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Limiting Factors on the Effective and Efficient Management of Health Records in General Hospital Eket

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Abstract

Effective management of health records is essential for ensuring quality patient care, efficient healthcare delivery, and compliance with regulatory requirements. However, many healthcare facilities, including Eket General Hospital, face constraints and limitations in effectively managing health records. This study explored the challenges and barriers to effective and efficient management of health records in Eket General Hospital which staff strength is more than 200 and only 100 was considered for this survey. This study is based on a review of existing literature on the challenges associated with effective and efficient management of health records in healthcare facilities. A physical survey of about 86 participating staff was also conducted using a questionnaire to gather information from the healthcare professionals working in Eket general hospital**.** The findings from this study indicated several limiting factors on the effective and efficient management of health records in Eket General Hospital. These included inadequate infrastructure and resources, lack of trained staff, poor record-keeping practices, and limited access to technology. Inadequate infrastructure, such as outdated record-keeping systems and limited storage space, hindered the efficient management of health records. The lack of trained staff in health information management leads to errors in record-keeping and data entry, compromising the quality and accuracy of health records. Poor record-keeping practices, such as incomplete or illegible documentation, further exacerbate the challenges in managing health records. Additionally, limited access to technology, such as electronic health record systems, restricts the hospital's ability to digitize and streamline health record management processes. The effective management of health records in Eket General Hospital is constrained by various factors, including inadequate infrastructure, lack of trained staff, poor record-keeping practices, and limited access to technology. Addressing these problems is crucial for improving the quality of patient care, enhancing healthcare delivery, and ensuring compliance with regulatory requirements. Further research is needed to explore potential solutions and interventions to overcome these challenges and enhance the management of health records in Eket General Hospital.

Keywords: Health records, Effective and efficient management, Patient care, Limiting factors, Lack of trained Staff.

1 | Introduction

Records management is the systematic control of an organisation's records, throughout their life cycle, in order to meet operational business needs, statutory and fiscal requirements, and community expectations [1]. The objectives of records management include cost reduction, improved productivity by quick access to needed records, enhanced litigation avoidance and support, increased audit compliance [2]. Effective

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management of corporate information allows fast, accurate and reliable access to records, ensuring the timely destruction of redundant information and the effort of archivists in Africa and other developing countries in the world to make sure that the digital information is preserved since "continuously change in software and hardware creates headache for staff working on digital longevity" [3]. Records management which is defined as the unit of the organization assigned with the function of managing records in order to ensure that the organization is able to comply with business operational needs, meet community needs and properly account to the citizens [4]. The health records in most Nigerian health institutions especially in hospitals has been facing some numbers of problems and challenges; which has affected the accessibility and utilization of health information in the treatment of people that have health challenges in those hospitals, as information needed on each patient is not being accessed on time or is not even available for immediate use [5]. The basic challenge being faced by hospital authorities in preservation and management of records in most developing countries include; Use of outdated forms; Need of constant revision; Shortage of experienced personnel; Need of trained personnel; inadequate planning in storage of inactive records; Need of effective storage and control of in-active records; Shortage of determination of records retention period; Need of determination of records retention period [6], [7].

The unwanted records should be destroyed to save the time and resources; also, delay in transfer of records: transfer of record entail two stages i.e. dating of unimportant records for destructions and ultimate disposal and moving the records from active to in-active files and from there to the storage area. [8]. A very germane issue facing the longevity of digital collections in developing countries is not only the storage media deterioration, but the problem of rapidly changing storage devices. Unlike analogue information which places emphasis on the preservation of physical artefacts, it is the informational contents of the digitized material that is preserved [9]. Sub-standard documentation of patient's record is associated with prolonged hospital stay of the patients and increased patient mortality. Thus, poor record-keeping practices amongst medical personnel leads to breakdown in communication amongst health care professionals. Poor record-keeping does not put the patient at the centre of care but increases medico-legal risks and hinders tracking of clinical care decisions and care goals [10], [11].

Despite numerous efforts by health managers to improve record-keeping, inadequate recording remains a global challenge in public hospitals which is frequently reported in research findings of many medical researchers. There are many factors ranging from personnel shortage and negative attitude of record officers towards recording; who perceive that they spend much time on manual recording, leading to incomplete recording and so the requirement for more staff. Health personnel are not recording or having incomplete recording because of work overload and most encounter major barriers to documentation owing to mismatches between staffing resources and workload [12]. The study further indicates that when staff experience extra workload, this predisposes them to decreased morale and inadequate work practices, including poor recording practices, which puts pressure on the quality of care rendered to patients [13], [14]. agrees with the study findings outlining that personnel find it difficult to cope with the increased workload associated with documenting patient information on the multiple records that are utilised at health facilities, leading to incomplete information documented on patient records. These authors recommend that the number of personnel at facilities should be increased to reduce the increased workload.

2|Importance of Record Management Practice

Information is every organisation's most fundamental and necessary advantage, and in familiar with any other business asset, recorded information demands effective management. Records management ensures information can be accessed easily, can be destroyed routinely when no longer needed, and enables organisations not only to function on a day to day basis, but also to fulfil legal and financial requirements (Shepherd and Yeo, 2003). The safeguarding of the records of government for instance ensures it can be held accountable for its actions, that society can trace the evolution of policy in historical terms, and allows access to an important resource for future decision making. Organisations are also producing increasingly large amounts of information and consequently greater volumes of records, in both paper and electronic form [15].

