Comparative Study on the Use of Temporary Case note in Federal and State Tertiary Hospitals in Bayelsa State, Nigeria

KUROKEYI, Ebimene Japheth Teddy
Department of Health Information Management, Niger Delta University teaching Hospital, Okolobiri, Yenagoa, Bayelsa State.
tedatnet1@gmail.com, kurokeyi.ebimene@lcu.edu.ng

Abstract

This research comparatively examined the use of temporary case notes at the Federal medical Centre (FMC) and the Niger Delta University Teaching hospital (NDUTH) in Yenagoa, Bayelsa State,Nigeria. The objective of the study was to among others, ascertain the cause(s) for creating temporary case notes and its purpose as well as the challenges bedevilling its use by medical professionals in hospitals. The study followed a survey research design in the collection of primary data from 185 healthcare professionals in the two medical hospitals. Moreover, frequencies, percentages and mean scores were used in the analysis of the data. The findings shows' that the respondents asserted that mislaying and misfiling of patient's original health records and the over-dependence on a manual system that is burdensome are often the catalyst of temporary case notes in hospitals. The findings also suggests that the purpose of deploying temporary case notes in most hospitals is to ensure a process that facilitates patient's access to healthcare services devoid of any impediments. The study however observed that respondents view the use of temporary case notes as not equivalent to the original medical record and therefore a challenge to qualitative healthcare service delivery. The research therefore recommends that a comprehensive health records management policy should be formulated to safeguard private medical records of patients and outline the conditions that guide the retrieval and use of medical records by public and private entities in the country. In addition, manual record systems should be overhauled with the introduction of electronic health record management systems to ensure efficiency.

Keywords: Comparative study, Use of Temporary Case-Note

Introduction

The healthcare system is very crucial to the survival of the population of any realm, and this is underscored by the well-tested truism that health is wealth. However, efficient health systems are the product of sound and reliable information management processes that is characterised by storage, retrieval and delivery of trustworthy medical decisions across the various segments of a healthcare facility. Health management information system (HMIS), defines a system where health data are recorded, stored, retrieved and processed to improve decision-making (WHO, 2004), and is the first line of service delivery in medical facilities. Health information management is an essential building block for efficient health service delivery and the development of a robust national health policy framework and its implementation. Accordingly, the health management information system is recognised as one of the six building blocks of the health system since it provides data needed for other components for efficient service delivery (WHO, 2010).

Medical record management in most public health facilities continue to rely on paper-based records while only a few health institutions have successfully migrated to computerise health record systems (Osundina et al., 2020). Consequently, it is important to evaluate some of the consequences of this continued dependence on paper-based health records in the administration of public hospitals in Nigeria. Reliable information in a medical facility in addition to well-trained medical doctors, health information professionals and high-quality medical facilities and equipment are key ingredients that make for quality medical care. The use and management of a comprehensive patients' medical records system are crucial for productivity in the hospital as they empower health professionals to make sound decisions in the treatment of patients.

Thus, the recognition of the importance of health information management systems in generating reliable information for effective medical care for people is growing across countries of the world. In many developing countries, health sector reform and decentralisation have brought about shifts in functions between the central government and other peripheral levels of government. These reforms have equally generated new requirements in the process of patients' data collection, processing, analysis and dissemination. Moreover, these reforms have also illuminated the need for standardisation of the health management processes given the association between the quality of medical information and patient's outcome (Postl et al., 2008).

(Mehta et al., 2014)describes a patient health record as the medium that conveys relevant information about the subject's progress to the physicians and other health professionals who are providing care to the patient. A health record is therefore an inevitable communication link among the patient medical care-givers. For those health professionals that provide care on subsequent occasions, the medical records afford critical information such as the history of illnesses and the treatment given to a particular patient. Also, health records provide evidence that may assist in

protecting the legal interest of the patient, the physician and the health institution (Osundina et al., 2020).Research report asserted that medical/health records are a fundamental part of a doctor's duties in providing patient care. In this context, medical records would include handwritten clinical notes, scanned records, consent forms, emails, text messages, verbal correspondence between health professionals, laboratory results, x-ray films, photographs, video and audio recording and any printouts from monitoring equipment (Abdelrahman et al., 2014). In other words, a patient health record present in a succinct but comprehensive manner, the records of a patients' illness and it is therefore the responsibility of the health records officer to ensure that this information is filed and stored in a manner that allows for easy retrieval when the need arises (Abdelrahman et al., 2014).

