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EFFECT OF CLINICAL DOCUMENTATION OF PATIENT CARE IN HOSPITALS IN CALABAR METROPOLIS CROSS RIVER STATE, NIGERIA

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The paper aim at examining the Effect of Clinical Documentation of Patient Care in Hospitals in Calabar Metropolis Cross River State, Nigeria. Survey research design was adopted for the study and 200 questionnaires were administered to health workers in Calabar Metropolis to elicit information for the study. 500 Health workers constitute the population of health workers will be used in the study of which 200 were selected for the study using Simple Random Sample Technique. The study was given first validity by expert in measurement. Furthermore, the data were analysis using Chi-square statistical analysis. In conclusion, the result of the analysis reveal that effective clinical patient document significantly promote patient as shown in hypothesis one, also it was discovered in hypothesis that sufficient clinical patient information significantly influence patient diagnosis and treatment. Finally, it was discovered in hypothesis three that the attitude of health workers significantly influence effective patient documentation in hospitals in Calabar Metropolis. The study recommended among others there should be regular inspection of patient health records/information and monitoring and evaluation in the various units of health record department.

Keywords: Clinical Documentation, Patient Care, Hospitals, Calabar Metropolis, Cross River State, Nigeria

INTRODUCTION

Effective Clinical documentation of patient is an important tool to perform the affair of treatment and prevention and are known as the reflecting mirror of the medical affairs in an institute. Regarding to the importance of registered data in medical record sheets and their application in accelerating the process and correcting treatment and medical and nursing staff performances, depending the patients and hospitals, medical/health organization planning and making proper and fundamental decisions, the clinical records are necessary to be perfect from any aspect.

Documentation of patient is often used to protect the researcher, train medical care staff, general studies and qualitative studies. Patient documentation and dissemination of information, which are used as the foundation of the programming and decision making management in education, research and health, are the most valuable criteria of hospital staff professional assessment. If patient's identifying data are not complete, the sheets may be mistakes with each other. Incomplete registration of data in a medical record will lead to duplication of tests and undergoing further expenses for patients.(Gartee, 2007)

Preparation of the inpatients medical reports in hospitals will help the doctors for planning patient's treatment, and care project in addition to document as records and disease diagnosis. The most important reason of incomplete records is that doctors and surgeons believed that the medical or surgical care required for patients are vital, but documentation of the data concerning to care is not considered as a part of treatment process by them, while the time spent to register and complete the patient's medical records most be considered as part of care process. In teaching hospitals, this problem maybe resulted from lack of supervision of attends on the performance of the assistants and interns.

Good medical care relies on well-trained doctors and nurses and on high quality facilities and equipment. Good medical care also relies on good patient documentation. Without accurate, comprehensive up-to-date and accessible patient case notes, medical personnel may not offer the best treatment or may in fact misdiagnose a condition, which

Can have serious consequences. Associated records, such as X-rays, specimen, drug records and patient registers, Must also be well cared for if the patient is to be protected. Good records care also ensures the hospitals administration runs

Smoothly. Unneeded records are transferred or destroyed regularly, keeping storage areas clear and accessible, and key records can be found quickly, saving time for its and resources, records also provide evidence of the hospitals accountability for its actions and they form a key source of data for medical research, statistical reports and health information systems.

Effective patient documentation enhance quality of health care services, improvement in health care and the timely dissemination of quality health data which is essential for health care provider at every level to achieve optimal result. The need to create and maintain patient documentation on every patient treated in the hospital is as old as medicine itself. In the ancient times health records used to be documented and store as caring on the wall of cares, graven plated, tracing on burnt days, tablet, monograph on the wall of tombs and temple long roll of papyrus as where medical treaties written on parchment rolls. Although these earliest record wee primitive in nature and different from present health record, they served a very good purpose and to record medical achievement for later generations.(Transberg, 2004)

. The medical record is a chronological documents that is primarily used for patient care during hospitalization and is an important element that helps in contributing to good quality careful patient research, training and protect the patient in case of litigation.

Clinical patient documentation is an indispensable tool that is very relevant in effective and efficient in health care services provision and monitoring of hospital services. In Nigeria and other parts of the develop countries, the quality of patient documentation is relevant for clinical health care services. Hospitals in Calabar metropolis, patient documentation is poor and suffered from neglect in the past decades.

