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Assessment of Medical Records System towards Ensuring Confidentiality of Patients Records Case Study of Medical Records Department in Federal Medical Centre, Ebute-Metta, Lagos, Nigeria.

BY

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APPROVAL PAGE

This project was reviewed and approved by the Committee to meet the requirements for the awarding of (BSc. HIM) Bachelor of Science Degree Health Information Management

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DEDICATION

This project work is dedicated for the academic advancement of Health Information Management Profession in Nigeria and Diaspora.

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ISSN No:-2456-216

ABSTRACT

This research is to assess Medical Records System Towards Ensuring Confidentiality Of Patients Records a Case Study Of Medical Records Department In Federal medical Centre, Ebute-Metta Lagos, Nigeria.;four (4) objectives were set up in order to achieve the desire alongside with four (4) research question, literature was extensively reviewed on assessment of medical records system toward ensuring confidentiality of patient record from different authors under the objectives mentioned. The research design was descriptive research method to obtain information from 72 respondent representing the entire population of the study area data collected were analyzed in tabular form using percentage some major findings include: findings show that provision of adequate working materials will enhance the production of accurate patient health information asserted by the table 4.7(52.54%)its equally shows that code and conduct should be follow and properly maintain to ensure confidentiality of patient record as asserted by the table 4.10(59.33%)and also observe that electronic medical record help with the standardization of patient record as asserted by table 4.14(72.88%)and also the recommendation were made suggestion the need for the hospital management should improve the welfare of the health information personnel in other to avoid any circumstance that will lead to poor management of patient information in the hospital. And also made of operation :The government should also provide adequate operating materials to the department of health information management to enable the delivery of quality healthcare services to patients in the hospital. Also made suggestion about the staffs in the health information management department should make sure they abide by every code and conduct of the profession for effective practice in the hospital. And also the hospital management should embark on electronic health record because it contains all standards of managing information.

ISSN No:-2456-216

TABLE OF CONTENT

ISSN No:-2456-216

ISSN No:-2456-216

CHAPTER ONE

BACKGROUND OF THE STUDY

A. Introduction

Assessment and validating of medical records system towards ensuring the confidentiality of patient information is essential for Building trust between patients, health care professionals and the public.

Trust between patients and their healthcare providers is a better way to get health information confidential. Trust-based physician-patient relationships can improve interactions and lead to higher quality visits.

A patient record system is a type of clinical information system, which is used to collect, store, manipulate, and make available clinical information that is important for the delivery of patient care.

Medical confidentiality is a set of rules that limits access to information discussed between a person and their healthcare practitioners. With only a few exceptions, anything you discuss with your doctor must, by law, be kept private between the two of you and the organisation.

The assessment of record system is a communication tools that supports clinical decision making, coordinating services, evaluation of the quality and efficiency of care, research, legal protection, education accreditation and regulatory process, documentation in normal course of its activities, the documentation must be authentication and hand writing must be legible in order to make the record confidential by unauthorized others.

Respecting the confidentiality of patient's records is an ethical mandate, many organizations explain this obligation, including the American Hospital Association (AHA), American college of Health care executives, joint commission on accreditation of healthcare organization and the ASCP. The AHA patient's Bill of rights stresses privacy as a basic right for all patients, stating that right for their medical, financial, and personal information, including religious affiliation, home address. And marital status should remain confidential.

Beyond the ethical considerations specific state and federal laws pertaining to patient confidentialityexist violation of these statutes can result in criminal prosecution. Most states have a confidentiality law, legislation called the medical records confidentiality Act was introduced in congress in 1995. How confidential medical information may be released is becoming more problematic as organizations computerize medical records to improve the delivery of care.

When you see a familiar name that of a celebrity, your neighbor, or coworkers family members in the course of your work, it might be tempting to announce it to your colleagues, doing this, however, violates the patens right to privacy. Information about patients should be shared only if it is crucial to your job duties. Similarly if you see test result of a coworker, if is in appropriate to say anything to anyone, including the coworker, about it. If someone wants you to know his or her personal business that person will share it with you.

