

# The Role of Records Management in Secondary Health Care Delivery System in Selected State Hospitals in Osun State, Nigeria.

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## ABSTRACT

The study examined the role of records management in secondary health care delivery system. The purpose of the study is to appraise the records and archive management in all the recorded information generated in the state hospitals under the secondary health care delivery system, through the process of creation, preparation, disposal distribution, use, storage, retention and disposition of records, determining the validity of documents and its existence in the hospital.

A descriptive survey was adopted with simple percentage analysis. 50 respondents were selected from two state hospitals in Osun State Nigeria. 50 copies of questionnaire was administered and 46 copies of questionnaire were returned with a response rate of 92%. The findings revealed that lack of uniform retention policy, absence of legal authority on disposal records and document, lack of funds to purchase standard filing shelves and cabinets, and lack of attention by the hospital managements was responsible for misfiling, mislaying, overcrowding and reduced storage space in the state hospitals.

It was recommended that legal authority should be instituted nationwide to support records retention and disposal schedules and archive documents for effective and efficient record management in secondary health care delivery system in Nigeria.

## 1. INTRODUCTION

Information is the life blood of the health care delivery system. The health records in manual or automated form, houses the medical information that describes all aspects of patient care. It is an essential tool in running the day-to-day activities of the organization. It is needed in carrying out business operations in offices, hospitals of private and public sector organizations. (Huffman 1994). The introduction of information technologies into business, health institutions and government has resulted in an information explosion, and caused an increase in records volume of incredible proportions. Hospitals and offices are most affected by this growth since much of the information is channeled into business, health care and government offices in the form of records for administrative and legal use.

The records managers and other category of staff in all the establishments, private or public health institutions and government officers need records and archives for planning, decision making and control. No organization can succeed in the present day business environment that is characterized with uncertainty, high risk, denial and increase crime rate, without functioning records and archive managements. Majority of the information needed for the smooth running of an organization are buried in the internally and externally generated records. Records are the corporate memory of the organization that created them and they are used to supplement human memory. Records is a documented evidence of our daily activities, it is a document, regardless of form or medium created, received, maintained and used by an organization (public or private) or an individual in pursuance of legal obligation, or in the transaction of business of which it forms a part or provides an evidence. (Popoola 2000)

Records is a written account of facts, events, official facts (as public records) written down at the time they occurred, and stored or preserved in writing as authentic evidence, set down in writing for future reference, preserve for use by writing or in other ways e.g. on a disc and other electronic media. It can also be likened to a history book which contains facts of past and present events which would be referred to by future generation. (Akanji 1994).

Documentary information is that which has been recorded on one kind of permanent form which includes written or printed manuscripts, magnetic tapes, microfilms, computer printout, correspondence, receipts, vital documents and many other forms.

### HEALTH RECORDS.

Health records are the clear concise and accurate history of patient life and illness written from the medical point of view. It is the primary source of medical statistics and clinic materials, for the present and future researchers. It is as well a device used for recording the significant characteristics of a patient and his illness and the events occurring in the course of professional care for the purpose of providing the best medical care to the patient, it undertakes teaching, research and study, appraisal of medical practice and legal requirements (Benjamin 1975).

Before a health records can be used for teaching, research, study, evaluation and treatment, it has to be complete, accurate and adequate, therefore the health records must contain sufficient information written in sequence of events to justify the diagnosis, warrant treatments and end result the quality of patient health care depends on proper managements of patients health records, efficient health care delivery system rest solemnly on a good system of health records storage and preservation.

### **SECONDARY HEALTH CARE SYSTEM**

The structure of Nigerian health care system is divided into three levels of health care services: the primary/local level, secondary/state level and tertiary/federal level. Each level has its own management board that is responsible for running the day-to-day affairs of the hospitals under each level. The secondary health care level is under the control of the state ministry of health in conjunction with the state hospitals management board. The category of hospitals been supervised by the board are: State hospitals, General hospitals and Comprehensive health centres.

