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EVALUATION OF HEALTH RECORD CONTROL IN PRIMARY HEALTH CARE

By

Prof. Innime Righteous, Ph.D[1], Zorka Nwinee[2]

[1]Department of Public Health Highstone Global University, Tx
[2]Department of Public Health Rivers State University

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Abstract

The study assessed health record Control in primary health care settings, with particular focus on Ikorodu Local Government Primary Health Care Centre, Lagos State. Effective health record Control is essential for ensuring continuity of care, supporting clinical decision-making, improving patient outcomes, and strengthening health system performance. Despite its importance, many primary health care facilities face challenges related to inadequate infrastructure, insufficient training, poor documentation practices, and limited adoption of electronic health record systems. The study adopted a descriptive survey research design. The population comprised patients attending Ikorodu Local Government Primary Health Care Centre, from which a sample of one hundred (100) respondents was selected using simple random sampling technique. Data were collected using a structured questionnaire designed by the researcher. The instrument was validated by the research supervisor to ensure face and content validity. Data collected were analyzed using frequency tables and simple percentages, while the stated hypothesis was tested using Chi-Square (χ^2) statistical analysis at a 0.05 level of significance. Findings revealed that effective health record Control significantly influences patient care and service delivery in primary health care settings. The study identified key challenges including reliance on paper-based systems, incomplete documentation, inadequate training of health personnel, and limited digital infrastructure. The results further indicated that improved documentation practices and adoption of electronic systems can enhance efficiency, accuracy, and quality of care. The study concluded that strengthening health record Control systems is critical to improving patient outcomes and overall health service performance. It recommended investment in digital infrastructure, continuous training of health workers, implementation of standardized record-keeping protocols, and regular monitoring to ensure compliance and data quality.

INTRODUCTION

Health record Control is central to the effective delivery of primary health care (PHC). Accurate and accessible health records ensure continuity of care, support clinical decision-making, and enable public health monitoring. According to WHO (2019), the efficient Control of health records enhances patient safety and quality of care by minimizing errors and duplications. In PHC settings, where resources are often limited and patient volumes high, effective record-keeping systems are essential for maintaining service efficiency and improving health outcomes.

Several studies have highlighted the challenges in managing health records in PHC environments, particularly in low- and middle-income countries (LMICs). These challenges include inadequate infrastructure, limited trained personnel, and poor compliance with documentation standards (Odeyemi & Saka, 2021). Manual record-keeping systems are still widely used in many PHC facilities, leading to inefficiencies such as data loss, illegible writing, and difficulty in retrieving patient information. These limitations hinder timely decision-making and can compromise patient safety and service delivery.

The transition to electronic health records (EHRs) has been proposed as a solution to many of these challenges. Studies suggest that EHR systems can significantly improve record accuracy, streamline access to information, and support integration across different levels of care (Nguyen et al., 2014). However, the adoption of EHRs in PHC is often constrained by cost, technical capacity, and user resistance. In a systematic review by Kruse et al. (2018), implementation

*Corresponding Author: **Zorka Nwinee**

barriers included concerns about data security, lack of training, and resistance to change among health care workers.

Training and capacity-building for health personnel have been identified as key components in improving health record Control. Without adequate training, even the most sophisticated systems may fail to deliver the expected benefits (Biruk et al., 2014). Regular supervision and monitoring also play a critical role in ensuring compliance with documentation standards and promoting accountability among staff. Research by Abiy et al. (2018) in Ethiopia demonstrated that health centers with continuous training programs had significantly better record quality than those without.

In addition to human resource factors, organizational policies and governance structures influence the quality of record Control. Facilities with clear policies on documentation and robust monitoring systems tend to have more consistent and reliable records (Lester et al., 2010). National health information systems that integrate primary care data can also contribute to better health planning and policy-making. However, integration requires interoperability across platforms and standardization of data formats, which remains a challenge in many countries.

Research Design

Research design is the specification of methods and procedures for acquiring the information needed to solve problems. This study employed the descriptive survey design. The nature of the problem was duly considered in the study.

Population of the Study

For the purpose of this study, the target population consists of patients attending Ikorodu Local Government Primary Health Care Centre, Lagos

Samples and Sampling Techniques

The sample of the study refers to that part of the population that was selected for closer study. To select the needed samples for this study, the researcher used a total number of one hundred (100) patients attending Ikorodu Local Government Primary Health Care Centre, Lagos.