It is essential that information is captured, managed and preserved in an organised system that maintains its integrity and authenticity. Records management facilitates control over the volume of records produced through the use of disposal schedules, which detail the time period for which different types of record should be retained by an organisation [16]. In effect, Health Record of a patient is the clinical representation of the patient that is created over a stage of moment by various clinicians with the consent, trust, privacy and confidence of the patient. It enables continuity of care and again, overtime, it becomes a comprehensive, clinical database from which various and salient clinical information is gathered through research. Moreover Health Records serve many functions but their primary purpose is to support patient care.

3|Limiting Factors of Proper Health Records

The sensitivity of Health Records presents many challenges for corporate governance. Common issues include storage, access, safety and security. Storage problems occur in hospitals that use manual Health Record systems. Access to Health Records is another challenge facing users and administrators. Sometimes there is conflict on the ownership and the right of access to a patient record [5]. The safety and security of Health Records is a challenge to personnel in-charge of patient records. Nicholson [17] revealed that there were numerous instances where case notes were not kept in secure conditions. In a number of examples cited by Nicholson, it would have been easy for unauthorized persons to have had access to case notes either from open libraries or from other uncontrolled areas. Case notes, for instance, were found unattended to in out-patient clinics and were sometimes left in clinic areas overnight because the Health Records department had closed. The scholar stressed that all users of case notes (doctors, nurses, medical secretaries, ward clerks, Health Records staff and others) should be aware of the importance of security. Nicholson [17] further provided that, unattended computer terminals, particularly if left logged on, are another risk as are fax machines and inadequately protected and controlled computer networks The challenges of managing Health Records are closely linked to the abuse of patient information. When Health Records are not properly managed, without proper security measures, they can be misused, which can lead to possible violations of privacy and confidentiality of Health Records [18].

In Nigerian healthcare sector, many reasons can be adduced why some hospitals (private or public) do engage the services of quacks. The following may subsist:

I. Ignorance: cases abound where some hospital proprietors particularly in the private sector ignorantly engage the services of quacks to perform health information services. And some take advantage of enforcement regulatory body which obviously lack determination to ensure compliance with standards [19].

II. Cost incentive: the private sector can hardly (mainly for economic reasons) afford to engage professional health information officers; they thus ultimately seek out a much cheaper alternative. Health information services rendered by unqualified persons are unusually below standard of practice for a much lower cost [20].

III. Funding: insufficient funding often time promotes quackery. Typically, the management of a health facility may be constrained with insufficient fund. In such situation, the health facility may not even have health information department let alone qualified health information officer [21].

IV. Unemployment: in this part of the world, with over dependency on oil which price is dwindling, the level of unemployment thus seems to be on the increase. Therefore applicants are so desperate to take up job without requisite for any amount.

V. Attitude: there have been immense improvement in the practice of health information and medicine in general. It is bewildering of course, to note that some hospital owners in recent years have shown the tendency towards smugness in engaging unqualified hands [22].

Most tends to work significantly for self and economic interest much more than for common good of the patients. Such unfortunate tendencies aid quackery and often make a caricature of the health information management profession.

4 | Research Design

This study adopts a descriptive research design. This type of research describes what exists and may help to uncover new facts and meaning. The purpose of descriptive research is to observe, describe and document aspects of a situation as it naturally occurs. In survey design, the researcher selects a sample of respondents and administers a questionnaire to collect information on variable of interest. A descriptive research is concerned with conditions, practices, structures, differences or relationships that exist, opinions held, processes that are going on or trends that are evident [23]. This comprises also the collection of data that will provide an account or description of individuals, groups or situations. Instruments we use to obtain data in descriptive studies include questionnaires, interviews (closed questions), and observation.

Survey research includes gathering quantitative and/or qualitative data from participants typically using a questionnaire or interview. A questionnaire could be delivered via mail, face to face or online. By using carefully controlled sampling procedures, it is assumed that samples responses to the survey will be representative of the target populations' likely responses. The survey was designed to gather information on the current practices and challenges related to the management of health records in General Hospital Eket. The questionnaire will be divided into sections to cover various aspects of health record management, including record keeping practices, access to health records, data security, and staff training. The questions will be designed to elicit detailed responses from participants to provide a comprehensive understanding of the problems faced by the hospital in managing health records.

4.1 | Population of the Study

In this study, the target population was 86 employees on permanent, contract and temporary terms at the Eket General Hospital, Eket, Akwa Ibom State. A high percentage of the population of the organization would need to be familiar with both the paper and electronic method of records as they were users.

4.2 | Response Rate

The study target was 120 respondents but only 86 filled and returned the questionnaires, resulting in a response rate of 71.7%. This response rate was satisfactory and representative to make conclusions for the study. According to [24], a response rate of 50% is adequate for analysis and reporting; a 60% is good and a 70% and above is excellent. Based on this, the response rate was excellent.

4.3 | Sample and Sampling Technique

The survey targeted healthcare professionals working in General Hospital Eket who are directly involved in the management of health records. A random sampling method was used to select participants from different departments within the hospital, including medical records, nursing, and administration. The sample size was determined based on the number of healthcare professionals involved in health record management in the hospital. This technique gives all the subjects an equal chance and reduces bias and errors. This was achieved using a web based random number generator.