The secondary health care hospitals create records that are needed for the treatments of patients, documenting the clinical significant of patients illness/diseases during and after hospitalization, and for administrative purposes. Hospitals use different forms and format which is standardized and centrally controlled by the health records department, reports and correspondences, mails, concerning patients treatment/history received from private hospitals or within the hospital clinical departments. The records officers or manager should control the unnecessary creation of records, standardized records uniformly, improve the quality of what is created and reduced the cost implication of records creation. The secondary health care records are public records that are created and maintained by state government for the treatment and recording the significant characteristics of patient illness and diseases, seen within the hospitals mentioned under secondary health care.

### **RECORDS**

Records are a documented evidence of our day-to-day activities of an organization be it private or public, records includes all the documents that an organization receives or created during the cause of our administrative or executive transaction. Records of the organization are the memory of the organization. Any organization that does not keep its records suffers from amnesia and would lose its identity. It is evidence of the activities that is done by an organization.

### **ARCHIVES**

Archive is a building or storage area (repository), designed purposely for the managements of records of enduring or permanent value. These are records that have administrative fiscal/financial, legal, historical/research and information values. Records and archives: all archive are records but not all records are archives, records pass through validity cycle. It has two concepts. – life cycle and continuum model.

Importance of records managements to secondary health care

- Records management saves money by discouraging the creating of records that are not needed, cuts down unnecessary overhead and expenditure for space.
- Records management reduces future costs by ensuring that expensive new equipment such as microfilms, cameras and computers are only purchased for better managements of information.
- Records management saves spaces by removing inactive records from busy crowded office to the storage area and ensures the timely destruction of records that are no longer needed.
- It saves time by ensuring that records are well organized and maintained.
- It promotes good government by making it easy for programme administrators to locate and use information needed to monitor programmes, ensure administrative continuity and make informed policy decision.
- It protects government by ensuring that contracts agreement and other records of the government legal rights and responsibilities are securely protected, well organized and easily located.
- It serves the cause of history by identifying and preserving important research records and evidential information.

Objectives of records management are:

- To furnish accurate, timely and complete information when it is needed in other to manage and operate the organization efficiency.
- To process and handle recorded information as efficiency as possible.
- To provide information and records as the lowest possible costs.
- To render maximum service to the customers (i.e. users of records)
- To support decision making and control in an organization.

(These objectives are primarily based on service, profit and social responsibilities)

## **II. REVIEW OF LITERATURE**

### **2.1. RECORDS MANAGEMENT**

Charman(1990) asserts that records management is the area of general administrative management concerned with achieving economy and efficiency in the creation, maintenance, use and the disposal of records during their

life-cycle, that is records creation, active records semi active records, inactive records and final disposition of records. It is the application of systematic and scientific control of the recorded information that is required in the operations of an organization, business; such control is exercised over the creation. Distribution, utilization, retention, storage, retrieval, protection, preservation and final disposition of all type of records within an organization. It is also concerned with all the records needed for the furtherance of government and business operations at a cost consistent with the services involved. Such a program uses a functional approach that is designed to achieve organization wide control so that an orderly, efficient and high quality flow of information is provided for management problem solving, decision making and to the users.

Effective managements of patient records and supporting documents is a critical factor in records managements, patients documents come from many sources, including administrative, diagnostic, and dispensing activities by professionals at hospitals, clinics and private practice follow up homecare and mobile services, health managements officers (HMOs), insurance cases, the legal community and government. Helpful in billing, compensation, in case of legal challenge, research, education, treatment and teaching.

### **Secondary Health Care**

The ministry of health provides health care services in a three-tier system-primary health care (health centers, extended health centers) secondary health care (regional referred hospitals) and tertiary health care (referral teaching hospitals, and a university hospital).

At a secondary health care facility, a medical records system collects information for better planning of health services. The sources of data is the patient in a direct admission or if the patients has been referred to the hospital, the medical records department collects all the demographic information and admission details about, patient's tribe and physiological and sociological information. There is no standard data collection format the format varies from clinic to clinic. Not enough shelves and cabinet to arrange the records, and inadequate health records officers, inadequate equipment.

**Storage and filing system** -Storage area must be secured and not in a public area i.e. waiting room or corridor.

Access to storage areas should be limited to appropriate staff via a coded door lock, swipe card or key etc. storage areas must be locked when unattended. There must be adequate fire precautions in place i.e. fire extinguishers, should be located in close proximity to the storage areas. Smoke detectors fitted. Ensure that staff access records safely i.e. shelves should not be too high, too low or overloaded: there are no obstruction to access e.g. boxes, furniture on the way.