Consequently, it could easily be deduced that health record management plays a vital role in the health service value chain as the consequences of a failure to produce patient's records during subsequent visits by the health records professional are likely to be challenging for the physician and catastrophic for the patient and hospital in general. This is so because the continuity of the patient care may be hindered, delayed and/or prolonged by the medical professional to avoid wrong diagnosis on the patient.Temporary health records are provided to patients whose medical records are not immediately within the reach of the health records officer. The objective is to ensure that the desire of the patient to seek medical care is not unnecessarily delayed by the inability of the records officer to quickly ascertain the location of the patient's medical folder. However, temporary medical records are not to replace the original medical records of the patient but act only in an interim capacity as a health record. In fact, the practice is that these temporary files are then added to the original folder of the patient when the latter is subsequently found in the archive of the health records.

Nevertheless, the use of temporary case-notes could hamper the process of delivering quality medical care to patients' especially in cases where the patients' original health record is not found. This is because temporary files do not contain case notes and other relevant documents that show the medical history of the patient, and therefore as an interim measure may not actually help the physician in the medical prognosis of any ailment. Therefore, it is in recognition of these issues that this study seeks to investigate the use of temporary folders in two tertiary health institutions in Bayelsa State, Nigeria. Although, other studies on health records management in Nigeria have previously been conducted by scholars (Anyira, 2020 & Osundina et al., 2020), but most of these focused on the general issues bedevilling health records management. However, this study is purposed to specifically investigate the causes, consequences and available solutions to the use of temporary Case note for patient health records in the health records department of hospitals in Nigeria.

Problem Statement

Case notes are created in order to provide healthcare team members with all the necessary information to accurately diagnosed, treat, follow-up and in many cases help to prevent medical conditions, disorders and diseases, wherein the use of temporary case-note emerges when the original cannot be retrieved or accessed. This implies that information in the original document cannot be used for clinical decision making. However, studies in health information management Nigeria have focused more on documentation practices while others on the storage and maintenance of health record.Personal observations by the researcher and interactions with other health professionals, and patients indicated that the use of temporary case notes is frequent, with some devastating effects on both service quality and patient care. It is established that the use of temporary case note leads to duplication of efforts, poor management of patients, delays in continuity of patient care, long waiting time by patients and consequently lack of patient care satisfaction, and moreover, medical quality review processes put in place by hospital management boards are hampered. It was on this basis that the study was designed in order to examine the use of temporary case notes in two tertiary health institutions in Bayelsa State.

Objectives of the Study

The general objective of this study is to examine the use of temporary case notes in two tertiary health institutions in Bayelsa Sate. Specifically, the objectives of the study are to:

i. Examine the causes of creating temporary case notes in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa, Bayelsa State.
ii. Evaluate the purpose of using temporary case notes in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa, Bayelsa State.
iii. Determine the challenges of using temporary case notes in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa, Bayelsa State.
iv. Investigate the effects of using temporary case note in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa, Bayelsa State.

Research Questions

In furtherance of the study, the following research questions have been answered.

1. What are the factors that lead to the creation of temporary case notes in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa, Bayelsa State?

2. What purposes using temporary case notes in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa?

3. What are the challenges of using temporary case notes in Federal Medical Centre and Niger Delta University TeachingHospital in Yenegoa, Bayelsa State.

4. What are the effects of using temporary case note in Federal Medical Centre and Niger Delta University Teaching Hospital in Yenegoa, Bayelsa State.

Literature Review

Health Records (Case Notes)

Case notes document the periodic visits of a patient to the healthcare facility and includes all the correspondence between the patient and the physician as well as other health professionals. It is often the practice that notes would be written by the physician, nurse or radiologist pertaining a patient's medical condition following an official visit to the hospital for a therapy, surgery or any other medical procedure as the case may be. Thus, all medical records containing patient's information such as demographic data, medical history, treatments, test results, family structure and other clinical information provided in the course of medical prognosis are effectively classed as case notes.