4.4 | Instrumentation

The data collection tools applied in this research include; questionnaires, interviews and observations. Questionnaires are commonly used to obtain important information about the population with emphasis put on the need for each question in the questionnaire to address a specific objective of the research question or hypothesis of the study.

4.5 | Method of Data Analysis

The responses from the questionnaire were analyzed using qualitative research methods to identify key issues and challenges faced by the hospital in managing health records. The data were coded and categorized to

identify common themes and patterns. The findings were presented in a descriptive form and were statistically presented in percentage and pie chart statistical tool.

Tables 1 and *2* are the questionnaire based survey of Staff formulated to investigate the limiting factors affecting effective and efficient management of health records at Eket General Hospital.

Table 1. What are the limiting factors against effective and proper handling of health records?

S/N	Questions	Options
1	Are there available health records in all the departments of the selected medical centre?	Yes No
2	If the answer to question one is yes, since when?	1990-2000 2001-till date No idea
3	What is the level of effectiveness of health records management practices in the selected medical centre?	High Moderate Low
4	What are the constraints faced by the health record officers in the effective management of health records at the Eket General Hospital?	Insufficient fund Practical skills Computer literacy Insufficient technological setups

Table 2. What are the major solutions to the possible threats affecting effective and efficient management of Health Records at the general hospital Eket?

S/N	Questions	Options
5	Does the General Hospital Eket have facilities for storage of health records in all the departments?	Yes No No idea
6	Does shortage of storage facilities in all the departments at the General Hospital Eket affect the management of health information?	Yes No No idea
7	Does the General Hospital Eket have health information staff with job experience?	Yes No
8	Does the experience and training they have enable them perform their job efficiently?	Yes No No idea

5 | Analysis of Findings

This section brings in the presentation of the findings obtained and their interpretation. It presents the results obtained from the questionnaire designed for 86 staff respondents who submitted the questionnaire that is used to examine the effective and efficient management of health record practice at the Eket General Hospital. Results obtained from the questionnaire is presented in *Fig.s. 2. to 9*.

Table 3. Target population (some staff of Eket General Hospital).

Category	No. of staff	Sample size
Doctors	26	20
Health records	20	17
Nurses	34	24
Pharmacists	14	8
Lab technologists	16	11
Administrative staff	10	6
Total	120	86

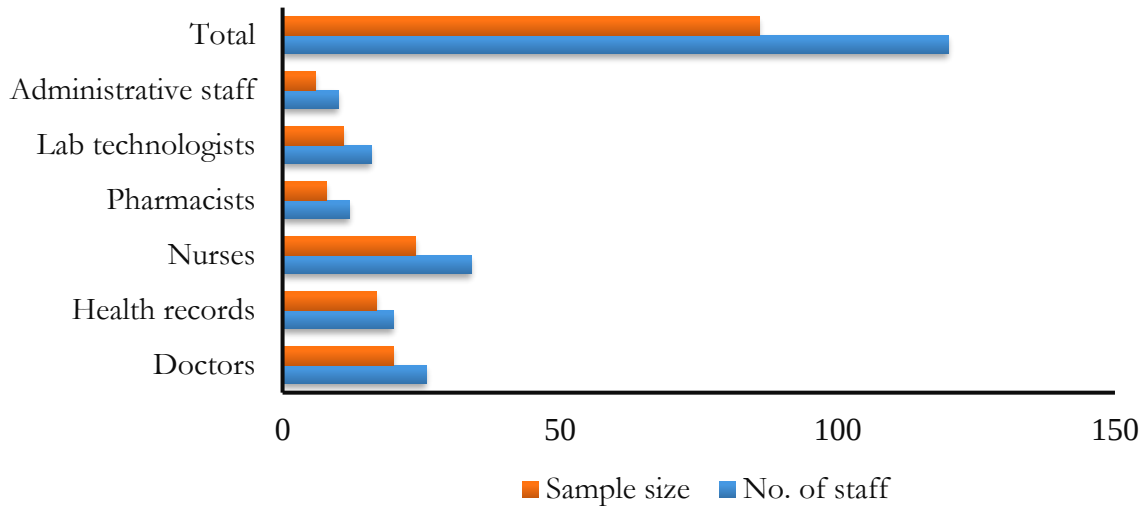

Fig. 1. Chart of the target population (some staff of Eket General Hospital).

Table 3. The constraints militating against effective and proper handling of health records.

S/N	Questions	Options	Percentage of Respondents
1	Are there available health records in all the departments of the selected medical Centre?	Yes	75%
		No	25%
2	If the answer to question one is yes, since when?	1990-2000	40%
		2001-till date	50%
		No idea	10%
3	What is the level of effectiveness of health records management practices in the selected medical centre?	High	66%
		Moderate	23%
		Low	11%
4	What are the constraints faced by the health record officers in the effective management of health records at the Eket General Hospital?	Insufficient fund	30%
		Practical Skills	25%
		Computer literacy	25%
		Insufficient technological setups	20%

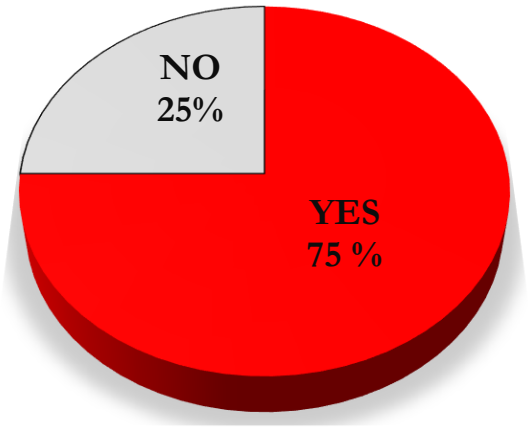

Fig. 2. Availability of health records in all the departments.