**Current Records Libraries**- All patient's records that are currently active must be kept in the current active section of the localities filing area. Previous volumes over 25 years old should be weeded from the shelves and be archived. The health records officers have to arrange archive storage. Current clinical information is regarded as current records and not closed records. (Les BorreH, 2009).

**Secondary health records policy**- North east London foundation trust policy (2009) ensures that there are comprehensive and effective procedures in place relating to the compilation, use, retrieval, storage and disposal of health care – records, which should be arranged, monitored and reviewed on a regular basis, for safe keeping of health records.

**Records manager** - The records manager is responsible for the overall managements and developments of the health care records practices and services across the state, ensuring that services are of a high standard in order to comply with appropriate governance standards and delivery of high quality patient cared.

**Data protection and confidentiality of patient information**- Health records are shared clinical tools that is available 24 hours a day 7 days a week for the purpose of clinical care. Comprehensive audit trails of health records are ensured to protect against unauthorized access or breaches in confidentiality. Relevant paper works that are old and deceased patient records, the date of death should be marked on the front cover of the records and should be archived. Records are the corporate memory providing evidence of actions and decisions and representing a vital document to support daily functions and operations.

Records support policy formation and managements decisions-making protect the interests and the right of patients, staff and members of the public. They support consistency continuity, efficiency and productivity and help deliver services in consistence and equitable ways.

Records management's strategy

All clinical and non-clinical operation records held in any format.

-All administrative record (e.g. personal, estates, financial and accounting records, notes associated with complaints) and

-All patients health records (for specialties and including private patients, including x-ray and imaging reports, registers, etc.)

Records managements are discipline which utilizes an administrative system to direct and control the creation, distribution. Filing, retention, storage and disposal of records, so that it is administratively and legally sound whilst at the same time serving the operational needs of the secondary health care and preserving an appropriate historical records. The key components are records creation, records keeping, records maintenance (including

tracking or records movements), access and disclosure, and transfer and retention, appraisal archiving and disposal.

The records manager/health records manager is responsible for the overall developments and maintenance of health records managements practices throughout the secondary health care, in particular for drawing up guidance for good records management practices and promoting compliances with the policy to ensure the easy, appropriate and timely retrieval of patient information.

-All staff of the secondary school health care, whether clinical or administrative, who create, receive and use records have records managements responsibilities because they must ensure that they keep appropriate records of their work in their work in the health institute on manage those records in keeping with the records managements policy.(Less Borrett 2009).

Registration of records collections.

Departments and other units register the records they are maintaining. The inventory of records collections will facilitate.

Classification of health records into series.

The recording of the responsibility of individuals

Creating records, the register will be reviewed annually.

Records management's audits

Hospitals regularly audit its records management's practices for compliances with this framework.

This audit will:

-Identify areas of operation; identify which procedure and guidance to comply with the policy

-Follow a mechanism for adapting the policy to cover missing areas.

-Set and maintain standards by implementing new procedures, including obtaining feedback where the procedures do not match the desired levels of performance.

-Highlight where non-conformance to the procedure is occurring and suggest a tightening of control and adjustments to related procedure.

Training: All staff must aware of their responsibilities for records – keeping and records managements.

Reviews; The records management's policy will be reviewed every two years if new legislation, codes of practice or national standard is to be introduced.

(Mhtml: file//C: users/owners/medical informatics).

### **2.1.2. Records life cycle.**

Pen etal (1994) believes that recorded information has a life similar to that of a biological organism in that it is born (creation phase), it lives, (maintenance and use phase) and it dies (final disposition). At each phase of the cycle there are issues to be addressed which have impact on the efficiency and effectiveness of the records management programme. The elements of records management programme include: records conception, records creation and control, active/current records management and control, inactive / non-current records managements and control, records disposition.

Records conception; Popoola (2000) asserts that records ought to have been conceived before it was born; the concept of records has to do with information processing in the brain of action/desk officer in an organization. The manager thinks whether to create records in paper or computer, if it is paper, how many copies to be created, what is the cost implication in all, or per one, thus the records is created by an officer and brought to the Centre for use.