Employees who have witnessed a breach of confidentiality should consult their institutions policy on confidentiality. Every health care organization should have a policy that defines confidentiality and delineates who is responsible for maintaining it.

A good policy will state that every person who works for the organization is responsible for ensuring patient confidentiality and for reporting policy violations. It also will state that managers are responsible for implementation and enforcing the policy as it pertains to their areas. Information about patients should be accessed or discussed only on a need to know basis according to job duties. To protect against law suits, organizations should present the policy to new employees in orientation, and have all employees sign a statement that they are aware of the policy.

To answer the readers' questions if no policy exists or the manager has ignored the employee: The employee should contact a representative from his or her human resources department for guidance. The employee should describe the violation in memo format. He or she may bring the memo to human resources or to a top administrative official of the organization. The organization should discipline the employee who first broke confidentiality and the manager who failed to reprimand the employee, according to the organizations disciplinary policy.

Depending on the level of administration at which complaints had been ignored, the employee who reported the violation should be prepared for some back lash. The employee who committed the violation and the manager who ignored it probably will be angry. Any reprisal attempts should be reported to the human resources department.

Mr. John responds: confidentiality of patient records is the responsibility of every health care employee. All communications and records, weather verbal, writing, or electronic, should be treated as confidential. Institution policies should emphasize that information about patients should be shared only with those who have a genuine need to know specific information, such as those providing care or diagnostic information, insurance companies, or those arranging placement or other financial assistance. Information should not be discussed with anyone else without the patient's written permission. Furthermore,

the law of often requires confidentiality for patients records specifically regarding tests for human immunodeficiency virus, treatment for psychiatric conditions, alcohol or substance abuse, and maternity or abortion.

The confidentiality policy of most institutions lists the chain of command that employees should follow when reporting confidentiality violations. In general, an employee should first report a breach of confidentiality to a supervisor. If the issue is not addressed at that level, the employee should report it to the next level of administration and pursue the issue until action has been taken at some administrative. Ultimately, the chain of command extends to the chief executive officer of the institution. Who has overall responsibility for confidentiality of patient Information.

If an employee believes the matter has not been resolved within the institution, she or he confide a complaint with the state agency that regulates health care institution, she or he can file a complaint with the state agency that regulate health care institutions. Weather that employee is liable for not reporting such matter to the agency may differ from state to state, depending on regulatory guidelines.

Patients should be able to expect and receive privacy concerning their medical care. As health care employees, we must do everything possible to preserve that right and expectation.

B. Statement of the problem

Patients routinely share personal information with health care providers. If the confidentiality of this information were not protected, trust in the physician-patient relationship would be diminished, most healthcare institutions faces challenges on how to make the patient information or records to be valid and confidential, this motivated me to carry out this research using FMCEB as a case study.

C. Scope of the Study

This research work is limited to the staff of Medical Records Department in Federal Medical Centre, Ebute-Metta, Lagos, Nigeria. Other relevant journals, magazines were studied for review accordingly.

D. Objective of the Study

- To provide accurate patient health information.
- To enable patient health information to be secured.
- To ensure confidentiality of the patient health information.
- To developing the method of making patient information to be confidential in Federal Medical Centre, Ebute-Metta.

E. Research question

1) What is the method of providing accurate patient health information?
2) How can we provide patient health information to be secured?
3) How to ensure confidentiality of the patient health information?
4) How can we provide the method of making patient record to be confidential in Federal Medical Centre, Ebute-Metta?

F. Research hypothesis

Ho: they are no method of providing accurate patient health information.
Hi: They are method of providing accurate rate patient health information.
Ho: we cannot provide patient health information to be secured.
Hi: we can provide patient health information to be secured.
Ho: we cannot ensure confidentiality of the patient health information.
Hi: we can ensure confidentiality of the patient health information.
Ho: we cannot provide the method of making patient record to be confidential in Federal Medical Centre, Ebute-Metta.
Hi: we can provide the method of making patient record to be confidential in Federal Medical Centre, Ebute-Metta.