Health records plays a crucial role in the provision of quality healthcare services. The availability or non-availability of these records in medical centers can have significant effects on patient care, treatment outcomes, and overall healthcare delivery. As shown in *Fig. 2*, question 1 indicates the availability of health records in all the departments at the General Hospital Eket and that the majority of the respondents were of a positive view that actually there are available health records at the medical centre. From the questionnaire, 75% of the respondents were of the opinion that there are available health records at the hospital while 25%

of the respondents responded negatively. From further investigation, it was discovered that the majority of the 25% were newly recruited staff who just got employed into the hospital or those on Government transfers to the facility, while those that were positive are staff who were long employed at the General Hospital Eket. It should be noted that when health records are readily available in medical centers, healthcare providers can access important information about a patient's medical history, previous treatments, allergies, and current medications. This information is essential for making informed decisions about a patient's care and treatment plan. Without access to this information, healthcare providers may be forced to rely on incomplete or inaccurate information, which can lead to misdiagnosis, inappropriate treatment, and potential harm to the patient. Furthermore, the availability of health records can improve communication and coordination among healthcare providers. When all members of a patient's care team have access to the same information, they can work together more effectively to provide coordinated and comprehensive care.

This can lead to better treatment outcomes, reduced medical errors, and improved patient satisfaction. On the other hand, the non-availability of health records in medical centers can have serious consequences for patient care. Without access to important information, healthcare providers may be unable to make timely and accurate decisions about a patient's care. This can result in delays in treatment, unnecessary tests and procedures, and increased healthcare costs. In addition, the non-availability of health records can also pose a risk to patient privacy and confidentiality. When records are not securely stored and protected, there is a greater risk of unauthorized access, data breaches, and identity theft. This can erode patient trust in the healthcare system and have long-lasting negative effects on the doctor-patient relationship. The availability of health records in medical centers is essential for providing high-quality healthcare services. It enables healthcare providers to make informed decisions, improve communication and coordination, and ensure patient safety and privacy. Therefore, it is imperative for medical centers to invest in robust health information systems and processes to ensure the availability and security of health records. Failure to do so can have serious consequences for patient care and the overall quality of healthcare delivery.

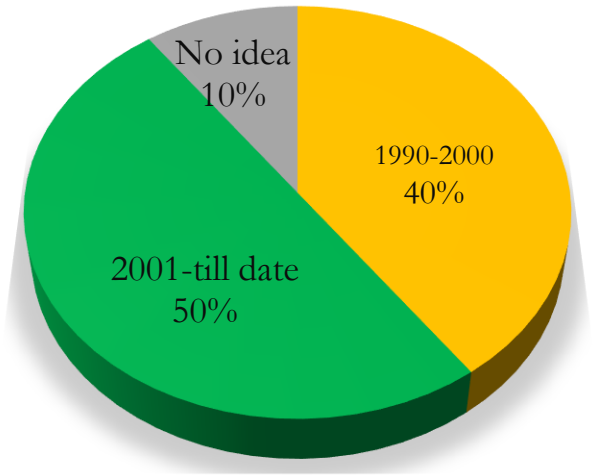

Fig. 3. Duration of availability of health records in all the departments.

Question 2 was designed to determine the duration of availability of health records in all the departments of the hospital. As seen in the questionnaire, question 2 has a direct relationship with question 1. But it should be on note that the duration or period of availability of health records in healthcare facilities can have significant effects on patient care, efficiency of healthcare delivery, and overall healthcare outcomes. This question explores the effects of longer and shorter durations of availability of health records in every department in Eket General Hospital. The chart in *Fig. 3* is to determine the time frames and durations of availability of the records in every department of the hospital. It should also be noted that about 40% of the respondents of this survey confirmed the availability of health records in every department since around 1990 to date while about 50% of them were positive that the records has been an ever present since around the year 2000 to date. In question 1 of this survey, about 25 % of the surveyed respondents were of the opinion that records are unavailable in every department of the hospital but and about a few of those respondents

(10% precisely) had no idea when the records became available in every department. But a longer duration of availability of health records in Eket General Hospital can have several positive effects.

I. It allows healthcare providers to have access to comprehensive and up-to-date information about patients, which can lead to more accurate diagnosis and treatment plans. This can ultimately result in improved patient outcomes and satisfaction.

II. Having access to historical health records can help healthcare providers identify trends and patterns in a patient's health, which can inform future treatment decisions.

III. The benefits of having health records available for longer period are highlighted as follows:

IV. Continuity of care: When health records are accessible over an extended period, healthcare providers can track a patient's medical history, treatment plans, and progress over time. This continuity of care allows for better coordination of services, more accurate diagnosis, and improved treatment outcomes. In contrast, shorter durations of availability can lead to gaps in information, which may result in delays in treatment or even medical errors.