Records creations and control- when a record is born it means records had been created in tangible format. He further stressed that probably 75% of the cost of administration in an organization can be traced to reckless creation of records and that 95% of records generated are collected internally, the rest are from the outside. In the hospitals, registration and documentation of patients information, creation of records for patients treatment as soon as records are created for the patients, consideration have to be given to space management, storage facilities, retrieval tools, filling and classification, if the hospital management fails to act on the above, the growth of the records can consume the available spaces in the organization.

Active/current records management and control – these are recorded information or knowledge that are being used on regular basis, that is daily and weekly basis in an organization. Active records take place in the registry.

A registry is a place that records, are purposely design/built or established for the management of active records, the following activities takes place: sorting, filing, numbering, classification of patient's records, collation of patient's statistical information, research study materials, budgetary provision, accommodation, space planning, records storage equipment, working materials, records manual.

Semi – active records- they are records that are being consulted on monthly or quarterly basis in a year in an organization. If they are in the registry they are to be transferred to the inactive records area. The records centre is an expensive building house, or space purposely built for management of dormant records or semi-active or inactive records. As soon as one identifies the semi/inactive, the records would be moved away from the registry to the records centre. Issues relating to volume of records, filing system, retrieval system, storage facility,

accommodation, records conservation and restoration, appraisal for continuum or archival/enduring value. Bad management of records at this stage may spell doom for the hospital.

Inactive/ noncurrent records- these are recorded information or knowledge that are intangible format that are being referred to once in every six months or on yearly basis in an organization, they are not frequently refer to such records are managed at the records Centre.

The issues addressed here are, finance, technology, materials, records policy, management plan, relation and disposal schedule, space planning, records retrieval system, mapping.

Semi-and inactive records have to be appraised at the records Centre before it is moved to disposal which is the last stage of the life cycle of records management. In the hospitals, old records that have spent up to 20 or 25 years of last attendance are regarded as inactive/non-current they are weeded from the shelve/cabinet, to be appraised either to the archive or for final disposal. Records inventory is a complete listing of the records of an organization by series or category with sufficient supporting information appraisal and evaluation to be done. ( Less Borret 2009).

### 2.1.3. Appraisal of health records

Appraisal is the evaluation of records. It helps to determine whether a record should be destroyed or to remain in the archive. It is a basic archival function of determining the eventual disposal of records based on their current and future administrative, historical, physical and legal uses, their evidential information and research values. It is also known as evaluation, selection, review, for passing judgments on the document. It is an ongoing process of determining the values of records for further use for whatever purpose and the length of time for which that values will continue. It is sometimes called evaluation or selection of non- current patient case notes from the record centre, before the final disposal is done. It has two purposes.

1. It involves deciding what records needs to be kept and for how long. In order for the organization to continue its work – continue utility.

2. It involves deciding what records merit, purpose of information because they have permanent enduring values. E.g, birth certificate, death certificate, medical history, pathological report, building plan, Certificate of Ownership, gazette and certificate.

Continue utility – the finite usefulness that patient records may have for the continuous of hospital services as evidence of treatment. Enduring values is the indefinite values that records may have for any purposes that justify their preservation.

Factors to be considered in appraising records.

The present and future benefit of patient records should be considered in the process of appraising records and documents.

-Historical values, -Fiscal – finance value, - Administrative values, -legal value

-Information value, -Research or evidential value.

Every records created must be assigned retention period to them. Every organization must embark on clearing its organization.

Appraisal strategy to be used in evaluating and selection of documents must be followed by the hospital, it has to be uniform, standardized, transparent, accountable and cut across the life cycle of the records in the hospital.

Appraisal strategy has two features.

-Principles of guiding how records are arranged.

-Principles of respect “desfonds” meaning, respect the creator of the document which is divided into two (a) provenance, which has to do with the office of origin, the archive has no right to change the name of the records brought to the archivist. (b) Original order- indicate that the archivist has no right to change the arrangement of the records, normally files are organized into document and document into series corresponding to the function and activities that are being documented.