However, inadequate funding leads to poor documentation as well as inadequate ICT culture, fear of change, lack of maintenance culture, inadequate infrastructure, ignorance/language barrier, illiteracy level and unfamiliar documentation system. Information is often much uncoordinated due to lack of adequate trained manpower to manned the system as well as lack of uniformity in designing forms.

Furthermore, lack of enough trained staff will also hinder the effect of documentation on patient care in hospitals in Calabar metropolis, because the health record officer must be competent skillful to be able to contribute effectively to enhance quality, efficiency, in health care services provision. Therefore, this study is carried out to find out the effect of clinical documentation on patient care in hospitals in Calabar metropolis.

OBJECTIVE OF THE STUDY

The specific objectives are to:

i. Examine the accuracy of effective patient clinical documentation in promoting patient care
ii. Determine if sufficient information during patient documentation justify the diagnosis, the treatment and end result
iii. Ascertain if attitude of health information management staff affect effective documentation.

HYPOTHESES

i. That accuracy of effective patient documentation does not significantly promote patient care
ii. That Sufficient information during patient documentation does not significantly justify the diagnosis, the treatment and end result of the patient
iii. Attitude of health information management staff does not significantly affect effective patient documentation in the hospital.

LITERATURE REVIEW

Clinical Records Documentation

Clinical Records documentation aimed at collecting from patients by doctors and other paramedical personnel like health records officers and pharmacist etc, when their come to the hospital for treatment. This information is documented and kept in a patient case note. The case note is a folder which contains all information documented about the patient illness and treatment render to the patient in the hospital.(Benjamin ,2017)

The health records that are documented in a patient case note are follows, on the outer cover, the hospital number, surname, first name, middle name, colour code made up of 0 to 9. While the inner paper of the first cover contains

information like surname, first name, number, home address, date of birth, name of next of kin, relationship, sex, marital status, address of next of kin, x- ray number, place of origin, tribe, occupation, religion in the first column.

The second column contains information about hospital history, date attended or admitted, referred by, physician or surgeon, ward clinic, date discharge, autopsy. The third column contains information about diagnosis date, diagnosis in order of principle, complication, associated conditions and code number. The fourth column contains the following information date, operation and code number and lastly hospital charges-per day, cost of all extras, total amount signature of medical officer, salary/wages (if armed forces personnel), brigade number and final case folder prepared by the clinical data are those information about the care rendered to a patient and it is being file according to the date of attendance and order of importance because the less value once are removed from the case folder. Patient health records information (case note) is an instrument for managing health services. It is giving to individual patient at his first contact in the hospital. The health records about patient illness and treatment giving to him/her in the hospital. The importance of having his/her medical records kept for the future references, follow up, employment, defenses, in the face of litigation cannot be under estimated. Efficient health delivery depends on the good system of medical records.

The records must be preserved in a case note. It is essential to day- to –day activities, indeed year to year care of the patient. As a document, the health records are not a repository of information. It is continuous records which act as a means of communication between members of the health team.

Patient health information data is the health tool that is very important for clinician to make their best decision and increase quality in the hospital. This means having access to a single view of the patient records that contains the entire care history, including up to date and validate demographics, diagnosis orders treatments prescription and well as clinician results. The agency further stated that patient health information in health care services pave way for better access and better information which is a key to operational efficiency. It is machinery for prompt health care delivery, communicating with patient and unit in the hospital.

Patient health records or information gives sufficient identification or clinical data, nursing and other diverse professionals details for future clinical reference in the hospital (Afuye, 1998).

Documentation in medical records facilitate diagnosis and treatment, communication pertinent information to the other care givers to ensure patient safety reduce medical errors and serves and important medical-legal function in risks management. Quality of documentation may also reflect the quality of care delivered.

Benjamin, (2017) stated that documentation is a set of documents provided on paper, or online, or on digital or analog media, such as audio tape or CDs. Example are user's guides, white papers, on-line help, quick reference guides. It is becoming less common to see paper (hard-copy) documentation. Documentation is distributed via websites, software products, and other online applications. Professionals educated in this field are termed documented lists. This field changed its name to information science in 1968, but some uses of the term documentation still exists and there have been effort to reintroduce the term documentation as a field of study.

Medical records documentation is required to records patient facts, findings and observation and about veteran's history including past and present illness, examination, tests, treatment and outcomes. The medical records document the care of the patients and it is an important elements contributing to high quality care. An approximately documented medical record can reduce many of the hassles associated with claims processing. Medical records may serve as a legal document to verify the care provided.