Accurate and complete medical notes are important for the successful diagnosis of a patient's medical ailment and therefore serve as a vital source of information to the physician. Hence, it is a standard requirement that patients on their subsequent visit to the medical facility must be given their case notes as provided by the health records department. However, in situations where the location of the patients' case notes cannot be immediately ascertained, a temporary folder is open to allow the patient access to medical care. Moreover, upon the discovery of the original folder, it is merged with the temporary folder. Nevertheless, there are also instances where medical records of a patient is declared missing, A medical record can be classed as missing when a record cannot be found in the archive of the health records department (Khanna, 2005). The problem of missing or incomplete medical records is often typical with manual paper-type health information systems as compared to electronic systems. It is however recommended that missing medical records of a patient should be reconstituted and populated as far as possible with all the relevant information necessary to enable the medical professional reach the right decision.

Life Cycle Theory of Health Record Management

The life cycle theory outlines the basic steps that should be followed in the life cycle of patient's health record management. The theory notes that there are three fundamental stages in the health record life cycle and these stages are the creation stage, maintenance and use stage, and the disposition stage. The creation stage defines the point at which patient health information is collected and stored. The creation of patient health record may be through the manual process of writing down of patient's personal data, filing a form or taking a photograph, etc. Thus, this stage

involves a lot of work as different levels of effort are required in the creation of a meaningful patient health record.

The second stage is the maintenance and use of health records. This stage is very critical to the patient and the medical facility in general. Therefore, it involves the storage of records in well-run, low-cost storage centre and all other practices that are used to eliminate inactive records, and free storage space for new records. This stage is quite critical given the legal, health and cost implications of poor health record maintenance on hospital management. Moreover, disposition is the third stage in the life cycle theory. This refers to the stage where record has become inactive and therefore, no longer required by the medical facility. However, the decision by the medical facility to dispose an inactive record would heavily depend on the value of the information it possesses. Nonetheless, it should be emphasised that the three phases of the life cycle theory are not exclusive but interrelated.

Methodology

The study therefore adopts the survey research design in the gathering, decoding, analyses and interpretation of data. This is due to the fact that the survey research design is amenable to qualitative and quantitative research.

Area of Study: The study is conducted in federal and state tertiary hospitals in Yenagoa local government area of Bayelsa State and the rationale is based on the fact that the local government is the political and administrative headquarters of the State, and would therefore give a more suitable representation of medical facilities in the study area. Moreover, the choice of Yenagoa local government is justified on the basis that it has all the tertiary medical facilities than other local government areas in the State.

Target Population: This research was carried out in two health facilities, namely; Federal Medical Centre (FMC) and State General Hospital in Yenagoa Local Government Area of Bayelsa. The target population of the study was healthcare professionals in the selected medical facilities. Specifically, health Information management officials, medical doctors, pharmacists and nursing professionals in NDUTH and FMC formed the population of the study. The rationale for choosing these professions' is that they are routinely engaged in the use of temporary case files in the administration of health care services in hospitals.

Sampling Procedure and Sample Size: For this study, total enumeration includes the entire population of health information officers, medical and nursing staff of the two selected hospitals for the study. The study adopts the Slovin's formula in determining the sample size from the target population of the study. Therefore, the sample size used for this study stood approximately at 254 healthcare professionals. Furthermore, the study followed the purposive sampling approach in the

distribution of the research instrument to 71 and 183 sampling units in the Niger Delta University and the Federal Medical Centre (FMC), respectively.

