	Patients who preserve records after follow-up		p-value (Extended Mantel-Haenszel chi-square for trend)
			1 month (n = 780) No. of patients	3 months (n = 800) No. of patients	
Gender					
Male	631 (63.2%)	294 (69.8%)	511 (65.5%)	521 (65.1%)	<0.001
Female	367 (36.8%)	127 (30.2%)	269 (34.5%)	279 (34.9%)	<0.001
Age (years)					
14–25	114 (11.4%)	84 (20%)	82 (10.5%)	88 (11%)	<0.001
26–35	132 (13.2%)	80 (19.0%)	108 (13.8%)	108 (13.5%)	<0.001
36–45	210 (21%)	100 (23.8%)	172 (22.1%)	172 (21.5%)	<0.001
46–55	251 (25.2%)	73 (17.3%)	189 (24.2%)	199 (24.9%)	<0.001
56–65	203 (20.3%)	50 (11.9%)	159 (20.4%)	163 (21.2%)	<0.001
66–75	50 (5%)	10 (2.4%)	36 (4.6%)	36 (4.5%)	<0.001
>75	38 (3.8%)	24 (5.7%)	34 (4.4%)	34 (4.3%)	<0.001
Residence					
Rural	766 (76.8%)	281 (66.7%)	578 (74.1%)	598 (74.8%)	<0.001
Urban	232 (23.2%)	140 (33.3%)	202 (25.9%)	202 (25.3%)	<0.001
Education					
Illiterate	658 (65%)	245 (58.2%)	508 (65.1%)	528 (66%)	<0.001
≤5th standard	124 (12.4%)	28 (6.7%)	104 (13.3%)	104 (13%)	<0.001
6th to 10th standard	140 (14%)	96 (22.8%)	104 (13.3%)	104 (13%)	<0.001
Graduate and above	76 (7.6%)	52 (12.4%)	64 (8.2%)	64 (8%)	<0.001
Marital status					
Married	852 (85.4%)	311 (73.9%)	668 (85.6%)	668 (83.5%)	<0.001
Unmarried	146 (14.6%)	110 (26.1%)	112 (14.4%)	112 (14%)	0.914
IPD/OPD					
IPD	502 (50.3%)	235 (55.8%)	424 (54.4%)	428 (53.5%)	<0.001
OPD	496 (49.7%)	186 (44.2%)	356 (45.6%)	372 (46.5%)	<0.001
Occupation					
Unskilled labor	188 (18.8%)	66 (15.7%)	148 (19%)	162 (20.3%)	<0.001
Skilled labor	270 (27.1%)	122 (29%)	208 (26.7%)	208 (26%)	<0.001
Businessman	109 (10.9%)	34 (8.1%)	93 (11.9%)	93 (11.6%)	<0.001
Employee/job	76 (7.6%)	30 (7.1%)	64 (8.2%)	64 (8%)	<0.001
Medical/paramedical Staff	12 (1.2%)	6 (1.4%)	12 (1.5%)	12 (1.5%)	<0.001
Student	44 (4.4%)	28 (6.7%)	32 (4.1%)	32 (4%)	<0.001
Unemployed	46 (4.6%)	6 (1.4%)	36 (4.6%)	36 (4.5%)	<0.001
Household work	243 (24.3%)	123 (29.2%)	181 (23.2%)	187 (23.4%)	<0.001
Others	10 (1.0%)	6 (1.4%)	6 (0.8%)	6 (0.8%)	0.825
Family type					
Joint	400 (40.1%)	157 (37.3%)	314 (40.3%)	322 (40.3%)	<0.001
Nuclear	598 (59.9%)	264 (62.7%)	466 (59.7%)	478 (59.8%)	<0.001
Total	998 (100%)	421 (100%)	780 (100%)	800 (100%)	<0.001

else. Moreover, 255 (44.2%) put their records in dustbin, destroyed, or threw them, 192 (33.3%) used them in household purposes, 95 (16.5%) gave records to children for playing, and 40 (6.9%) used in making decorative items like flower pot, window sheets, etc. Maximum 339 (58.8%) of patients disposed their records after the disease cured and rest 238 (41.2%) had some other reasons.