Osundina (2005) stated that health care records are classified into primary secondary and transitory records. Primary documents are the basic information that should be retained as long as possible or even forever e.g. clinical/medical history sheet, pathology reports. Discharge summaries, diagnosis, and operations. They are vital in the treatment of patients in the present and future illness. Secondary documents – are documents which are valuable only during the period of in-patient treatment which may be needed in case of litigation e.g. nurses note, fluid sheets, TPR forms. Transitory document – are document which have neither medical nor legal significance, they are no continue utility e.g. referral letter, correspondence, drafts, duplicate, they have no continue utility.

### 2.1.4 Retention of health records

Popoola (2001) stressed that records retention is the function of presenting and maintaining records for continuous use, because it has value, agency or building or shelves. The emanation of records retention and disposal schedule from good records inventory and appraisal exercise can greatly reduce keeping costs, the end product of records retention schedule is records disposal schedule. Retention scheduling is the determination of the length of time health records should be kept, where and how they should be kept, and as a consequence or outcome of the medical records audit in a medical and health institution. Due to lack of space to file even



growing patient records in the hospital, the health records officer/practioners review the types and frequency of request made for medical records, which assist the director health records services to make decision regarding storage space, microfilming and retention schedules. There are state laws and regulations that set a time limit on the number of years, patient's records would be retained in health records department before finally microfilmed or destroyed. In the absence of state laws or other regulations each head of the hospital, the director/chief medical records officer and the advice of the medical staff, medical records committee and state attorney may decide how long the hospital, shall keep its health records for medical, teaching, research, legal and administrative purposes.

Period of retention of health records: this is the length of time as provided for by legislation regulation or administrative procedures that records should be retained in an office or records centre before they are transferred to an archival institution or otherwise dispose off.

Decision as to how long the medical records are to be kept in the inactive file, or are they to be retained, or destroyed after a certain time, or if they are retained are they going to be kept in their original form, or are they going to be processed, or microfilmed all these decisions must be made by the hospital authority in consultation or discussion with the advice of the medical records officer and the state attorney.

The period of retention depends on legal requirements which vary from country to country. In some countries, the retention period for patient's medical records is 20 years while other is 25 years of last attendance where as in Nigeria there is no specific period for the retention of medical records case notes but conventionally, we use 20-25 years which vary from state to state or the decisions of different hospital management boards. The public records Act 1958 enacted the minimum period for the retention of nearly all general outpatient document, for at least six years based on the premise that the rate of recall of medical records that have remained or in use for five to six years is extremely low and that any illness after 20-25 years would not have any bearing with the former illness or diseases. A standing medical advisory committee on standardization of hospital medical records in 1965 recommended that medical records must be classified according to the benefits derivable from record that is legal, research, educational, evidential information and teaching before finally disposed or destroys the records.

#### **Purpose of health records retention schedule**

- Provide knowledge of what records exists for users in medical and health institution.
- Ensuring records are retained for as long as they are needed.
- Promoting efficient control over medical records usage.
- Identification of unnecessary duplication of records.
- Avoiding costs for the purpose of additional space and filing equipment
- Relocation costs from costly office space to less expensive more efficient storage space called a record Centre.
- Identifying records of long term values as early as possible to secure them from accidental destruction or disaster and to plan for their preservation.
- Providing standards and consistency in the management of medical records medical and health institution.

Risks et al (1992) asserts that there are two main goals of a retention schedule and these are

- to meet the legal requirements and organizational information needs which involves enabling the right information to be accessible to the right person, at the right time and at the least cost. Litigations appear to be increasing and a lack of supporting evidence, or the presence of incriminating evidence, can be costly. It is therefore important to make informed decision about retention and destruction of medical records, rather than adhoc ones, variations from state hospitals management board to another federal hospitals to state hospitals or to local government hospitals for the same records would be avoided. Record series here means a body of recorded information arranged in a particular order (numerical, chronological, or alphabetically) or arising from a specific activity or purpose and filed and used as a unit.

The health records retention schedule essentially document the decision that have been made and agreed at senior management level at hospitals management boards/hospitals and becomes the "bible" for records retention and destruction by confirming the life cycle of the records series.,

Features of Health records retention schedule.

A typical health records retention schedule contain the following

- The title of the record series agreed by the users(s)
- A description of each records series
- Identify official record holder
- The total retention period for each records serves e.g. years (6years) for GOPD records, case notes, x-rays films, 25 years of date of last attendance for health record case note, that after 25 years medical case will not have any bearing with the former episode of treatment.