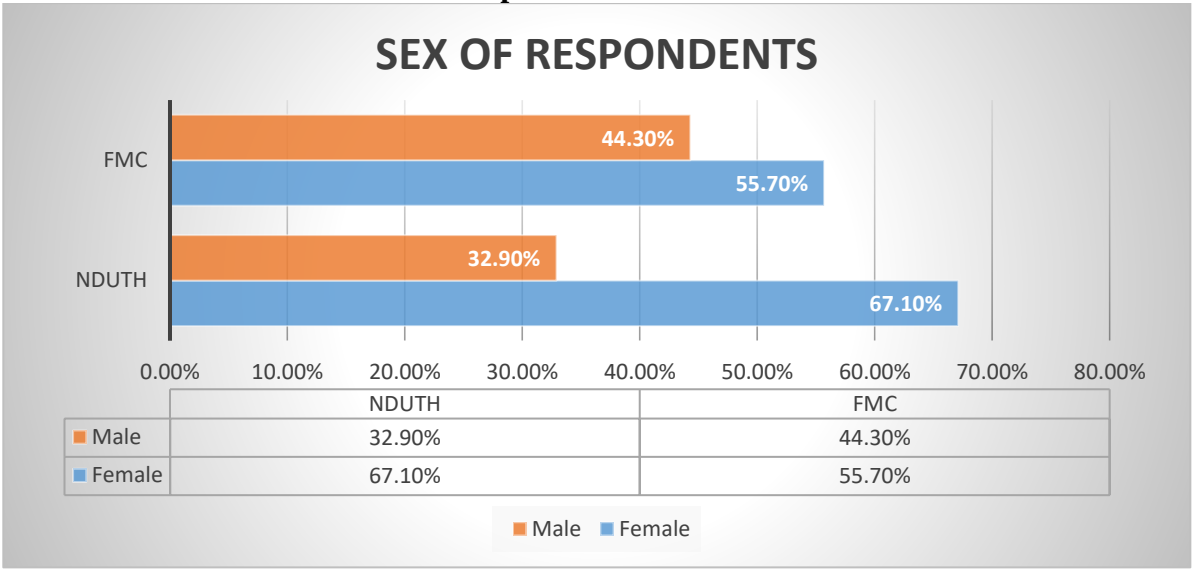
Method of Data Collection: The study used primary data collection, as questionnaire was used to elicit the required data for the research. The method of primary data collection was approached through the administration of questionnaire and direct interview of respondents.

Validity: After designing the questions in a close-ended format, a pilot test was be conducted on a population of fifty (50) participantssimilar to the target population in a selected public medical facility in Yenagoa Local government area. Thus, to ensure the reliability of the instrument, a pilot study wasfirst conducted on a population similar to the target population in Yenagoa Local Government Area. The research instrument was administered twice to a few identical subjects for the study with at least two-week gaps in-between the first and second test. Moreover, fifty (50) health information professionals, doctors, nurses and pharmacists were employed in the pilot test to enable the researcher identify if there were any ambiguities and modifications that should be done to the questionnaire.

Data Analysis: Qualitative data from the retrieved questionnaire was systematically coded, re-arranged and classified into broad descriptive categories linked to the research objectives/questions so as to appropriately situate their relevance to the study. Moreover, tabular summaries based on frequencies, mean scores and standard deviation were used to analyse the data. The hypothesis was evaluated through the use of Pearson correlation statistic with the help of the Statistical Package of Social Sciences (SPSS), version 23.