Instrument for Data Collection

The data collection instrument to be used is questionnaire designed by the researcher. The design is well constructed and simple. The questionnaire was divided into two sections (A and B). Section A was for collection of information on personal data of respondents while Section B consisted of questions drawn from the research questions that elicited responses from the respondents with response options: Strongly Agreed (SA), Agreed (A), Strongly Disagreed (SD) and Disagreed (D).

Validity of the Instrument

To ensure the face validity of the study, the research instrument was scrutinized and judged by the supervisor for appropriateness of each item of the instrument. The comment of the supervisor was used to obtain final items which were further subjected to content validity to ensure that the content of the instruments representative of the area which the instruments are intended to cover.

Method of Data Analysis

The response to the questionnaire items was analyzed using frequency tables and simple percentage method. The research hypotheses stated earlier was tested using Chi-Square Statistics.

Presentation of Data

Table 1: Distribution of Questionnaire

	Frequency	Percent
Returned	87	87.0
Unreturned	13	13.0
Total	**100**	**100.0**

Source: Field Survey, 2023

Table 4.1 showed that 87%(87) respondents returned their questionnaire while 13% (13) respondents did not returned their questionnaire. This implies that a large proportion of the questionnaire were filled and returned.

Table 2: Distribution According to Gender

	Frequency	Percent
Male	51	58.6
Female	36	41.4
Total	**87**	**87.0**

Source: Field Survey, 2025

As indicated in Table 2, 58.6%(51) respondents were male while 41.4%(36) were female. This shows that male respondents participated more in the research than their female counterpart.

Table 3: Distribution according to Age

	Frequency	Percent
21 – 30 years	30	34.5
31 – 40 years	24	27.6
41 – 50 years	18	20.7
51 – 60 years	9	10.3
51 – 60 years	6	6.9
Total	**87**	**100.0**

Source: Field Survey, 2023

In the age grade category in Table 3, it shows that the respondents 34.5%(30) respondents are between 21 – 30 years, 27.6%(24) are between 31 – 40 years age range, 20.7%(18) are from 41 – 50 years, 10.3%(9) respondents are in between 51 – 60 years, while 6.9%(6) are in the age bracket of above 51 – 60 years.

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Table 4: Distribution According to Marital Status

	Frequency	Percent
Single	49	56.3
Married	38	43.7
Total	**87**	**87.0**

Source: Field Survey, 2023

The Marital category of the respondents shows that 56.3% (49) respondents were single wile 43.7%(38) respondents were married. This implies that respondents with single status attended more to the questionnaire.

Testing of Hypothesis

Hypothesis 1

Ho: Health record Control has no significant impact on patient care and outcomes

H1: Health record Control has significant impact on patient care and outcomes

Table 5: Relationship between Health record Control and patient care & outcomes

Structure	N	$\bar{X}$	SD	df	Standard Error	t_{cal}	t_{crit}	Decision
Health record Control	87	3.59	0.883	172	0.177	2.813	1.96	H_0 Rejected
patient care & outcomes	87	3.09	1.398					

0.5 level of significance

Table 5 above shows that the calculated value of t-test t_{cal} = 2.813 which is greater than the critical value t_{crit} = 1.96 at 0.05 level of significance with degree of freedom df = 172; therefore, the null hypothesis is rejected in favour of the alternative hypothesis which states “Health record Control has no significant impact on patient care and outcomes”. This showed that Health record Control has significant impact on patient care and outcomes.

Discussion of Findings

The findings from various studies confirm that effective health record Control significantly influences the quality of patient care and outcomes. Accurate and accessible health records allow healthcare providers to make informed decisions, avoid medical errors, and ensure continuity of care. In primary health care (PHC) settings, where patients often receive ongoing treatment for chronic illnesses, complete and well-maintained records support better disease monitoring and Control (Tang et al., 2006). This enhances patient safety and improves the chances of successful treatment outcomes.