G. Significance of the Research

This research will enhance the MedicalRecords Department staff and the hospital management way or process of assessing patient record to be valid and confidential to secured by unauthorized uses in Federal Medical Centre, Ebute-Metta.

H. Definitions of Terms

- **Health:** The WHO defines health as an entire stage of one's mental, physical and spiritual well-being.
- **Record:** This can be defined as any instance where information is stored or placed on a medium that preserves it for future reference.
- **System:** This can be described as a system that enables us handle a situation.
- **Assessment of medical records:** It involves the evaluation of complete medical records. It covers information governance, authorship validation, amends, record corrections, and auditing the record to verify documentation validity for reimbursement claims.
- **Validation** is the state of authenticity, completeness, and authentication of medical documents.

ISSN No:-2456-216

- **Confidentiality** refers to the protection of personal data. Confidentiality refers to keeping client information confidential between you, the client, and others, such as co-workers, family members, friends, and relatives.
- **The patient:** Any recipient of health services. Most often, the patient is ill or injured and requires treatment by physiotherapies physician assistants dentist podiatrist veterinarian or another health care provider.
- **Health Record:** This is an information storage system and retrieval system that is the authoritative resource for a specific data element in a system with multiple sources. For data integrity to be maintained, there should only be one system of records for any given piece of information.

ISSN No:-2456-216

CHAPTER TWO

LITERATURE REVIEW

A. Introduction

This chapter deals with overview of the related literature about the previous research work that carried out by different researchers in the same topic or similar topic in text books and online materials about the subject matter.

B. Literature review

Maj Open (2017) has his research on manual examination of electronic medical records in a validation study.

Canadian primary care sentinel surveillance networks (CPESSN), have previously validated case definitions for chronic diseases (diabetes and hypertension, diabetes, osteoarthritis and depression, Parkinsonism and dementia), using direct review of "raw" electronic medical record data. While this method proved to be effective, it was slow and could present organizational and methodological problems. We wanted to see if the processed and standardized information contained in the (CPESSN] database could serve as a reference for case definition validation.

Zaherdsad (2013) conduct research on validation of the health care record best practices for HER. Many features of electronic record tools are intended to improve both the quality as well the validity and communication between all healthcare providers. These tools address well-known requirements regarding record principles, while also supporting extensive new technologies. However without appropriate management and guidance, these features may cause information validity concerns, such as incorrect auto population of data fields or manufactured documentation aimed for increased expected reimbursement. To ensure that records for health information used in research, care, and management are accurate, valid, and trustworthy, processes must be put in place. Zaherdsad (2013)

There are a number of existing rules and regulations on record principles and guidelines that primarily address record authorship principles, auditing, and forms development in a paper health record. New guidelines are being sought by the health care industry that ensure and reserve record to be validity in an age of electronic exchange and changes in the legal evidentiary requirements for electronic business and health records. Zaherdsad (2013)

With the continued advancement of electronic health records (EHRs) there is increasing concern that a potential loss of record, validity could lead to compromised patient care, care coordination, and quality reporting and research as well as fraud and abuse. This practice brief provides guidance for maintaining patient record to be valid. While using automated HER functions Zaherdsad (2013)

Validity of record means that the complete health record is accurate. It includes information governance, patient ID, authorship validation, amends and corrections, as well as auditing the records for documentation validity when submitting reimbursement requests. EHRs allow you to use smart phrases and templates as documentation tools. These tools can be misused incorrectly and data validity could be question. For confidentiality to be maintained, it is important that there are established policies and procedures, such as audit functions. Zaherdsad (2013)

Without safeguards in place, records could reflect an inaccurate picture at the patient's condition, other at admission or as it changes over time the provider must understand the necessity of reviewing and editing all difficult data to ensure that only patient specific data for that visit was corded, while all other irrelevant data pulled in by the default template is removed. For example, the automatic generation of common negative findings within a review of systems for each body area or organ system may result in a higher level of service delivered, unless the provider documents any patient positive result a deletes the incorrect auto generated entries. Zaherdsad (2013)

Berg (2014) is one of the many who are concerned about misuse of health information. Most concerning is the misuse or disclosure of health information for financial gain or to cause injury or embarrassment. Previous literature suggests that these threats manifest not only in unauthorized user but also in those authorized to view files. Privacy was breached by legally sanctioned activities like billing procedures from remote locations and casual or careless discussions between medical professionals in hospital elevators. (weiss (2015).