Bankole, (1999) Documentation can appear in a variety of forms, the most common being manuals. When you buy a computer products hardware of software, it almost always comes with one or more manuals that describe how to install and operate the product. In addition, many software products include an online version of the documentation that you can display on your screen or product on a printer.

Legal implications of records documentation

The health information begins with the patient though the paper on which it is written belongs to the hospital that initiates it, the information recorded has come from the patient, relates to the patient and is held on behalf of the patient. The information should not be divulged to any person outside those who are ready within the confidence of the patient unless the patient has given his or her permission or unless the information is required to be produced to a court of law to facilitate the administration of justice. The importance of confidentiality is underwritten by law and the penalties entailed by a breach can be severe and facility together with the medical and allied staff would be joined in such suite.

Litigation, negligence, authentication and errors in document: The information required from health information may not be freely given on request. This might happen if it is felt that the request is simply an attempt to dredge for information that might disclose a basis for action which did not prima facie already exist. However, it then necessary for the court to issue subpoena to enforce the production of the information, which must be obeyed otherwise, the person upon whom it has been served is liable to be treated as in contempt of court. Medical negligence is distinctly divided into two; due to incompetence/mere negligence and due to non-maintaining organized patient records. The avoid negligence suit the medical record officer must ensure that the documentation is in commensurate with the care rendered will effect as any deficiencies would indirectly or directly lead to negligence and malpractice. The medical record is therefore the

basic reference document used for medical malpractice/negligence litigation. A well organized, well written records the best defense for the competent health care provider.

Ethical issues relating to documentation: There ought to be clearly defined and understood policy as to the conditions in which and the extent to which information can be released. There should be a written statement from the state to provide the lead health information manager with a day to day guidance. If there is no health record committee this is a matter upon which that committee advise. The professional ethics for health information officers stipulates that he or she should preserve health information and not release health information in his or her custody to unauthorized persons or without the consent of the patient or subpoena from the court. (Brender, 2006).

Impact of Effective records Documentation in Promoting Patient Care in the Hospital

Effective and efficient management of health resources with the intension of achieving organizational objectives and goals measure to enhance accurate documentation of patient health records. Adequate management is an instrument or a tool that will help in creating, capturing, and transferring knowledge and generate value in patient health records services.

Brender, (2006), asserted that avoidance of breach of confidentiality to a third party without patient consent or court order of private information that the patient has learned within the patient physician relationship are remedy of effective records documentation in the hospital.

The agency further reported that medical staff discipline and physician's ethical oath should be taken to maintain patient confidentiality in return for the patient's honesty. In documentation point, confidentiality should be initiated right from documentation point where patient is expected to disclose his/her identification information, patient need to be reassured that information gathered during documentation will be managed with high degree of protection. Also ideal registration or documentation environment should be created to the hospital to ensure full disclosure which will enhance proper diagnosis and appropriate treated. Confidentiality information must only be disclosed consent in exceptional circumstances or when permitted or required by law, example where disclosure is by order of the court on the public interest overrides, the need to keep information confidential (Afuye, 2001).

Transberg, (2004) observed that sound record keeping also plays a role in quality assurance practices. According to the society's outline, writing accurate initial assessments and progress notes improves patient care by requiring medical professionals to think carefully about what they do. Over times, practitioners develop a capacity for self-reflection that's vital to professional develop, maintaining professional skills, and continuing to provide high quality clinical care. Members of a treatment team can also learn from each other, and coordinate their approaches, which also serves to improve the quality of patient care.

Olurm, (1989) maintained that document can be relevant to patient care in the following ways:

- It present the present and past state of the patient health
- Analysis of present illness in terms of diagnosis
- Serves as a source of reference for continuity of care
- Enable the initiation of quick treatment, the reducing length of stay
- Protect from over-prescription, unnecessary repetition if investigation, hence save cost
- Protect from legal action
- Protect from unexpected medical error e.g allergies
- Obtaining birth and death certificate

Challenges facing effective records documentation in the hospital

Nigeria health review (2006) stressed that documentation of effective and efficient health records for health care services provision is challenge by non-availability of accurate up-to-date reliable and sufficient health information which is essential in strengthening health planning and decision making.

The agency further said that poor provision of trained staff affect the documentation of health information for the provision of health care services. The agency added that death or scarcity of complete health information from patient affect the treatment, diagnosis of patient in the hospital.