V. Improves patient engagement and empowerment: Patients who have access to their health records can actively participate in their care decisions, monitor their progress, and take ownership of their health. This can lead to better health outcomes, increased patient satisfaction, and improved adherence to treatment plans. On the other hand, shorter durations of availability may limit patients' access to their own health information, which can hinder their ability to actively participate in their care.

VI. It benefits healthcare providers and the healthcare system as a whole: Having access to comprehensive health records allows providers to make more informed decisions, reduce duplication of tests and procedures, and improve overall efficiency. This can lead to cost savings, better resource allocation, and ultimately, improved quality of care. In contrast, shorter durations of availability may result in fragmented information, which can impede providers' ability to deliver timely and effective care.

On the other hand, shorter or moderate durations of availability of health records may have negative impact on patient care and treatment outcomes such as incomplete medical history of the patient. Therefore, it is crucial for healthcare institutions to prioritize the maintenance of health records for longer periods to maximize the benefits for both patients and providers. Without access to complete and accurate health records, healthcare providers may be more likely to make errors in diagnosis and treatment. This can lead to unnecessary tests, treatments, and potentially harmful outcomes for patients. The duration of availability of health records in Eket General Hospital can have significant effects on patient care and healthcare outcomes. A longer duration of availability can lead to improved patient outcomes and satisfaction, while a shorter duration can result in errors in diagnosis and treatment. It is essential for healthcare facilities to prioritize the maintenance and accessibility of health records to ensure the delivery of high-quality healthcare services.

The assessment in question 3 was to determine the level of effectiveness of health record management practices and its significant impact on the overall quality of care provided to patients. As shown in *Fig. 4*, 66% of the respondents of the surveyed data were of the opinion that the level of effectiveness of health records management practiced in the selected medical centre is very competitive while a moderate respondent of 23% and low respondent of 11% were of contrary opinions. This analysis further confirms that at a high level of effectiveness, health record management practices are characterized by efficient and accurate documentation of patient information. This includes timely recording of patient data, proper organization of records, and secure storage of sensitive information. High levels of effectiveness in health record management can lead to improved patient outcomes, as healthcare providers have access to comprehensive and up-to-date information about their patients.

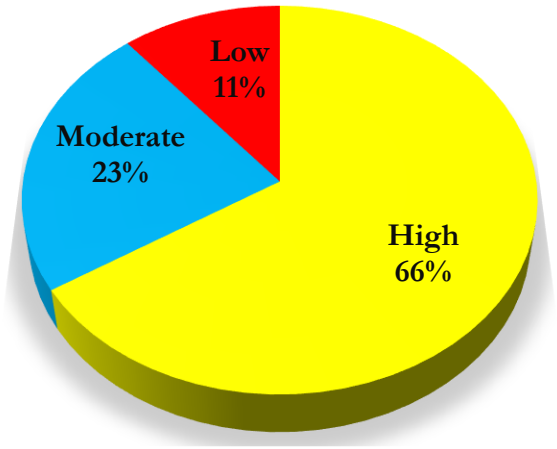

Fig. 4. Effectiveness level of health records management practices.

On the other hand, moderate levels of effectiveness in health record management may result in some inefficiencies and errors in documentation. This can lead to delays in accessing patient information, duplication of tests and procedures, and potential risks to patient safety. While moderate levels of effectiveness may not have as severe consequences as low levels, they can still impact the quality of care provided to patients. At a low level of effectiveness, health record management practices are characterized by disorganization, incomplete documentation, and inadequate of security measures. This can have serious implications for patient care, as healthcare providers may not have access to critical information when making treatment decisions. In addition, poor health record management practices can also lead to legal and regulatory issues, as patient confidentiality may be compromised. The effectiveness of health record management practices in a medical center is crucial for ensuring high-quality patient care. High levels of effectiveness can lead to improved patient outcomes, while moderate and low levels can result in inefficiencies, errors, and potential risks to patient safety. It is essential for healthcare organizations to prioritize and invest in effective health record management practices to ensure the delivery of safe and high-quality care to patients.

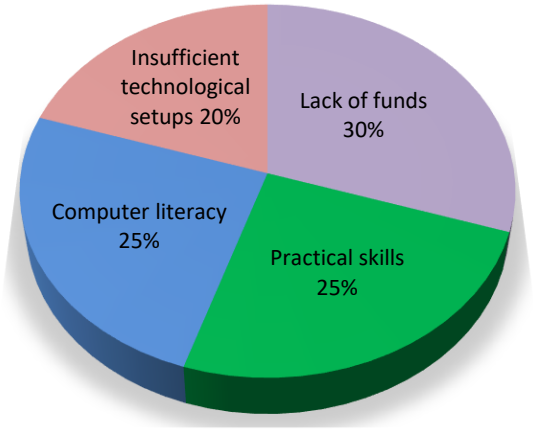

Fig. 5. Challenges faced by the health record officers in effective management.