It is important to keep in mind that not only is misuse of medical information found in records about health possible in paper records but also electronic records. Electronic tools such as electronic mail, digital imaging, and telemedicine are now essential to conduct business in the electronic healthcare field. Because records can be accessed remotely, they are vulnerable. To prevent unauthorized access of electronic patient records, an effective security system is required (Meclanahan (2016).

Gatee (2015) states that electronic health records can be used frequently and offer many access to information. It also reduces errors in clinical care often caused by poor handwriting. E-health records could also help to reduce the cost of managing patient records. These records can also be used to improve communication between healthcare professionals and patients Shaw (2014)

ISSN No:-2456-216

Even though electronic health records have many benefits, they also present some challenges. Gartee (2010) argues that they are costly and require substantial financial resources to be set up. A second disadvantage of electronic records is their technical nature, which means that they need training before being used. It is also difficult to implement because they lack standard terminology and an architecture. Security issues are one of the main challenges associated with electronic health records.

Gartee (2017) also states that security breaches could compromise the confidentiality and privacy of electronic health records. Data encryption is used to protect records and allows for internet transfer protocols to manage access. This allows for the tracking of electronic health records to determine who has received disclosed data. Biometrics are another way to safeguard electronic health records. To secure computer access on networks and storage devices, fingerprint ID recognition is used (M. clanahan (2008)

Gatee (2008). Records of an organization (such as the hospital) are the corporate memory. These records supplement human memory, and provide guidance for planning and decision making. Teaching hospitals have the advantage of having records. In order to make use of past experiences, accurate records are essential for planning the future of the hospital.

Popola (2010) stated information and records management were the foundation of business activity. Without information management, planning and decision-making would be difficult. Information is the input factor in rational organizational decision making. It also helps to deliver high-quality services. It is necessary to establish, deliver, assess and evaluate the effectiveness organizational policies, make informed decisions about alternative course of action, provide the basis and allow for transparency and accountability, protect individual right and enforce legal obligations. In a nutshell many authors, both from developing and developed countries, agreed that health records were an essential ingredient in health institutions. However, proper management of health records requires storage areas, controlled access, and appropriate preservation measures to increase efficiency, safety, and quality of career Popola (2010).

C. Overview of the study extent

- Definitions
  - Validation and verification of health records: The source of information used for many purposes including quality evaluations of care. However, the records are a valuable resource. There have been few attempts at validating the records content against the verbal content between the patient and the physician. Romp (2012)
  - Validation of medical record: is involves the accuracy of the complete medical record. It encompasses information governance, patient identification, authorship validation, amendments and record corrections as well as auditing the record for documentation validity when submitting reimbursement claims. The dyers (2016)
  - Confidentiality of the health record: refers to the obligation of professionals who have access to patient records or communication to hold that information in confidence. Rooted in confidentiality of the patient provider relationship that can be traced back to the fourth century. (Meway, 2013)
  - Confidentiality of health records: is the professional obligation to keep health information confidential is supported in professional association codes of ethics, as can be seen in principle of the American health information management association code of ethics " advocate, uphold, and defend the individual right to privacy and the doctrine of confidentiality in the use and disclosure of information" (Anima, 2011)
  - Confidentiality is recognized by law as privileged communication between two parties in a professional relationship, such as with a patient and a physician, a nurse or other clinical professional. (Broderick, Billy, Rinehart Thompson, Reynolds, 2012)

D. Problems:

Umyrt (2014). Heath records are sensitive and have caused many problems in managing institutions. Common problems include storage, access, safety, and security. Many hospitals that use manual-based systems for their health records have storage difficulties. Users and custodians also face access issues. There can be conflict between the owner and right to access a patient's record. The 2003 fair health information practice act (Use Fair Health Information Practice Act) aims to reduce friction by requiring health care providers to permit individuals to view their health records. This also includes provisions for civil and criminal penalties for failing to comply with this requirement. (Wageredal 2003)