Results

Table 1.1Gender Distribution of Respondents

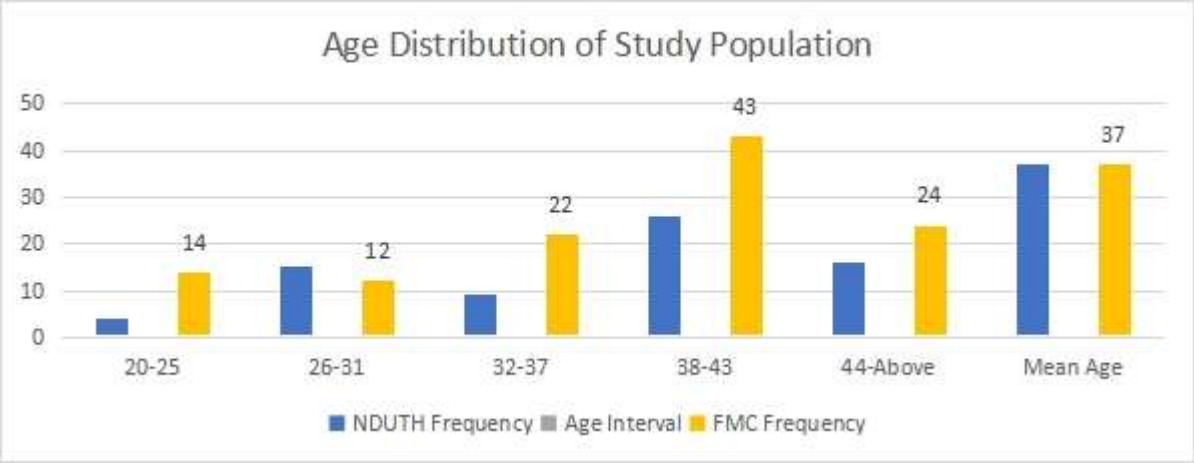


Source: Field Survey, 2024.

The bar chart above shows the gender distribution of respondents to the survey from the two selected tertiary healthcare facility in Bayelsa State. The Table indicates that male and female participants in the survey from NDUTH were 23(32.9%) and 47(67.1%) respectively, and 51(44.3%) and 64(55.7%) in the case of FMC.

Moreover, the table shows that the survey respondents' cut across both sexes in the study, which is imperative to generate diverse opinions on the use of case notes by healthcare professionals in medical facilities in Bayelsa State. The gender distribution also shows that more female health professionals in the two medical facilities participated in the survey. Moreover, the survey had more participants from the Federal Medical Centrecompared to NDUTH. This disparity could be related to the differing mandates of the two healthcare facilities and the size of the workforce in these medical facilities. The FMC was conceptualised as a multi-purpose healthcare institution; hence, professionals in varied areas of healthcare provision and other allied professions form the bulwark of its active workforce, compared to NDUTH which is modelled as a medical training facility with an attendant small-sized work force.

Table 1.2Distribution of Respondents by Age



Source: Field Survey, 2024

The chart displayed above shows the age distribution of the respondents in the survey. The table indicates the age range of the respondents in two medical facilities that participated in the survey. The highest age of respondents in NDUTH (i.e. 44 and above) had not more than 16(22.9%) participants. More respondents within the age bracket of 38-43 participated in the survey. In addition, the age interval of the respondents in FMC showed that those between the ages of 38-43 years responded more to the research instrument used in the survey. Moreover, the mean age of the respondents (37 years) implies that they are in their middle ages which suggest that they are mature and knowledgeable in the normal routines of medical practice. Moreover, it also suggests that the respondents in the two hospitals must have stayed in a healthcare facility long enough to answer research items on the use of case notes in the delivery of qualitative medical services to patients.

Table 1.3Distribution of Respondents by Work Experience

No. of Years	**NDUTH**		No. of Years	**FMC**	
	Frequency	**Percentage**		**Frequency**	**Percentage**
0-5	**16**	**22.9**	0-5	**21**	**18.3**
6-11	**27**	**38.6**	6-11	**40**	**34.8**
12-17	**18**	**25.7**	12-17	**31**	**27.0**
18-23	**7**	**10**	18-23	**15**	**13.0**

24-Above	**2**	**2.86**	24-Above	**8**	**6.96**
Mean	**10**	**100**	Mean Age	**11**	**100**

Source: Field Survey, 2024

The table showcase the work experience of the respondents that participated in the survey in the selected medical facilities in Bayelsa State. It reveals that the mean years of work experience for participants from NDUTH and FMC is 10 and 11 years, respectively. The mean years of work experience of professionals in both health facilities presupposes the fact that they have been in the health profession for quite some time and may have experience issues relating to the use of temporary case notes in medical facilities, hence, they could effectively respond to questions pertaining to its' workability in a healthcare facility.