Question 4 from the questionnaire was designed to determine the challenges faced by the health record officers in effective management of health records. It was observed that their role in the effective management of health records within healthcare facilities are very significant. However, they face a number of challenges that hinder their ability to perform their duties efficiently. Some of the key challenges include insufficient funds, practical skills, computer literacy, and insufficient technological setup. In this survey, as shown in *Fig. 5*, some respondents highlighted the problems encountered while carrying out their roles as health record officers. A simple majority of 30% stated insufficient funds as a major challenge while 25% of the respondents went for practical skills. Another 25% went for computer literacy and 20% others were of the opinion that insufficient technological set up is the main challenge. However, one of the main challenges faced by health record officers is the insufficient funds allocated for the effective management of health records. Without

adequate financial resources, health record officers may struggle to implement and maintain electronic health record systems, purchase necessary equipment and software, and provide training for staff. This can result in inefficiencies in record-keeping processes, leading to errors, delays, and potential risks to patient safety. Another challenge is the shortage of practical skills among health record officers. Many health record officers may not have the necessary training or expertise to effectively manage health records in a digital environment. This can result in difficulties in accurately documenting patient information, maintaining data integrity, and ensuring compliance with regulatory requirements. Without the proper skills, health record officers may struggle to perform their duties effectively, leading to potential issues with patient care and organizational efficiency. In addition, computer literacy is a significant challenge for health record officers.

Table 3. Solutions to the possible threats affecting the effective management of Health Records at the general hospital Eket.

S/N	Questions	Options	Percentage of Respondents
5	Does the General Hospital Eket have facilities for storage of health records in all the departments?	Yes	65%
		No	23%
		No idea	12%
6	Does shortage of storage facilities in all the departments at the General Hospital Eket affect the management of health information?	Yes	60%
		No	30%
		No idea	10%
7	Does the General Hospital Eket have health information staff with job experience?	Yes	79%
		No	21%
8	Does the experience and training they have enable them perform their job efficiently?	Yes	69%
		No	21%
		No idea	10%

As healthcare facilities increasingly transition to electronic health record systems, health record officers must be proficient in using computers and software applications to manage and retrieve patient information. Many health record officers don't not have the necessary computer skills to navigate complex electronic health record systems, leading to inefficiencies in record-keeping processes and potential errors in patient documentation. Furthermore, insufficient technological setup can pose a challenge for health record officers in managing health records effectively. Without access to reliable hardware, software, and internet connectivity and constant power supply, health record officers may struggle to perform their duties efficiently. This can result in delays in accessing patient information, difficulties in updating records in real-time, and potential risks to patient safety. Inadequate technological setup can hinder the ability of health record officers to maintain accurate and up-to-date health records, leading to potential issues with patient care and organizational compliance. Health record officers face a number of challenges in effectively managing health records, including inadequate funding, practical skills, computer literacy, and insufficient technological setup. Addressing these challenges is essential to ensure the accurate and timely management of health records, which is critical for providing high-quality patient care and maintaining organizational efficiency. Healthcare facilities must invest in the training, resources, and infrastructure needed to support health record officers in their important role in managing health records.

The availability and non-availability of facilities for storage of health records have significant effects on the healthcare system *Fig. 6*. Proper storage facilities ensures that patient records are secure, easily accessible, and well-maintained. On the other hand, the shortage of adequate storage facilities can lead to lost or damaged records, which can have serious consequences for patient care and the overall efficiency of healthcare delivery. From our findings in *Fig. 6*, states the level of storage facilities available in each department as 65% of the respondents were of the opinion that all the departments have storage facilities while 23% were indifferent and 12% had no idea whether all the departments have storage facilities for storage of health records. One of the key effects of having proper storage facilities for health records is improved patient care. When records are stored securely and are easily accessible, healthcare providers can quickly access important information about a patient's medical history, medications, and treatment plans.

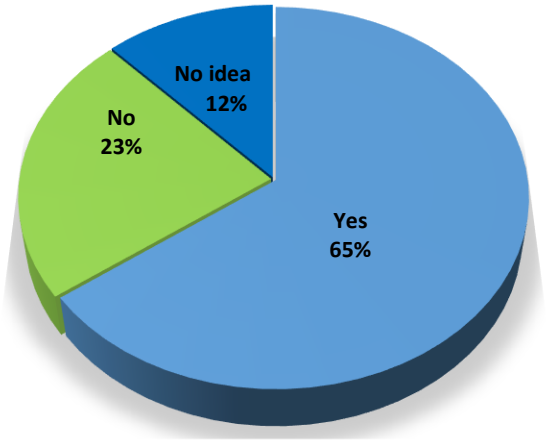

Fig. 6. Storage facilities for health records.

This allows for more efficient and effective care, as providers can make informed decisions based on accurate and up-to-date information. Additionally, proper storage facilities help to ensure the privacy and confidentiality of patient records. By storing records in a secure and controlled environment, healthcare organizations can protect sensitive patient information from unauthorized access or breaches.

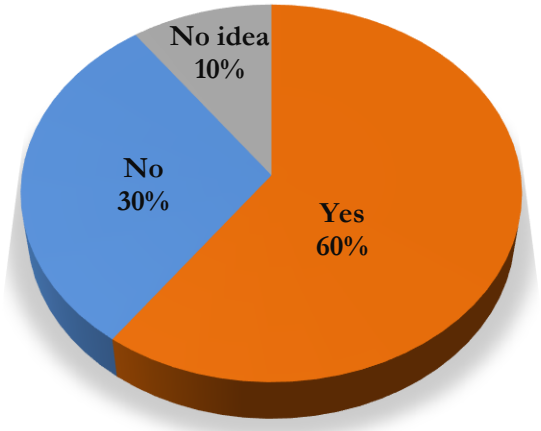

Fig. 7. Effect of inadequate storage facilities in all the departments.