Documentation of health records is challenge by lack of equipment such as computerized database which would afford the hospital the opportunity to retrieve quality health data for rational decision as well as proper monitoring and evaluation.

Gartee, (2007), reported that poor networking or link with integrated science or national health system network affect documentation of patient in health care services.

Osuhor, (1964), noted that poor health resources in terms of lack of proper management of funds, health equipment affect the documentation of patient health records in the hospital. Other human resources problem includes dichotomy in the distribution of public private services, lack of motivation, health records cabinets and logistics affect effective

documentation of patient health records in the provision of quality health care services.

Also, poor time management in discharge health records duties and responsibilities timely and as when is due are challenges that affects the documentation of patients health records services.

Osuhor, (1964), said lacks of technical skilled personnel to convert technical skills to practical results are factors that hinder effective documentation of patient health information in the hospital.

Afuye, (1998), noted that without a well-supported and secure records management system, loss of patient information are likely to occur thereby leading to trouble in finding files that provide information on patient that have attended before.

Afuye, (1998) also noted that, this affect the ability of the hospital to provide the best health care to patient. He further said that, when information of patient cannot be easily retrieve, the institution is likely to experience loss of patients which contribute to poor result. With poor records management, you usually see significant time wasted in attending to a particular patient.

Accuracy of Effective Patient Documentation in Promoting Patient Care in the Hospital

Accurate and complete data are critical for patient care but are also becoming increasingly important to support quality measurement for pay for performance initiatives. Data used to support clinical care and quality improvement must be comprehensive and as up-to-date as possible. Improved communication between patient and providers will acetates documentation. More and more, physicians, and patient are working together, increasing the exchange of information and sharing the decision-making. The collaborative care model advocates for the patients expertise of his/her own life to compliment the physicians knowledge of diseases when discussing health maintenance. Chronic diseases treatment often involves coordinating shared care with a specialist that could also benefit from information provided by the patient. When physicians incorporate the patient as a partner in clinical decision they help to encourage confidence and promote a healthier lifestyle. (Transberg, (2004).

In a nut shell, medical records should contains sufficient, legible information to demonstrate clearly why the course of treatment was not undertaken, simply put, the records must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course and result of the treatment accurately. At a minimum, the records must include patient histories, subjective complaint, examination results, including, x-rays, objective assessment, treatment plans, reports of consultation and hospitalizations, records of drugs prescribed, dispensed, or administered, and account of the actual treatment rendered, and copies of records or other document obtained from other providers and relied upon by the provider in determining and appropriate treatment for the patient.

Overtime, practitioners develop a capacity for self-reflection that's vital to professional development, maintaining professional skills, and continuing to provide high quality clinical care. Members of a treatment team can also serves to improve the quality of patient care. (Transberg, 2004)

Attitude of Health Information Staff toward Effective Documentation of Patient in the Hospital

Currently, National urban and Health Mission (NUHM) helping towards health care reforms highlight the implementing information as a means of cutting costs and improving efficiency in health care field. The quality of documentation of patient care rendered at health care destination is very important to showcase the growing statue of health in India.

As maintaining the health records is very important, strange and retrieve of information is very for future patient care. In this regards implementation of medical records in hospital is essential. Their perception was that medical records improve timely decision making and patient care due to dispersion of records, multiplicity of form types consuming major and inability to understand doctor's note.

Over the recent years, the quality of documentation in medical records has become an important issue, which is not only to promote better health care but also to reduce health care cost by the government. In some developing countries, when funding began to be based on medical records data, it was found that more attention should be paid to the quality of medical records, and documentation of the original health care data. In many countries some problems facing medical records includes poor medical records documentation, large back backlogs of medical records waiting to be coded, poor coding quality, and poor access to and utilization of morbidity data. To address these problems and improve the quality of data collected and the information generated from these data, quality control measure needs to be implemented.

The use of health records in the health care industry is becoming of standard the intent of initiating documentation system in acute care hospital is to improve efficiency, safety and quality of patient care.

Olurm, (1989), medical and Medicaid are awarded to providers, including hospital, to increase the use of medical records based upon the recovery act.

In other for this initiative to be successful it is important to evaluate factors that affect the use of medical.

In 1980s there was dramatic growth in documentation systems intended to assist health record officers.