Data Analysis

Table 4.4 Comparative assessment of factors causing the creation of temporary case notes in Medical Facilities

	NDUTH			FMC		
Items	**Mean Score**	**STD**	**Ranking**	**Mean Score**	**STD**	**Ranking**
1. When the original case note is used for research	55.75	61.462	High	96.5	107.5	Very High
2. When the original case note could not be retrieved	57	70.743	High	94	98.26	Very High
3. The original case note is with the consultant	63	81.232	Very High	92.25	110.5	High
4. Mislaying of the original case notes because of inadequate filing equipment	59.5	68.046	Very High	94.25	108.7	Very High
5. Misfiling of the original case notes by quacks in the health records department	56.25	71.63	Very High	91.5	100.1	High
6. Poorly illuminated health records library	56.5	69.811	Very High	87.75	118.6	High

7.	**Non-implementation of Electronic Health Records system.**	56	59.172	High	98	107.8	Very High
	Grand Mean	57.714	2.6474	Grand Mean	93.4642	6.769	Very High

Source: Field Survey, 2024

As shown in the table above,the opinion scores of the respondents in the two selected hospitals to the factors that lead to creation of temporary case notes in medical facilities in Bayelsa state. The results show that respondents in NDUTH strongly assert that when original patients' health records are domiciled with medical consultants, mislaid by health records' staff and or stored in poorly illuminated health records libraries, it could lead to the creation of temporary case notes in the hospital. This is shown by the high perception scores of items 3,4, 5 and 6 respectively. Also, in FMC, the results show that items 1,2,4 and 7 are above the criterion mean, indicating that they are assessed highly by the respondents in the hospital as factors that significantly cause the creation of temporary case notes in medical facilities. Moreover, the grand mean is above the criterion means of the two health facilities, denoting the fact that that the items are significant predictors in the examination of factors that cause the creation of temporary case notes in hospitals.

Table 4.5 Rationale for using Temporary Case notes in Hospitals

Items	NDUTH			FMC		
	Mean Score	**STD**	**Ranking**	**Mean Score**	**STD**	**Ranking**
1. For prompt patient care	58.5	69.69218	**Very High**	92	110.0666	**High**
2. For follow up care	53.25	65.91598	**High**	90	108.9342	**High**
3. For research purposes	55.75	80.64893	**High**	92.25	108.1862	**High**
4. For patient care evaluation	59	65.91914	**Very High**	98.25	111.9594	**High**
5. For referral	60	68.25443	**Very High**	84.25	92.32686	**Moderate**
6. For the purpose of reducing patient waiting time		70.76722		88.75	108.9017	**Moderate**
Grand Mean	57.41667	2.483277	**Very High**	90.91667	7.178106	**High**

Source: Field Survey, 2024.

Table 4.5 is a tabular outline of the opinion scores of respondents in the selected medical facilities on the reasons necessitating the creation of temporary case notes for patients visiting medical hospitals. The table shows that respondents in NDUTH view items 8, 11 and 12 as highly significant in determining the reasons why medical professionals utilise temporary case notes in the course of medical prognosis since the mean scores are above the criterion mean (57.2). This is in addition to the high perception given to such factors as the need for the follow-up of patients' medical care and research which were ranked high, respectively. Moreover, the ranking of respondents mean scores in FMC indicates that most of the items were perceived highly (8. 9.10and 11) and moderately (12 and 13) as factors responsible for the use of temporary case notes in hospitals. Of particular interest, is the values of the standard deviation for FMC which are above the mean scores showing how widely dispersed the opinion of the respondents were on each of the items. Furthermore, the table shows that the grand mean (57.4) for NDUTH is above the criterion mean (57.2) and its standard deviation is a little above 2 standard deviation points from the grand mean affirming that the factors elucidated in table 4.2.1 to a very high extent significantly denote the rationale for the use of temporary case note in the hospital facility. On the other hand, the grand mean for FMC (90.9) is below the criterion mean (93.4) and signals that the items in the section to a high extent are reasons for the use of temporary case notes in the medical facility.

Table 4.6Mean Scores of Respondents on the challenges of using temporary case notes in hospital

Items	Mean Score	STD	Ranking	Mean Score	STD	Ranking
1. Lack of previous clinical Examinations	61.25	79.26065	Very High	98	112.5848	Very High
2. Lack of previous history	59	67.02238	Very High	100.25	122.3993	Very High
3. Absent of laboratory investigations	57.5	63.06346	Very High	95.25	99.42292	Very High
4. No knowledge about previous prescriptions	55.75	51.46115	Very High	93.5	100.7058	Very High
Grand Mean	**58.375**	**2.331845**	**Very High**	**96.75**	**10.84294**	**Very High**

Source: Field Survey, 2024.