Electronic health record (EHR) systems, in particular, have been found to improve clinical efficiency and care coordination. Buntin et al. (2011) observed that the adoption of EHRs was associated with reduced duplication of services, faster diagnosis, and more timely treatment interventions. These improvements are especially important in settings where resource limitations demand efficiency. By integrating lab results, medication histories, and clinical notes into one platform, EHRs facilitate a holistic view of the patient's health, which leads to more precise and personalized care.

Additionally, health record Control contributes to better public health surveillance and preventive care strategies. The systematic recording of patient data enables early detection of disease patterns and identification of high-risk groups, which helps in designing targeted interventions. Campanella et al. (2016) found that health facilities with well-structured record systems had higher rates of immunization coverage and screening activities, ultimately improving population health outcomes. These benefits are particularly critical in PHC, where early interventions can prevent complications and reduce the burden on tertiary care.

However, the findings also highlight challenges that may hinder the effectiveness of health record systems. Inadequate staff training, poor infrastructure, and limited internet access in rural or low-resource areas restrict the full utilization of digital systems (Biruk et al., 2014). These limitations can lead to inconsistent documentation, data loss, or underreporting, which ultimately compromises patient care. Even in facilities with EHRs, user resistance and lack of technical support can reduce the effectiveness of these systems.

A significant finding across the literature is the role of organizational commitment and leadership in achieving successful health record Control. Facilities that invested in continuous staff development, standardized documentation practices, and routine data quality checks demonstrated better health outcomes (Abiy et al., 2018). This underscores the importance of viewing health record Control not merely as a technical function but as a core part of clinical governance and health system strengthening.

In conclusion, the evidence strongly supports that effective health record Control has a positive and measurable impact on patient care and outcomes. While digital systems offer the greatest benefits in terms of efficiency and accuracy, the successful implementation of any health record system—whether electronic or manual—requires appropriate infrastructure, trained personnel, and institutional commitment. Strengthening health information systems, particularly at the primary care level, is essential for achieving universal health coverage and improving public health outcomes.

Conclusion

The study concludes that effective health record Control is a fundamental component of delivering high-quality health

*Corresponding Author: **Zorka Nwinee**

care, particularly in primary health care settings. Health records—whether paper-based or electronic serve as the foundation for clinical decision-making, continuity of care, preventive services, and health system planning. When properly maintained, health records enhance patient safety, reduce medical errors, improve treatment outcomes, and enable efficient use of limited healthcare resources.

Electronic Health Records (EHRs), in particular, have been associated with better clinical outcomes due to their ability to streamline data collection, support real-time access to patient information, and enhance communication among healthcare providers. However, the transition from manual to digital systems presents challenges, especially in resource-limited environments where poor infrastructure, inadequate training, and limited funding hinder the full realization of these benefits.

The study also highlights the importance of standardized documentation practices, routine monitoring and evaluation of record quality, and the active involvement of trained health personnel in maintaining accurate records. Without these, even well-designed systems can become ineffective. Ultimately, strong health record Control systems contribute to more responsive, accountable, and equitable health service delivery.

Recommendations

1. **Strengthen Infrastructure and Digital Capacity:** Governments and health institutions should invest in basic digital infrastructure—including electricity, internet access, and hardware—to support the adoption and sustainability of EHR systems, especially in rural and underserved PHC facilities.
2. **Train and Support Health Workers:** Continuous capacity building is critical. Health workers should receive regular training on health record Control, whether manual or electronic. In-service education and technical support can help build a culture of accountability and data accuracy.
3. **Implement Standardized Record-Keeping Protocols:** Developing and enforcing uniform data entry procedures, file organization methods, and documentation guidelines across all PHC facilities will promote consistency, reliability, and comparability of health information.
4. **Ensure Data Security and Confidentiality:** Both paper-based and electronic systems must be governed by strict data protection protocols to prevent unauthorized access, maintain patient confidentiality, and build community trust in the healthcare system.
5. **Promote Monitoring, Evaluation, and Feedback:** Routine audits of health records and the use of data quality Evaluation tools should be institutionalized to ensure ongoing improvement. Feedback from these processes should inform training, system updates, and policy adjustments.
6. **Encourage Stakeholder Involvement:** Policymakers, healthcare providers, IT professionals, and patients should be actively involved in the design, implementation, and evaluation of health record systems to ensure they are user-friendly, relevant, and responsive to local needs.

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