Personal responsible for the security and safety of patient records faces many challenges. Nicholson (2017) stated that in many instances, case notes weren't kept in a secure state. In the numerous examples Nicholson provided, it would have been very easy for unauthorised individuals to gain access to case records either from uncontrolled areas or open libraries. One example is that case notes were not attended to in outpatient clinics. Because the health records department had closed, some cases were left in Dynic Area overnight. Nicholson also stated that any unattended computer terminals are a potential risk, as well as fax machines and insufficiently controlled computer networks. There are many risks associated with managing patient information.

E. Identify causes of problem

1) Uses of manual or paper – based record
2) Laziness
3) Wrong data
4) Lack of training

5) Negligence
6) Inadequate provision of working materials
7) Lack of conducive working environment
8) Illegible handwriting
9) Lack of concentration
10) Shortage of manpower

F. Solution to the Problems

Some of the possible ways of finding solution to the problems mentioned are as follows:

By using electronic health records or by using computerized system of keeping record:

- Easier to limit unauthorized access: connected system provide more consistent and measurable security than paper based systems. Instead of filing cabinets, lock and guards electronic records are kept behind log ins or biometric sensors (Billytab, 2014)
- Easier to track who views your medical information: anyone who attempts to log in to the system and review private health care information will have to provide authorization. unlike paper records, which can be misplaced or copied, electronic records can be constantly monitored and tier access tracked, patients concerned about the unauthorized release of personal information will realize a level of security that is, in health care this far unknown because even these who attempt unauthorized access will have left their electronic fingerprints in the system (Billytab 2015)
- Records are always available with instant access: interoperable electronic health information system provide constant access to data for authorized users, if a doctor or patient needs a medical history, lab results, or radiological images at any time, the information can be reviewed instantaneously (Billytab 2015)
- Records less likely to be cost: electronic healthcare information stored on an interoperable system will be preserved in backup copies, so it is highly unlikely that records would be lost (Mj mike 2016)

G. Improve quality of care:

- Notes, prescriptions, and data are always readable. Paper records are written at least partly by hand, but electronic records are stored as digitized text, visual image files and matrices of standard options there will never be any doubt about text recorded in the electronic information (Mj mike 2016)
- Patients with chronic conditions can take better care of themselves: these with chronic condition such as diabetes can benefit from improved interaction with their healthcare providers and increased access to health care information. With an interoperable system, those patients will be able to more easily contact their health care providers allowing those patients to more effectively manage issues of day to day care when healthcare providers establish on line links to articles and information about various conditions, their patients gain tools for maintaining their health. (Mj mike 2016)
- Provision of enough machines will make the result to be done easier and faster.
- Employing more staffs that are well train in the activities of record keeping.
- Make a good and standard plan to the activities of the hospital.
- Provision of qualitative materials that will ease the work of the staffs.
- Provision of adequate working materials.

Zaherdsad (2013) Electronic record tools offer many features that are designed to increase both the quality and the validity of clinical record, enhancing communication between all healthcare provider, these feature address traditional well known requirements for record principles while supporting expansive new technologies use of these features without appropriate management and guideline however, ma create information validity concerns such as invalid auto population of data fields and manufactured documentation aimed to enhance expected reimbursement. Processes must be in place to ensure the record for the health information used in cared research and health management was valid, accurate and health trustworthy. (Mj mike 2016)

Beers (2014) among others was concerned about the misuse of health records and state that the confidentiality of health records was threatened in many different ways most news worthy is the misappropriation and disclosure of health records of financial gain or to course harm or embarrassment.