Table 3 shows questions administered to patients and their response regarding their way of storing documents. It was found that 214 (50.8%) of them kept them in thick carry bag, 198 (47%) in prescription file, while 9 (2.1%)

patients kept them without file or bag; 388 (92.2%) patients kept them flat, 74% of them in folded manner, and 0.5% did not care; 114 (27.1%) kept records on flat surface with cover and 35 (8.3%) without cover; 154 (36.6%) kept records in cupboard/drawer/box/suitcase and some of them 86 (20.4%) hung on wall; 32 (7.6%) on window or door. In 71 (16.9%) patients records were within reach to the children; 39 (9.3%) patients kept records in different places, whereas 382 (90.7%) kept in one place; 260 (61.8%) patients brought records in unarranged manner when reporting to the doctor, while 161 (38.2%) brought them in arranged manner.

Table 2: Questions and response of patients who do not store records

Response	Number of patients (n = 577)	Percentage
<i>Why?</i>		
Do not care/not necessary	125	21.7
Do not know that they have to store records	161	27.9
Storage not necessary as disease cured/course completed	221	38.3
Lost or destroyed by someone else	70	12.1
<i>Do you?</i>		
Give records to children for playing	95	16.5
Use for household purposes (in place of window, dusting or cleaning purposes, etc.)	192	33.3
Put them in dustbin/damage or throw	255	44.2
For making decorative item	40	6.9
<i>At what time you dispose (or throw)?</i>		
After death of patient	28	4.9
After disease cured	344	59.6
After present course of treatment	66	11.4
During course of treatment	44	7.6
After the next X-ray is done	40	6.9
Got old and damaged by its own	60	10.4

DISCUSSION

The primary objective of patient-related documents is to enable the treating health care practitioners to provide quality health care to the patients. It is thus a living document that tells the past and present story and forecasts the happenings in the future, if the records are adequately preserved and maintained and it also facilitates the health care professionals at each visit. In other words, the patient's health record is a powerful tool that facilitates the treating physicians to view the patient's medical history and identify their problems or pattern of sickness that may help to determine the course of health care.

This appears to be the first study on this subject ever conducted in the field of medicine. Various studies have been carried out pertaining to the storage of records by hospitals in developed countries,^{5,6} but in developing countries like India, where these facilities are not available in all hospitals, the patients have no alternative except to store their records in a proper manner. For this, the patients are given health education in various health education awareness programs in the Department of Pulmonary Medicine and Community Medicine of RMCH.

Health awareness programs are regularly carried out in OPD and IPD through audiovisual aids, such as (1) liquid crystal display projection, (2) motivation (group and individual). Regular group health education activities are being carried out twice a week in wards for

Table 3: Questions and response of patients who store records

Response	Number of patients (n = 421)	Percentage
<i>How do you keep them?</i>		
Prescription file	198	47.0
Carry bag made of polythene, paper, or cotton	214	50.8
Without file or bag	9	2.1
<i>Do you keep them?</i>		
Flat	388	92.2
Folded	31	7.4
Do not care	2	0.5
<i>Where do you keep records?</i>		
Hanging on wall	86	20.4
Hanging on window or door	32	7.6
On flat surface with cover	114	27.1
On flat surface without cover	35	8.3
In cupboard, drawer, box, or suitcase	154	36.6
<i>Do children reach to records?</i>		
Yes	71	16.9
No	350	83.1
<i>Where do you keep them?</i>		
One place	382	90.7
Different places	39	9.3
<i>How do you bring them to doctor?</i>		
Properly arranged (with respect to date, in one place or file and complete records)	161	38.2
Unarranged (not in sequence, not in one place or file and incomplete records)	260	61.8

patients, their relatives and friends by: (3) Distribution of booklets, leaflets, and through health education boards, (4) various camps, such as World TB Day, World Asthma Day, World No Tobacco Day, World chronic obstructive pulmonary disease Day, and World Health Day camps, (5) thick envelope, thick files with clips, and hard poly bags are provided to patients to store their documents safely in proper manner. The health education activities and health day camps are carried jointly by the Department of Pulmonary Medicine and Community Medicine (Figs 1 to 7).

**Fig. 1:** Liquid crystal display TV projection in OPD



Fig. 2: Group motivation in ward



Fig. 3: Health education in ward



Fig. 4: Individual motivation in OPD

Thus, good record keeping by the patients has been observed to promote the better understanding of the health problem by the treating physicians in better way and within the short possible interaction session. The properly preserved records of the patients embrace transparencies and in fact these records speak themselves in

a clear way and these may further promote better communication, understanding, and a sound health care provider and beneficiary relationship.