In particular, the results suggests that absence of patients' medical history, including previous clinical examination and laboratory diagnosis are challenges that could effectively affect the medical professional in the course of employing temporary case notes during treatment and in the process of managing the care provided to a recuperating patient. Moreover, the grand mean is above the criterion mean and further attest to the fact that respondents in the two medical facilities significantly view the items in the section as possible demerits of deploying temporary case notes in hospitals.

Table 4.7: Mean scores of the effects of using temporary case notes in Hospitals

Items	NDUTH			FMC		
	Mean Score	**ST.DEV**	**RANK**	**Mean Score**	**ST.DEV**	**RANK**
1. **Low Quality care**	57	63.62913	High	96.75	104.1389	Very High
1. Patient care dissatisfaction	50.25	47.27491	High	93.5	98.92927	Very High
2. Duplication of efforts	57.25	69.95892	Very High	89.75	85.87733	High
3. Makes patient follow-up difficult	55	53.02829	High	95.25	106.3246	Very High
Grand Mean	54.875	3.243583	High	93.8125	9.167592	Very High

Source: Field Survey, 2024.

Table 4.7 shows the mean scores of respondents in the two selected medical facilities on the effect of deploying temporary case notes in the course of providing healthcare services to patients. The study shows that research participants in NDUTH opined that duplication of efforts was amongst the highest effect of the use of temporary case notes in hospitals, even though they also assert that it could affect the quality of care and make the follow-up of patients difficult. On the other hand, respondents in FMC as shown in the rankings of items 18, 19, 21 affirmed that the use of temporary case notes could impact the quality of patient care and lead to patient dis-satisfaction, as well as affect the follow-up efforts of the physician. The grand mean suggests the extent to which these

items are regarded by respondents as capable of significant impacts to the use of temporary case notes in hospitals.

Hypothesis

Table 4.8 Pearson Correlation Statistic

		FMC	NDUTH
FMC	Pearson Correlation	1	.043
	Sig. (2-tailed)		.853
	N	21	21
NDUTH	Pearson Correlation	.043	1
	Sig. (2-tailed)	.853	
	N	21	21

Source: Author's Computation, 2024.

Table 4.8 shows the results of the Pearson correlation statistic. The table points to the fact that the value of the correlation coefficient is 0.043, indicating that it was less than the significance level of 0.05%. This suggests that there is positive and significant relationship in the views of respondents on the issue of temporary case notes in the two selected medical facilities.

Discussion of Findings

The comparative assessment of the use of temporary case notes in federal and state tertiary medical facilities in Bayelsa State has shown that the respondents in the two medical facilities generally opined that factors such as the use of patients records by consultant, mislaying of patient files, storing in poorly illuminated libraries and inadequate filing equipment are the factors that cause the creation of temporary case notes in hospitals. Also, the results from NDUTH is in conformity with FMC, Yenagoa, which strongly assert that when original patients' health records are domiciled with medical consultants, mislaid by health records' staff and or stored in poorly illuminated health libraries, it could lead to the creation of temporary case notes in the hospital. This is shown by the high perception scores of items 3, 4, 5 and 6 respectively. Also, in FMC, the results show that items 1, 2, 4 and 7 are above the criterion mean, indicating that they are assessed highly by the respondents in the hospital as factors that significantly cause the creation of temporary case notes in medical facilities. Moreover, the grand mean is above the criterion means of the two health facilities, denoting the fact that that the items are significant predictors in the examination of factors that cause the creation of temporary case notes in hospitals.

The findings of this study is in unison with a similar study result (Anyira, 2020), wherein reported that the major threats to medical records in healthcare facilities include rodents and pests,

misplacement, tampering, physical damage, lack of skilled staff, dust, wear and tear,poor power supply, and lack of ICT deployment. (Osundina et al., 2015) indicated that the absence of enough shelves and cabinets, and the use of over-crowded store rooms due to paucity of funds, were the main problems affecting health record management in Nigeria.