Permanent records such as birth certificate, death certificate, medical history, x-ray films, operation notes should be retained

- The active, semi-active and archival retention within the total retention period for each series records.

-Clarification status – vital records for continuity of an organization's activities, records have to be protected from fire, flood, nuclear attack, war e.t.c. It should be protected against manmade and natural disaster, it should be duplicated and kept off – shore site. Also clarifying according to continue utility and enduring value for archive.

-Storage medium e.g. paper, microfilms, electronic.

-Authority rules or regulation governing the retention.

Method of destruction of records e.g. shredding, incineration, recycling, pulping and dumping.

Stephens (1988) discussed five steps in developing health records retention schedule which are – clarifying the records, assessing their value, designing the retention schedule, publishing and implementing the schedule and maintaining the schedule. He went further to state that there are five basic principle of making good records retention and decision which are:

-Avoid trying to accommodate every conceivable need.

-Retain information if it is likely to be needed in the future and if the result of not having it would be substantial.

-Be conservative i.e. avoid inordinate degree of risk.

-Ensure systematic disposal of records immediately after their period expires.

-Base retention periods on the consensus of opinions of knowledgeable people within and outside health care system.

#### **2.1.5 Record Survey.**

Popoola (2001) asserts that records survey is the process of gathering vital information about records, their quantity, physical form, type, location, physical condition storage facilities, rate of accumulation, use and similar data for the purpose of planning acquisition and disposal programme, microfilming operations, new facilities and related archival activities in line with the goals of the organization. The senior management within the agencies should consists the representative of the records and archives, they will study existing material relating to the structural and function of the agency such as legislation, goals of the organization, organizational charts, job descriptions, work plans and annual reports in order to establish an understanding of the present and past duties, responsibilities and activities in the hospital, records management problems resources to tackle it, the team should conduct survey round the chief medical director office and other top management officers offices, head of department and to the health records library, and authority will be given to perform that special job. Access to resulting reports and records inventory may be denied. Questionnaire method are usually sent to each unit of agency or the team to complete the questionnaire themselves, their efforts is to check for omissions, anomalies and discrepancies. They should work seriously to meet the deadline. A report would be submitted, itemizing the findings of the survey accessing the rate of growth of records, comments on effectiveness of records and information retrieval, estimate potential for savings in storage costs and staff time. Purpose consequential action, estimate the resources needs and costs of that action.

#### **2.1.6. Records Inventory**

The complete listing of the records of an organization of an organization by series or category on sufficient supporting information to enable and informed appraised and evaluate to be done. It would identify how many files are there in the hospital, including personnel and patient records, why they are kept. Inventory records could be automated thereby making it simple to access and update information, which allows sorting of records of uncertain origin to ascertain their provenance, function and series they belong. Again the survey conducted triggers appraisal and disposal action, when disposal schedule already exists the disposal actions recommended be implemented.

#### **2.1.7. Records disposal**

Records disposal is the last stage of life cycle of records managements. It is the actions taken with regards to records as a correspondent to the appraisal and expiration of their retention period it could be destruction. The semi-active and inactive records that have been removed from the registry based on their period of usage and provenance that has been expired are transferred to the records Centre or archive or destroyed. Destruction is the disposal of document of no historical, financial, legal, evidential information, research and administrative value. Whereas those documents that have permanent enduring value are kept in the archive, those records that can assists in the operation of the hospital are regarded as continue utility at the records Centre. About 5% of dormant records that are available in an organization constitute an archive, therefore after conducting a thorough appraisal of all the records, the non-current records are called useless records, and will be totally destroyed.

#### **2.1.8. Disposal schedule**

The control documents recovering appraisal decision and prescribing disposal action, also known as disposal list, disposition schedule, records schedule, retention schedule, retention and disposal schedule. The purpose is to identify all the records of an agency irrespective of the medium of format.

-Document decision about length of time records needs to be retained because of their continue utility to the creating agency.

-Document decision of about approximate disposal action to be taken at the end of retention period.

-They serve as authority to disposal action.

Methods of Disposition.