Prior literature suggests that the threat of abuse of health records manifest: not just in unauthorized users but in those authorized to access file as well often confidentiality was breached through legally sorictioned activities such as billing procedures conducted from remote locations as well as casual or careless carver stations among medical professionals in hospital elevators (Weiss 2015)

It is also important to note that the misuse of health information found in medical records was not only manifested in paper-based records, misuse an also occur in electronic medical record: electronic tools such as the internet, electronic mail, digital imaging and telemedicine are now indispensable for conducting business in the electronic healthcare field and are equally vulnerable. They are vulnerable because the electronic environments allow remote usage of records, in this regard effective security system are needed to limit unauthorized access to electronic patient records (Meclanahan, 2016).

ISSN No:-2456-216

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

A. Introduction

This chapter contains the method used in conducting the research work. The chapter would be discussed under the following subheading: research design, description of the study area, population of the study area, sample size and sampling techniques procedure, instrument for data collection, source of data, study instrument, validation of the instrument, reliability of the instrument, method of data analysis, limitation of the study.

B. Research design/study design

The research design used for this research is descriptive method: this consists of collection of data through the use of constructed questionnaire distributed to the respondent which was conducted among the staff of department of health information management in Federal Medical Centre, Ebute-Metta.

C. Description of the Study Area

Federal Medical Centre, Ebute-Metta, Lagos has gone through various stages of metamorphosis. It began in 1964 as department of health services of the Nigerian Railway Corporation (NRC). The hospital was created to cater for the health needs of Railway workers and their families. It was also annexed to the Lagos University Teaching Hospital from 1967-1970 to cater for wounded soldiers during the Nigerian Civil war. Then between 1984 and 1985, it served as a referral centre to parastatals under the Ministry of Transport and Aviation. However, the Federal Executive Council approved its upgrade from Nigerian Railway hospital to Federal Medical Centre on the 24th of May, 2004. Then, on the 31 st of January, 2005, the hospital was formerly handed over to the Federal Ministry of Health as a Tertiary health care institution and designated Federal Medical Centre, Ebute-Metta, Lagos. The hospital handles such medical cases as: Internal Medicine, General Surgery, Ortho paedic surgery, Obstetrics and Gynecology, Pediatrics, Dental Surgery, Ophthalmology, Radiology and pathology, functional Dialysis centre among others. The hospital has continue to develop and sustain a dynamic and comprehensive health service delivery system through highly efficient personnel with the aid of training and re-training of its professionals of staff in various fields. As one of the Federal Government owned hospitals in Lagos State, Federal Medical Centre, Ebute-Metta offers very highly qualitative and patient friendly medical care services.

D. Population of the Study

The population of the study was limited to staff of medical record department in the Federal Medical Centre, Ebute-Metta, and the department has the total number of staff of (72) in the Hospital which means the population of the study will be 72 people research to cover.

E. Sample Size and Sampling/Techniques/Procedure

The research considered the population size and make the sample size to be equal to the total number of the population because the researcher can cover the whole population which means no sampling technique were use.

F. Instrument for Data Collection/Source of Data

The instrument used for data collection is questionnaire developed by the researcher. Seventy two 72 questionnaires were distributed to the respondent. The questionnaires consisted of two (2) sections. Section (A) contains demographic data of respondent while, section (B) contains the research questions. The researcher used type five point scale in which the statements are to be answered by the respondents according to how best each statement represents the respondents feeling based on agree, strongly agree, or undecided, disagree, and strongly Disagree rating scale.

G. Method of Data Analysis

For the purpose of easy understanding and clarity all the data gathered was analyzed and interpreted first before being presented in tabular form and percentage.

ISSN No:-2456-216

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

A. Introduction

The data obtained from the respondents on the assessment of medical records system toward ensuring confidentiality of patient record. 72 questionnaires were administered to the respondents and only 59 questionnaires were successfully retrieved representing 72. Therefore analysis of the information was based upon the 59 questionnaire returned.

B. Data Presentation and Analysis

Sex	Frequency	Percentage
Male	36	61.02%
Female	23	38.98%
Total	59	100%

Table : 1 shows the sex of the respondents

Source: 2019 students field survey

From table 1 shows that 36 respondent representing 61.02% were male, while 38.98% were female respondent respectively.