Furthermore, the findings show that the purpose of utilising temporary case notes ranged from the need to provide prompt medical care to patients, and of providing a means for follow-up. The study also revealed that temporary case notes help reduce waiting time and could serve as means for medical referral of the patient. Moreover, the findings also suggest that there was unanimity of agreement in the response of the both tertiary hospitals as regards the challenges faced by healthcare professionals in the deployment of temporary case notes in hospitals. The result show that these challenges include the absence of patients' medical history and any previous medical prescriptions in the new folder created for the patient. In addition, the findings show that absence of documents detailing laboratory investigation and previous clinical assessment pose significant challenges in the use of temporary case notes by medical professionals.

Also, on the effects of using temporary case notes in hospitals, the findings show that respondents in FMC assert that it could lead to low quality of patient care and lead them to display behaviour that suggest their dissatisfaction of the service they had received. Moreover, the findings suggest that it could affect the process of patient follow-up outlined by the medical professional. The outcome of this study is in conformism with (Osundina et al., 2020) survey result, which stated that mislaying and misfiling of patients' health records had deleterious consequences on the patient's health as well as legal and cost implications on hospital administration.

The Pearson correlation test of the hypothesis affirmed the existence of positive relationship in the views expressed by participants in the two medical facilities on temporary case notes and its deployment in hospitals in Bayelsa State. The study of Adebayo et al.(2021) revealed a positive significant correlation between adoption factors and EMRS systems' success (r= 0.440) and there was a strong positive correlation between usage evaluation and system success of EMRS in the two healthcare facilities (r= 0.618).

Conclusion/Recommendation

The deployment of temporary case notes in hospitals cannot be effectively ruled out where the process of collection, storage and management of patients' health records is heavily dependent on manual filing systems. However, manual health record systems could be burdensome since it is time consuming and does not provide avenues for back-up of records in health records libraries of medical facilities.

The use of temporary patient case notes is to act as an intermediate machinery that is capable of facilitating patients' access to medical services in situations where the original folder is inaccessible, asit is not devoid of problems in its administration in the hospital. And given its sensitivity in the process of health care delivery may impact on the quality of healthcare service

delivery in hospitals in the country. Therefore, the processes and strategies that should be adopted in mitigating the issues arising from the use of temporary case notes in hospitals should not only be effective in the short-term but must be such that fosters lasting solutions to the storage and management processes of patients' health records in public hospitals in the country. This is because of the importance of preserving health records in the health sector to the economic development of the country and the maladies engendered in the sector where health record systems are inefficiently managed.

On the basis of the findings of the study, the following policy recommendations are proffered to mitigate the challenges posed by the use of temporary case notes in the tertiary hospital facilities:

1. Regulators and Hospital management are encouraged to formulate a comprehensive health records management policy to safeguard private records and outline the conditions that guide the retrieval and use of medical records by public and private entities in the country. This will ensure that more people including patients are aware of the policies that guide these records and eliminate alienation, remove any bridge in communication and heighten the level of involvement of health professionals in the regulation of the use of temporary case notes in the sector.
2. There is the need for the government to train and re-train health information management officers on the standard practice involved in the management of patient health records to justify the purpose for the introduction of temporary case notes in the provision of health care services. In addition, health records department in public hospitals should be adequately equipped with storage facilities in a conducive environment that promotes the durability and longevity of temporary case notes.
3. To eliminate the challenges that often bedevil the use of temporary case notes due to its heavy dependence on manual health record systems, hospital management are advised to completely overhaul their system with the introduction of electronic health record systems in the retrieval, storage and management of patient records in their facility.
4. The effects of the deployment of temporary case notes devoid of original copies of the medical case history of patients is a potential source of inefficiency and low productivity among healthcare professionals. Hence, it is recommended that management of health record systems should be proactive in locating and resolving issues that may cause the use of temporary case folders in the hospital. This could be done by improving the health records management.

Suggestions for Further Studies

The study envisages opportunities for further studies on the possibility of deploying electronic health record management systems in the retrieval, storage and management of health records systems and their compatibility in public hospitals at the sub-national levels in Nigeria.

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