

NAMIBIA UNIVERSITY

OF SCIENCE AND TECHNOLOGY

FACULTY OF HEALTH AND APPLIED SCIENCES

DEPARTMENT OF HEALTH SCIENCES

QUALIFICATION: BACHELOR OF HEALTH INFORMATION SYSTEMS MANAGEMENT		
QUALIFICATION CODE: 07BHIS	LEVEL: 6	
COURSE CODE: HIM621S	COURSE NAME: HEALTH INFORMATION MANAGEMENT	
SESSION: NOVEMBER 2019	PAPER: THEORY	
DURATION: 3 HOURS	MARKS: 100	

	FIRST OPPORTUNITY EXAMINATION QUESTION PAPER
EXAMINER	MS ROSWITHA MAHALIE
MODERATOR	MR ERWIN NAKAFINGO

INSTRUCTIONS	
 Answer ALL the questions. 	
Write clearly and neatly.	
3. Number the answers clearly.	

PERMISSIBLE MATERIALS

None

THIS QUESTION PAPER CONSISTS OF 4 PAGES

(Including this front page)

SECTION A [55]

QUES	TION 1		[20]
1.1	Define 1.1.1 1.1.2 1.1.3 1.1.4	the following terms Rule-out Indicator Data quality Patient account number	(10) (3) (2) (2) (3)
1.2	Indicat 1.2.1 1.2.2	e which of the following statements are TRUE or FALSE. Health information systems are organised collection of people, procedur software, databases and anecdotes used to provide routine information. In the HIM professional Care Model focus on information analysis,	
	1.2.3 1.2.4	transformation and clinical decision support plays a less significant role. The smallest unit of data that is collected is referred to as a data field A record also refers to all of the data collected about a patient's visit or a of the patient's visits.	ıII
	1.2.5	Information is recorded on an admission or registration record, also referred to as a face sheet in paper-based systems forms part of medical data.	
	1.2.6	Information documented in a complete physical examination for the musculoskeletal system should include the following: coordination, reflexes, biceps, triceps, patellar, achilles, abdominal, gait, sensory.	
	1.2.7	Documents the patient's current complaints and symptoms lists his or her past medical, personal, and family history should be included during physical history taking.	
	1.2.8	The traditional model of practice is department focused and most appropriate for today's information-intensive and automated healthcare environment.	
	1.2.9 1.2.10	A record is a combination of different types of data. The Patient's discharge summary is a classical example of one of the type of clinical data that are documented in the patient's admission health record.	es
QUES	STION 2	2	[15]
2.1	Explain proper	to a first year HISM student why it is important to manage health record ly.	s (7)
2.2	A data quality audit is a process of verifying the quality of reported aggregate data Discuss the generic objectives of a data quality audit to the M&E officers at Tuwilika Consultancy.		

QUESTION 3 [20]

3.1 You have been working and funding a community program for 2 years in Outjo. You would like to hold a meeting to collect data from the community on what changes have occurred due the program interventions- you announce that there is a mandatory meeting for the community on a certain Sunday, and that anyone who has been receiving program assistance has to be there- is there an ethical concern here? If yes or no, justify your response. (6)

3.2 Discuss ways to help ensure that your organizational data meet recognized ethical requirements. (14)

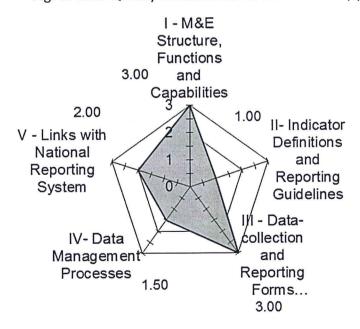
SECTION B [20]

QUESTION 4 [20]

4.1 Windhoek Central Hospital is a public hospital in Windhoek, Namibia. Getting the right data to the right audience for decision making remains a daunting task. Following your educational excursion to the Windhoek Central Hospital Complex, describe at least nine (9) data quality issues mentioned by Sr Thomas at the HIS office.

Interpret and summarize your findings from the spider graph depicted below in one paragraph. This information will be added to the quarterly district report of Rondo clinic (minimum of 60 words).

Fig. 1: Data Quality Assessment for Rondo clinic (spider graph)



SECTION C [25]

QUESTION 5 [25]

5.1 Describe the criteria you will use when assessing the quality of your data in any health care organisation. (15)

5.2 Mr Ebenhardt is admitted and prepared for a Trans-Urethral Resection (TUR) at the Windhoek Central hospital on the 25th of July 2019 at 14h00 by Sr Malaika. Sr Malaika documented the following information in the patient admission file i.e. BP 134/95; Pulse 72bpm; Respiration 18bpm; Saturation 85%. Propose guidelines (with examples) on the medical decision-making process to be used by health care workers to assess the patient post-operatively. (10)

TOTAL MARKS = 100