As shown in *Fig. 7*, feedback from respondents revealed the effect of inadequate storage facilities in all the departments of the selected medical centre. The non-availability of adequate storage facilities can have detrimental effects on patient care and the healthcare system as a whole. Without proper storage facilities, health records may be lost, damaged, or misplaced, leading to delays in treatment, errors in medication administration, and overall inefficiencies in healthcare delivery. This can result in compromised patient safety and satisfaction, as well as increased costs for healthcare organizations. As presented in Question 6, feedback obtained from different respondents revealed that over 60% of our respondents in this survey were of a positive opinion that if storage facilities are unavailable in every department of the hospital, management of health information will be as effective as it should be, while 30% of the respondents feels it could be managed if there is a central office where health records are stored, then 10% of the respondents had no idea if storage facilities in every department can help in effective and efficient management of health information.

Conversely, the shortage of proper storage facilities can also hinder the ability of healthcare providers to effectively collaborate and communicate with other members of the care team. When records are not easily accessible, providers may struggle to share important information and coordinate care, leading to fragmented and disjointed treatment plans. The availability and non-availability of facilities for storage of health records in all the departments have significant effects on the healthcare system. Proper storage facilities are essential for ensuring the security, accessibility, and integrity of patient records, ultimately leading to improved patient

care and outcomes. Healthcare organizations must prioritize the implementation of adequate storage facilities to support the delivery of high-quality and efficient healthcare services.

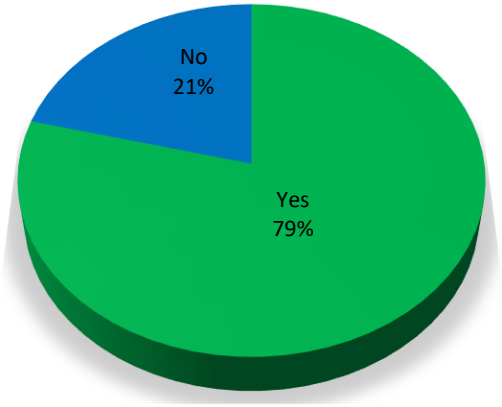

Fig. 8. Health information staff with job experience.

In the healthcare industry, the role of health information staff is crucial in ensuring the accuracy and efficiency of health records and patient information. The level of experience of health information staff can have a significant impact on the overall quality of healthcare services provided in a hospital setting.

In this survey conducted at the Eket General Hospital (see plot in *Fig. 8*), 79% of the respondents were of the opinion that experience is the best teacher and they are they affirm that their health record officers are highly experienced while 21% of the surveyed respondents were negative in their valuation. Conversely, having health information staff with experience in a hospital can lead to several benefits. This indicates that the feedback obtained from the survey do not lack essence and practical background but has an ideal basis considering the years that these workers have spent in their respective field of health record practice. Experienced staff members are familiar with the various systems and processes involved in managing health information, which can lead to increased efficiency and accuracy in maintaining medical records. They are also more likely to have a deeper understanding of medical terminology and coding practices, which can help prevent errors and ensure that patient information is properly documented. An experienced health information staff are better equipped to handle complex cases and situations that may arise in a hospital setting. They are more likely to have developed problem-solving skills and the ability to effectively communicate with other healthcare professionals, which can lead to better coordination of care for patients. On the contrary, having health information staff with no experience can pose challenges for a hospital. Staff members who are new to the field may require additional training and supervision to ensure that they are able to perform their duties effectively.

This can lead to increased costs and potential errors in managing health information, which can have negative consequences for patient care. Additionally, inexperienced staff members may struggle to keep up with the fast-paced and demanding nature of the healthcare industry. They may be more prone to making mistakes or overlooking important details, which can impact the quality of care provided to patients. The experience level of health information staff in a hospital setting can have a significant impact on the overall quality of healthcare services. While having experienced staff members can lead to increased efficiency and accuracy in managing health information, having staff with no experience can pose challenges and potentially compromise patient care. It is important for hospitals to invest in training and development opportunities for their staff to ensure that they are equipped to handle the demands of the healthcare industry.

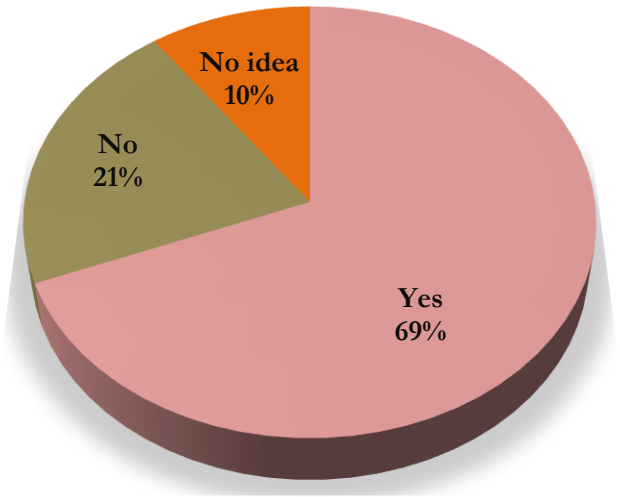

Fig. 9. The level of experience and training for efficient job performance.