The following method of final disposition of non-current records could be adopted. Pulping and recycling, shredding, incinerating, dumping, burying.

-Pulping and recycling: It is the preferred option provided. It is the preferred, it can be done by contractions and the securities and the sensitivity of the record from leakage can be guaranteed.

-Shredding: an industrial shredding machine could be used to shred large quantity of records

-Incinerating: usually not necessary for confidential paper records in an open burn time combustion is likely to be incomplete and some legible document litters around.

-Dumping: dumping of public records in land fill site is not appropriate, such action could reduce public confidence in the government ability to protect the privacy of patient's information. The completion of disposal schedule is not the end of the retention and disposal scheduling has to be monitored and updated constantly in the light of changes that affects records, new patients, new edition should be issued from time to time, with the edition number, hospital number, and date clearly displayed.

### **Micrographics management and control**

Microfilms is a photographic process on films by which the size of all document, are optically reduced to a fraction of its original measurement while every details is completely and accurately preserved and will reduce storage space. Microfilms copy of replaceable records can be deposited in a location other than that housing the original records so as to provide security against loss by natural disasters. (Osundina, 2005).

Benefit of microfilms in records management includes:

-Protection of records from wear and tear.

-Simple duplication of original information.

-It saves space.

-Microfilm x-rays are also admissible.

Copy reproductions provide exact copies of original document as preserved and do not reduce space. Other health information technology for preserving and processing of health information includes, computerization of health records, the use of computer input and output devices such as magnetic tape, diskette, disk for storing patient health records.

Archive management and control.

Archive can be in any format, pictures, video, paper, CD, it can be in any media. In an office around 5% of the documents are called archive. Archive records are records of enduring value, they are inactive records that are retained for legal, physical or financial, administrative, historical research and evidential/information reasons. These records are copy rights, deeds, reports, personal records, medical history, operations reports, discharge summaries. All these records have information or historical values for both the organizations and individual engaged in historical research.

The purpose of archival management programme includes:

-To identify general appraisal standard for ascertaining the archival value of records.

-To supply records appraisal standard in such a way that neither too many or few records are retained.

-To determine the most effective and economical means for protection of the organization records that possess archival values.

It is in line with this concept. That will aid our understanding of the role of records management in secondary health care delivery system.

### **2. 2. 1. Theoretical Framework**

This study is based on records life cycle model.

### **III. Methodology**

This study was carried out at the State Hospitals, Osogbo and Ilesa, Osun State, South-West Nigeria. The study is limited to the health records officers, the chief consultants/principal medical officers, and the administrative heads of the hospitals. A descriptive survey was used with simple percentage analysis. 46 respondents were randomly selected from the population of 65 senior hospital staff from the two state hospitals. The population of the study comprised the health records officers, the administrative/hospital secretaries and the chief consultant/principal medical officers of the two state hospitals, that is state hospital Osogbo (49) and state hospital Ilesa (16) making a total of 65. Among these 65 senior hospital staff of the two hospitals were 13 chief consultants, 5 administrative officers/hospital secretaries, and 28 health records officers. A structured questionnaire was drawn to elicit the response of the respondents; copies of questionnaire were distributed and administered to the top senior hospital staff from the two state hospitals.

### **IV. Findings**

The findings revealed that five research questions were analyzed using simple percentage analysis. Therefore, the results of the respondents were presented in the following tables.



Table . 1: What are the causes of inadequate space and lack of standard filing equipment in the state hospitals? Percentage distribution of the respondents showing cases of inadequate space and standard filing equipment in the state hospitals.

Response	Frequency	Percentage
Poor hospital planning	10	21.74
Ignorance of the importance of records	12	26.09
Lack of funds	18	39.13
Lack of interest by the head of the hospital	6	13.04
Total	46	100

The table above shows that majority of the respondents about (86.96%) that is 21.74%, 26.09 % and 31.13% felt the lack of funds and poor hospital planning were held responsible for the inadequate space and inadequate standard filing equipment, lack of interest and importance of records documents by the head of the hospitals also led to the inability to create enough space and facility for keeping health records. This could cause some delays to patient treatment, overcrowding of patient records, thereby making it difficult to access records for treatment research and teaching.