METHODOLOGY

Design

The study adopted a survey research design. According to Isangedighi, Joshua Asim and Ekuri (2004), survey research design involves the collection of data to accurately and objectively describe existing phenomena studies that make use of this approach are employed to obtain picture of present condition of a particular phenomenon. Survey research is therefore very useful for opinion and attitude studies for people.

Population of the Study

The population of the study consists of 1500 medical and health worker in the state hospitals in calabar metropolis. The population consisted of health information personnel, nurses, medical laboratory, and doctor, nutritionist, radiography and pharmacist.

Sample Size and Sampling Techniques

The sample for the study consisted of respondents which were randomly selected from the health workers in state hospitals in calabar metropolis. Simple random sampling technique was used and balloting was also adopted to give equal chance to everybody in the sample space to be selected to participate in the investigation.

In view of the above, the health workers were examined accordingly using the simple random sampling in which paper cutting were written “Yes” or “No” for the subjects. At the end, 200 subjects were pulled and used for the study.

Data Collection Instrument

The data collection instrument adopted for the study was a set of questionnaire which consisted of 20 item questions. The questionnaire was divided into two sections. Section A consist of 6 item questions, while section B consists of 14 item questions on the subject matter in the hospital in calabar metropolis which are University of Calabar Teaching Hospital, General hospital and Federal Neuro Psychiatric Hospital calabar, Cross River State. The 200 copies of the questionnaire were personally administered to health workers.

Reliability and Validity of the Instrument

Reliability refers to the degree of consistency that an instrument demonstrates in measuring what it does measure. The reliability of the instrument was tested by the consistency of response, which was evaluated by repeated pilot testing, that is the researcher gave some group of the respondents the questionnaire to complete after two weeks interval the same questionnaire were given again and the score for the questionnaire administered were collected. This method gave the instrument reliability overtime.

Furthermore, the face validity was established by using experts from the department of health information management and the supervisor.

Method of data analysis

The data collected were first presented on a tabular form to show the various question which the data were collected. The analysis of the data was descriptive in nature and was statistically presented in the percentage and chi-square analytical technique was used in the study.

RESULTS AND DISCUSSION

Hypothesis 1

Ho: That the accuracy of effective patient documentation does not significantly promote patient care.

Table 1. Observe (o) and Expected (e) frequency table

Research Item	Yes(o)	(e)	No(o)	(e)	Total
Male	66	(72)	14	(8)	80
Female	114	(108)	6	(12)	120
Total	180	(180)	20	(20)	200

Source: questionnaire

To get the expected frequency
$= \frac{CT \times RT}{GT} = \frac{180 \times 80}{200} = 72$
Therefore to get the 1st hypothesis at 5% level of significance
= (c - r) (r - 1)
(2 - 1) (2 - 1)
(1) (1)= 1df at 0.05 = 3. 84
$X^2 = \frac{\sum (oi - ei)^2}{ei}$
$X^2 = \frac{(66 - 72)^2}{72} + \frac{(14 - 8)^2}{8} + \frac{(114 - 108)^2}{108} + \frac{(6 - 12)^2}{12}$
$\frac{36}{72} + \frac{36}{8} + \frac{36}{108} + \frac{36}{12}$
$X^2 = 0.5 + 4.5 + 0.33 + 3$
X^2 cal. = 8.33

Decision: Therefore, since x^2 cal 8.33 is greater than x^2 tab 3.84, I reject **Ho:** and accept **Hi:** That the accuracy of effective patient documentation significantly promote patient care.

Hypothesis Two

Ho: That sufficient information during patient documentation does not significantly diagnosis, the treatment and end result of a patient.

Table 2. Observed (O) and Expected (E) Frequency Table

Research Item	Yes(o)	(e)	No(o)	(e)	Total
Male	75	(68)	5	(12)	80
Female	95	(102)	25	(18)	120
Total	170	(170)	30	(30)	200

Source: questionnaire

To get the expected frequency
$= \frac{CT \times RT}{GT} = \frac{170 \times 80}{200} = 68$
Therefore, to test the 2nd hypothesis at 5% level of significance
= (c - r) (r - 1)
(2 - 1) (2 - 1)
(1) (1) = 1df at 0.05 = 3. 84
$X^2 = \frac{\sum (oi - ei)^2}{ei}$
$X^2 = \frac{(75 - 68)^2}{68} + \frac{(5 - 12)^2}{12} + \frac{(95 - 102)^2}{102} + \frac{(25 - 18)^2}{18}$
X^2 cal $= \frac{49}{68} + \frac{49}{12} + \frac{49}{102} + \frac{49}{18}$
X^2 cal = 0.72 + 4.08 + 0.48 + 2.72
= 8.