Age	Frequency	Percentage
20-30	24	40.68%
32-40	22	37.29%
41-50	9	15.25%
51-60	2	3.39%
61-?	2	3.39%
Total	59	100%

Table : 2 the age of the respondents

Source: 2019 students field survey

From table 2 show that 24 respondents representing 45.76% were age of 20-30, followed by 22 respondents representing 37.29% were the age of 31-40, while 9 representing 15-25 were the age of 41-50, followed by 2 respondent representing 3.39% of the age of 51-60 and 2 respondent representing 3.39% were the age of 61 and above.

Marital Status	Frequency	Percentage
Single	27	45.79%
Married	25	42.37%
Widow	7	11.86%
Total	59	100%

Table : 3 Marital status

Source: 2019 students field survey

Table : 3 illustrates 27 which is equivalent to 45.76% of the total respondents were singles, while 25 (42.37%) were married while only 7 which equivalent to 11.86% of the respondents were widows.

Respondents	Frequency	Percentage
HIT/ND	26	44.07%
HND	22	37.29%
PGD	7	18.64%
TOTAL	57	100%

Table : 4 Qualifications of the Respondents

Source: 2019 students field survey

The qualification of the respondents is shown in table : 4 illustrating the HIT/ND respondents as the highest with 44.07% of the respondents, HND with 37.29% of the respondent and PGD with 11.86% of the respondents

C. Section B research question

Strongly Agreed (SA), Agreed (A), Undecided (UD), Disagreed (D), and Strongly Disagreed (SD).

Respondents	Frequency	Percentage
SA	43	72.88%
A	15	25.43%
UD	0	0%

ISSN No:-2456-216

D	1	1.69%
SD	0	0%
Total	59	100%

Table : 5 Health information personnel are a key to provide accurate medical records?
Source: 2019 students field survey

From table 5 illustrates the responses to the questions health information personnel are a key to provide accurate medical records SA with 72.88% respondent, A with 25.43% of the respondent, UD with O% of the respondent, D with 1.69% of the respondents, and SD with 0% of the respondents.

Respondents	Frequency	Percentage
SA	28	47.46%
A	19	32.20%
UD	10	16.95%
DD	2	36.39%
SD	0	0.0%
Total	59	100%

Table : 6 both physician and patient have the vital role in providing accurate patient medical information?
Source: 2019 students field survey

From table : 6 shows the responses to the question both physician and patient have the vital role to play in providing accurate patient medical information SA with 47.46% respondents, A with 32.20% of the respondents UD with 16.5% of the respondents. D with 3,39% of the respondent and SD with 0% of the respondent.

Respondents	Frequency	Percentage
SA	31	52.54%
A	23	38.98%
UD	4	6.79%
D	1	1.69%
SD	0	0.00%
Total	59	100%

Table : 7 provision of adequate working material will enhance the production of accurate patient medical information?
Source: 2019 students field survey

From table : 7 shows the responses to the question provided adequate working material will enhance the production of accurate patient medical information SA with 52.54% respondents, A with 38.93 respondent, UD with 6.79 respondents, D with 1.69% of the respondent and SD with 0% of the respondents.

Respondents	Frequency	Percentage
SA	40	67.80%
A	15	25.43%
UD	3	5.08%
D	0	0.00%
SD	1	1.69%
Total	59	100%

Table : 8 privacy should be maintained to ensure the secured patient health information?

Source: 2019 students field survey

From table : 8 shows the response to the questions the privacy should be maintain to ensure the secured patient health information, SA with 67.80%, A with the 25.43% of the respondent, UD with 5.08% of the respondent, D with 0% of the respondent and SD with 1.69% of the respondent.

Respondents	Frequency	Percentage
SA	14	23.73%
A	34	57.63%
UD	7	11.86%
D	4	6.78%
SD	0	0.00%
Total	59	100%

Table : 9 the well structure medical records department will enhance the secured of patient record?
Source: 2019 students field survey

ISSN No:-2456-216

From table : 9 show the responses to the question: the secured of patient record department will enhance the secured of patient record, SA with 23.73% of the respondents, A with 6.78% of the respondents and SD with 0% of the respondents.