In the healthcare industry, the performance of staff members in hospitals very important for providing quality patient care and ensuring the smooth operation of medical facilities. The level of experience and training of hospital staff can significantly impact their work performance, with high, moderate, and low levels of experience and training leading to varying outcomes. As shown in *Fig. 9*, 69% of the respondents revealed that the professional training and experience of the record officers have efficiently and effectively helped them in the performance of their duty over the years while 21% of the respondents were a bit different in their evaluation. Some claiming that the experienced can be gotten as soon as they resume working with the facility. Then, about 10% of the respondents concluded that they don't have any idea if their experiences and trainings counts in effective and efficient service delivery since they are not the doctors that directly treat patients. But it should be noted that staff members with high levels of experience and training are often more proficient in their roles, as they have accumulated knowledge and skills over time. These individuals are likely to be more confident in their abilities, leading to increased efficiency and effectiveness in their work. Additionally, experienced and well-trained staff members are better equipped to handle complex medical cases and emergencies, resulting in improved patient outcomes.

On the other hand, staff members with moderate levels of experience and training may exhibit a mix of strengths and weaknesses in their work performance. While they may possess a solid foundation of knowledge and skills, they may not have the depth of expertise and confidence that comes with years of experience. This can lead to inconsistencies in their performance, with some tasks being completed more effectively than others. Staff members with low levels of experience and training are at a disadvantage when it comes to work performance in the hospital setting. These individuals may struggle to meet the demands of their roles, leading to errors, inefficiencies, and decreased patient satisfaction. Without adequate training and support, staff members with low levels of experience may also be more prone to burnout and turnover, further impacting the overall performance of the hospital. It is essential for hospitals to invest in ongoing training and development opportunities for staff members at all levels to ensure high-quality patient care and optimal performance in the healthcare setting.

6 | Conclusion

It is evident that there are numerous limiting factors that hinder the effective and efficient management of health records in Etinan general hospital. These factors include inadequate funding, shortage of trained personnel, poor infrastructure, and inadequate technology. These limitations have a significant impact on the quality of healthcare services provided to patients, as well as on the overall efficiency and effectiveness of healthcare delivery in Etinan general hospital. Some of the major factors facing the effective and efficient management of health records in Etinan general hospital are as follows:

I. Inadequate funding: The insufficient financial resources makes it difficult for hospital to invest in the necessary infrastructure, technology, and personnel needed to effectively manage health records. This results in a shortage of proper storage facilities, outdated technology, and a shortage of trained personnel, all of which contribute to the poor management of health records.

II. Shortage of trained personnel: Etinan general hospitals do not have enough staff who are trained in health information management. This results in a shortage of expertise in managing health records, leading to errors, inefficiencies, and delays in accessing patient information. Without properly trained personnel, hospitals are unable to maintain accurate and up-to-date health records, which can have serious implications for patient care and safety.

III. Poor infrastructure: Etinan general hospital lacks the necessary infrastructure, such as secure storage facilities, reliable internet connectivity and adequate computer systems, to effectively manage health records. This results in a reliance on paper-based records, which are prone to loss, damage, and theft, leading to inaccuracies and inefficiencies in record-keeping.

IV. Inadequate technology: Etinan general hospital lacks the necessary technology, such as electronic health record systems, to efficiently manage health records. This results in a reliance on manual record-keeping processes, which are time-consuming, error-prone, and inefficient. Without the proper technology, hospitals are unable to securely store, access, and share patient information, leading to delays in care and potential risks to patient safety.

In conclusion, the limiting factors of effective management of health records in Etinan general hospital have a significant impact on the quality of healthcare services provided to patients. In order to address these challenges, it is essential for the hospital to invest in adequate funding, trained personnel, infrastructure and technology to effectively manage health records. By addressing these constraints and limitations, Etinan general hospital can improve the efficiency and effectiveness of healthcare delivery, ultimately leading to better patient outcomes and improved healthcare services.

6.1 | Recommendation

Proper management of health records is crucial for ensuring the delivery of quality healthcare services in Etinan general hospital. However, there are several constraints and limitations that hinder the effective management of health records in these healthcare facility. The following recommendations are suggested on how the constraints and limitations associated with management of health records in Etinan general hospital can be improved. Some of the major constraints facing the proper management of health records in Etinan general hospital includes:

I. Shortage of adequate infrastructure and resources: the hospitals do not have the necessary technology and equipment to properly store and manage health records. This can lead to the loss or misplacement of important patient information, which can have serious implications for patient care. To address this constraint, it is essential for the government to invest in upgrading the infrastructure of Etinan general hospital and provide them with the necessary resources to effectively manage health records.

II. Shortage of trained personnel: etinan general hospital do not have enough staff who are trained in health information management. This can result in errors in the documentation and management of health records, which can compromise the quality of patient care. To address this constraint, it is important for the hospital to invest in training and capacity building for their staff in health information management. This will ensure that health records are properly managed and maintained by competent personnel.

III. Shortage of standardized policies and procedures: without clear guidelines on how health records should be managed, there is a risk of inconsistency and inefficiency in the management of these records. To address this constraint, it is important for the Etinan general hospital to develop and implement standardized policies and procedures for the management of health records. This will help ensure that health records are managed in a systematic and efficient manner, leading to improved patient care.

The proper management of health records is essential for ensuring the delivery of quality healthcare services in Etinan general hospital. To address the constraints and limitations that hinder the effective management of health records in these healthcare facility, it is important for the government to invest in infrastructure and resources, provide training for staff, and develop standardized policies and procedures. By implementing these recommendations, Etinan general hospital, Etinan, can improve the management of health records and ultimately enhance the quality of patient care.

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