In our study, 577 (57.8%) patients did not preserve their health records and among them 161 (27.9%) patients were ignorant about the benefit of health record keeping as they had not been told by anyone to store their health records; 221 (38.3%) thought in their mind that its storage was not necessary as the disease got cured or course had been completed and the next time doctor would not consider their old records and would advise new investigations. In these patients health education has shown remarkable change during two counseling done in first and 3 month of follow-ups, as the percentage reduced to 21.8% and further 19.8% (Table 2). This created a hope that merely on health educating on different occasion, we can change or correct the perception of an individual.

Not only educating individuals to store their health records, our aim also included to make them aware to the proper method of health records storage, so that they do not get damaged and persist with patient for longer duration. The health records should be kept in thick carry

<p>रोहिलखंड मेडिकल कॉलेज एवं हॉस्पिटल पीएलसीबीत बाईपास रोड, बरेली। Ph.: 0581-2526010-12</p> <p>रोगियों के लिए आवश्यक निर्देश</p> <ul style="list-style-type: none"> अपने एक्स रे, जांच रिपोर्ट, दवा के पर्चों आदि को एक फाइल कवर में रख कर किसी अच्छे किसम के प्लास्टिक के बैग, बैग या पैकेट में संभाल कर रखें जिस पर पानी का असर न हो। बैग या पैकेट को सीधे रखें, मोड़े नहीं। इसे गर्दू से साईट के नीचे अथवा सड़क की तली में अथवा बाह्य विद्या का पैकेट के साथ सीधा रखें। पानी, चाय, दूध, तरल औषधि या किसी भी प्रकार के द्रव्य को एक्स रे, जांच रिपोर्ट आदि पर न गिरने दें। जब भी चिकित्सक द्वारा मांगा जाए, एक्स रे, जांच रिपोर्ट व दवा के पर्चे अवश्य दिखाएं। अपने एक्स रे, जांच रिपोर्ट और दवा के पर्चों को पूरे जीवन भर संभाल कर, सुरक्षित रखें। ओ०पी०डी० के दिन के अनुसार या जब डाक्टर द्वारा बुलाया जाए तो नियत तिथि पर अवश्य उपस्थित हों। दवायों निचयित रूप से बिना नागा के ले। खाने के पूर्व की औषधि को ठीक से समझ ले तथा इसे खाली पेट ही ले। दवाओं के पत्ते पर उत्पादन व अवसान (एक्सपाइरी) तिथि वाले भाग की टिकिया/कंप्यूले सबसे बाद में प्रयोग करें। जहां उत्पादन या एक्सपाइरी तिथि लिखी हो, सर्वप्रथम उससे दूर के भाग से दवा लेना प्रारंभ करें। दवायों चिकित्सक के निर्देशानुसार लें। दवा की मात्रा तथा आवृत्ति बताई गई तिथि के अनुसार लें। औषधि सेवन या इन्जेक्शन के विषय में कोई जानकारी चाहिए तो चिकित्सक या कक्ष सं० 1090/2 में उपस्थित कार्यकर्ता से संपर्क करें। 	<p>रोहिलखंड मेडिकल कॉलेज एवं हॉस्पिटल पीएलसीबीत बाईपास रोड, बरेली। Ph.: 0581-2526010-12</p> <p>तम्बाकू/धूम्रपान छोड़ने के लाभ व उपाय निम्न प्रकार है।</p> <ul style="list-style-type: none"> धूम्रपान छोड़ने के लिए इसके बुरे प्रभावों को एक डायरी में लिखें और प्रतिदिन उसे पढ़ें और समीक्षा करें कि आपने क्या खोया और क्या पाया। इससे धूम्रपान छोड़ने में मदद मिलेगी। धूम्रपान छोड़ने से फेफड़े के कैंसर, हार्ट अटैक या उसके दिमागी असर से बचा जा सकता है। धूम्रपान छोड़ने से व्यक्ति की सांस कम फूलती है और घर का प्रदूषित वातावरण स्वच्छ हो जाता है। इससे घर के सदस्य अच्छा महसूस करेंगे और वह व्यक्ति राहत महसूस करेगा तथा रिश्तेदार और मित्रों के बीच एक अच्छा स्थान बनेगा। धूम्रपान छोड़ने के लिये अपने परिवार व मित्रों का सहारा लेने का वातावरण तैयार करें। अपने डाक्टर की समय-समय पर सलाह लें। धूम्रपान छोड़ने के लिए एक तिथि नियत करें और अमल करें। धूम्रपान दृढ़ इच्छा शक्ति के सहारे छोड़ा जा सकता है। जिन दुकानों से आप सिगरेटें खरीदते हैं उन जगहों का त्याग करें। अपनी जेब, कार, स्कूटर व घर में धूम्रपान का सामान रखना एक दम से छोड़ दें। धूम्रपान छोड़ने से थकावट, सिरदर्द हो सकता है। इसे बर्दाश्त करने का संकल्प करें। ये लक्षण धीरे-धीरे खतम हो जाते हैं। 	