Decision: Therefore, since x^2 cal 8 is greater than x^2 tab 3.84, I reject **Ho:** and accept **Hi:** That sufficient information during patient documentation significantly justify the diagnosis, the treatment and end result of a patient.

Hypothesis Three

Ho: That attitude of health information management staff does not significantly affect effective patient documentation in the hospital.

Table 3. Observed (O) and Expected (E) Frequency Table

Research Item	Yes(o)	(e)	No(o)	(e)	Total
Male	71	(76)	9	(4)	80
Female	119	(114)	1	(6)	120
Total	190	(190)	10	(10)	200

Source questionnaire

To get the expected frequency

$$= \frac{CT \times RT}{GT} = \frac{190 \times 80}{200} = 76$$

Therefore, to test the 3rd hypothesis using 5% level of significance

$= (c - 1)\ (r - 1)$

$(2 - 1)\ (2 - 1)$

(1) (1) 1df at 0.05 = 3.84

$$X^2 = \frac{\sum(oi - ei)^2}{ei}$$

$$X^2 = \frac{(71 - 76)^2}{76} + \frac{(9 - 4)^2}{4} + \frac{(119 - 114)^2}{114} + \frac{(1 - 6)^2}{6}$$

$$X^2 = \frac{25}{76} + \frac{25}{4} + \frac{25}{114} + \frac{25}{6}$$

$X^2 = 0.33 + 6.25 + 0.22 + 4.17$

$= 10.97$

Decision: Therefore, since x^2 cal 10.97 is greater than x^2 tab 3.84, I reject Ho and accept Hi That attitude of health information management staff does not significantly affect effective patient documentation in the hospital.

DISCUSSION OF RESULT

After a careful analysis of the above data, it was agreed that the accuracy of effective patient documentation significantly promote patient care in the state hospitals in calabar metropolis, as approved in hypothesis one. This is in line with Afuye, (1998), affirmed that accurate and complete data are critical for patient care but are also becoming increasingly important to support quality measurement of patient care. Every medical professional and medical practice needs to keep accurate medical records. This is not only vital for the provision of good patient care, but necessary for the protection of the medical practitioner as well. In the past doctors kept medical notes on their patients largely to remind them of their condition the next time the patient visited them. But with clinics now becoming the prevalent form of healthcare, a patient may not see the same doctor on every visit, having accurate records is vital to allow any practitioner to take over the patient's treatment simply by referring to their records.

More so, it was affirmed that sufficient information during patient documentation significantly justify the diagnosis, the treatment and end result of a patient in state hospitals in calabar metropolis as proved in hypothesis two. This is in line with Transberg, (2004), the medical record contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and result, and promote continuity of care among health care providers.

Finally, it was again discovered that attitude of health information management staff affect effective documentation of patient in the hospital as proved in hypothesis three. This is In line with Olurm, (1989), who stressed that health workers attitude and perceived behavior such as wrong spellings, inconsistency affects documentation of patient health information.

CONCLUSION

Patient documentation plays a vital role in strengthening the health care system, planning and budgeting. It is very important to note the documentation of patient care in hospitals in calabar metropolis has positive impact and relevant in general health care planning of clients in the hospital. Patient documentation enhances quality of health care service improvement in health care and timely dissemination of quality health data which is essential for health care provider at every level to achieve optimal level or goal. It helps in research and teaching of the previous cases of past and present and recurrences events in regards to patients' health as a tool for preferences in the hospital. Since the preservation of patient's health record/information is important, accurate and effective management should be enhance to guide against

illegal released of patients' records/information to the unauthorized persons or party.

RECOMMENDATIONS

Based on the findings the following recommendations were made;

i. Government should employ trained health information managers to handle patients' documentation accurately in the hospital, in order to enhance effectiveness of patient care.
ii. Government should trained more health personnel in this field in order to cope with the enormous responsibilities.
iii. Government should put in place accurate and effective equipment for good patient documentation to avoid trying and wearing of records.
iv. There should be regular inspection of patient health records/information and monitoring and evaluation in the various units of health record department.
v. Funding, should be provided for the up keeping of the departments
vi. There should be adequate space for the documentation of patient in the state hospitals in Calabar metropolis.

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