Table. 2: Are health records and hospital documents created, maintained and used in the state hospitals.? Percentage distribution showing creation, maintenance and use of health records and hospital document.

Response	Frequency	Percentage
Yes	31	67.39
No	15	32.61
Total	46	100

The Table above shows that 67.39% of the respondents felt that, health records and hospital documents are created, maintained and used in the state hospitals, therefore it become difficult to explain why the hospital refused to provide storage equipment, shelves and cabinets, for safekeeping of the hospital records. It shows that the hospital does not value the end result or the outcome of its activities and could result to embarrassment in case of litigation.

Table 3: What is responsible for non-provision of standard library and skilled professionally qualified health records officers in the hospitals?

Percentage distribution showing non-provision of standard library and skilled professionally qualified health records officers in the hospitals.

Response	Frequency	Percentage
Inadequate knowledge	6	13.04
Wrong priority of hospital functions	17	36.96
Non-challant attitude of hospital management to standard library	9	19.57
Absence of medical legal cases	14	30.43
Total	46	100

The Table above shows the majority of the respondents 86.96% agreed that wrong priority of hospital functions, absence of medico legal cases and non-challant attitude, of hospital management to standard library in the state hospitals were held responsible for non-provision of standard library which has resulted to misfiling, delays in retrieving of patient records, delay in patients waiting time and patient record scattered on the floor. Also inadequate knowledge of records management from employing skilled and professionally qualified health records officers in the state hospitals, thereby resulting to many inadequacies and bad professionals practices.

Table 4 What are the obstacles facing uniform records retention and disposal schedules in the state hospitals. Percentage distribution showing the Obstacles facing Uniform Health record retention and disposal schedules in the state hospitals.

Response	Frequency	percentage
Lack of records retention	16	34.78
No legal authority backing disposal of records and documents	15	32.61
Lack of space and filing shelves	7	15.22
The knowledge of experts in records management was not sought.	8	17.39
Total	46	100

Table 4 shows that majority of the respondents (84.78%) were of the opinion that, lack of retention policy, lack of legal authority to back disposal of records and documents and un- consented knowledge of experts in records

managements were responsible for the lack of uniform records retention and disposal schedules in the state hospitals. This has resulted to un-necessary creation of records, back logs of disorganized or unidentified current, semi current and non- current records, reducing the available space for filing and constitute threat to the library.

Table 5: Why did the management not paying attention to the records of enduring value to the secondary health care.

Percentage distribution showing reasons for the lack of attention to health records and documents of enduring values to the secondary health care.

Response	Frequency	Percentage
Failure to recognize the benefits that can be derived from records of enduring value	16	34.78
Lack of research activities at secondary health care level	13	28.26
Lack of consultants/specialists to generate records of enduring value.	6	13.04
Inadequate medical diagnostics equipment and services at the secondary hospitals	11	23.92
Total	46	100

It was observed from table 5 above that most respondents about (89.96%), were of the opinion that failure to recognize the benefits that can be derived from records enduring value, lack of research activities, and inadequate medical diagnostics equipment and services at the secondary health care level were responsible for the reason the management did not pay attention to records of enduring value. The implications of the findings will result to inadequate information to defend the policy decisions made by the hospital, no document of historical value, fiscal/financial value, administrative value, legal value, information value and research or evidential value in the state hospitals which could result to loss of focus and thereby turn the hospitals into a glorified prescription clinic, and under-utilization of the professionally trained health workers.

#### V. Conclusion and recommendations

. It was observed from the study that uniform records retention and disposal schedule. And laws guiding its operation were not available. The state hospitals under the secondary health care system should provide a standard and equipped library and a repository for storing its records and archive documents so that efficient and effective management of records and archive generated in the hospital could be achieved. Based on the findings of this study it was recommended that: There should be provision for enough storage space as library of the hospitals. There should be a legal authority to support records, retention and disposal schedules. Equipment and technology for proper records and archive management should be put in place Employment of skilled and trained health records professionals should be done by the hospital management board. The head of the hospital should place much emphasis on the present and future benefits derivable from records and archive documents and not on personal or professional interest. The records and archive management programme should be fully adopted and implemented in the state hospitals. The records management policy should be reviewed every two years if new legislation, codes of practices or national standard is to be introduced.

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