<p>रोहिलखंड मेडिकल कॉलेज एवं हॉस्पिटल पीएलसीबीत बाईपास रोड, बरेली। Ph.: 0581-2526010-12</p> <p>डाट्स सेंटर (घैस्ट एवं क्षय रोग विभाग)</p> <ul style="list-style-type: none"> डाट्स सेंटर सरकार द्वारा मान्यता प्राप्त है। यहां पर बालगम को जांच मूकन की जाती है। जिन रोगियों को दो सप्ताह से अधिक खांसी होती है वे संदिग्ध क्षय रोगी माने जाते हैं। मरीज को दो बार बालगम लेकर उसकी जांच की जाती है जिससे कि बीमारी का सही तरीके से पता चल सके। यदि मरीज को जांच के बाद क्षय रोग (टी.बी.) पाई जाती है तो टी.बी. को दवाइयों मुक्त में उपलब्ध कराई जाती है। टी.बी. के मरीज को दवाइयों 6 से 9 महीनों तक चलनी है। प्रारंभ के 2 महीनों तक मरीज को डाट्स सेंटर प्रति सप्ताह, बुधवार और शुक्रवार को आकर दवाई खानी होती है। फलसोअप रोगियों को सप्ताह में एक बार दवा खाने आना पड़ता है। दो मास दवा की घर के लिए दी जाती है। दवा की एक भी मात्रा का भाग रोगी को नुकसान पहुंचा सकता है। दवाइयों प्रशिक्षित एवं योग्य स्वास्थ्य कर्मियों की देख रक्ष में डिस्पेंसरी दी जाती है। 2 महीने के बाद मरीज को घर के लिए एक एक हफ्ते की दवाई दी जाती है। उपचार की अधि में बालगम एवं एक्स रे परीक्षण द्वारा रोगी को ठीक होने की स्थिति का पता लगाया जाता है। दवाइयों का पूरा कोर्स कर लेने के बाद टी.बी. पूर्ण रूप से ठीक हो जाती है और अब एक स्वस्थ एवं सामान्य जीवन व्यतीत कर सकते हैं। दवाइयों लेने के दौरान आप अपनी दैनिक दिनचर्या को जारी रख सकते हैं। यदि दवाएं खाने समय आपकी कोई स्वास्थ्य सम्बंधित परेशानी हो रही है तो अपने क्षय रोग चिकित्सक से परामर्श के बिना कोई दवाई न लें। खाने में कोई परिवर्तन नहीं है। संतुलित भोजन लाभप्रद है। दूध व दूध के पदार्थ, हरी सब्जी, फल-सब्जी, पपीता, अनार, मौसमी, अमरूत, आम, दाल-सूत व अरहर, टमाटर, राजन इत्यादि खाने की वस्तुओं का इस्तेमाल करें। यदि आपको निम्न में से कोई परेशानी हो तो अपने चिकित्सक से तुरन्त सम्पर्क करें। दो हफ्ते/सप्ताह या उससे अधिक खांसी है। यदि खांसी समय खून आ रहा है। यदि आपका दम फूल रहा है या सोने में दर्द है। आपका बजन लगातार कम हो रहा है। अगर आपको रोग शंभय को बुझा आता है।
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Fig. 5: Health education boards



Fig. 6: Health education through booklet/leaflet



Figs 7A and B: (A) Thick OPD files; and (B) hard envelopes

bag or file, unfolded (especially X-rays, CT, MRI, etc.) in proper safe place away from the reach of small children and properly arranged in one place, which reduces inconvenience to the doctor and allow him to understand the disease early. The awareness was spread among the patients who were not aware of the proper method of health records storage.

CONCLUSION

With the sustained and regular health education/motivation, the patients realized the importance of record keeping. It also improved the proper diagnosis, management, and prognosis of the case. On postcounseling, there was marked improvement in data storage.

This study has shown that the documentation of the patients suffering from respiratory diseases can be improved by the health education activities on this aspect. These findings can also be utilized in other medical specialties, such as orthopedics, pediatrics, medicine, surgery, etc.

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