Respondents	Frequency	Percentage
SA	27	37.29%
A	35	59.33%
UD	1	1.69%
D	1	1.69%
SD	0	0.00%
Total	59	100%

Table : 10 code and conduct should be follow and maintain to ensure the confidentiality of patient record?
Source: 2019 students field survey

From Table : 10 show the responses to the question code and conduct should be follow and maintain to ensure the confidentiality of patient record, SA with 39.29% of the respondent, A with 59.32% of the respondent, UD with 1.9% of the respondent, D with 1,69% of the respondent and SD with 0.00% of the respondents.

Respondents	Frequency	Percentage
SA	17	28.81%
A	23	38.98%
UD	8	13.56%
D	7	11.87%
SD	4	6.78%
Total	59	100%

Table : 11 the form and format of maintaining patient record in FMCEB is satisfactory?
Source: 2019 students field survey

From table : 11 shows the responses to the question the form and format of maintaining patient record in FMCEB is satisfactory, SA with 28.81% of the respondent, A with 38.98% of the respondent, UD with 13.56% of the respondents, D with 11.86% of the respondent, and SD with 6.78% of the respondents.

Respondents	Frequency	Percentage
SA	20	33.90%
A	29	49.16%
UD	7	11.86%
DD	3	5.08%
SD	0	0.00%
Total	59	100%

Table : 12 good interdepartmental relationship will enhance the confidentiality of patient record in FMCEB?
Source: 2019 students field survey

From the table : 12 shows the responses to the question; good interdepartmental relationship will enhance the confidentiality of patient record in AKTH, SA with 33.90% of the respondents, a with 49.16% of the respondent, UD with 11.86 of the respondent, d with 5.08 of the respondent and SD with 0.00% of the respondents.

ISSN No:-2456-216

Respondents	Frequency	Percentage
SA	43	72.88%
A	15	25.43%
UD	1	1.69%
D	0	0.0%
SD	0	0.0%
Total	59	100%

Table : 13 electronic health record plays a vital role to make the patient information to be confidential?
Source: 2019 students field survey

From table : 13 shows the responses to the question; electronic health record plays a vital role to make the patient information to be confidential, SA with 72.88% of the respond dents, A with 25.43% of the respondents, UD with 1.69% of the respondents, D with 0.0% of the respondent, and SD with 0.00% of the respondents.

Respondents	Frequency	Percentage
SA	43	72.88%
A	13	22.04%
UD	1	1.69%
D	2	3.39%
SD	0	0.00%
Total	59	100%

Table : 14 can electronic health record help with the standardization of patient record?
Source: 2019 students field survey

From table : 14 show the responses to the question; can electronic health record help with the standardization of patient record, SA with 72.88% respondent, A with 22.04% the respondents, UD with 1.69% of the respondent, D with 3.39% of the respondent, and SD with 0.00% of the respondent.

Respondents	Frequency	Percentage
SA	37	62.71%
A	22	37.29%
UD	0	0.00%
D	0	0.00%
SD	0	0.00%
Total	59	100%

Table : 15 there is impact of electronic patient record?
Source: 2019 students field survey

From table 4.2.15 show the responses of the questions; there is impact of electronic patient record, SA with 62.71% of the respondents, A with 37.29% of the respondent, UD with 0% of the respondents, D with 0% of the respondent, SD with 0% of the respondent.

D. Summary of the Major Finding

The study had being carried out and has been able to show the Assessment of medical records system towards ensuring confidentiality of patient records a case study of FMCEB.

- Base on the above the research find out that health information personnel are key to provide an accurate medical record with total number of 43 respondents which are equivalent to 72.88% of the entire respondents.
- This research work also revealed that good interdepartmental relationship will enhance the confidentiality of patient record in FMCEB as responded by 49.16% of the respondents.
- This study work encountered that code and conduct should be follow and properly maintain to ensure confidentiality of patient record as responded by 35 of the respondents and that amounted to 59.33% of the total percentage of the entire percentage of the respondent.
- The research work revealed that electronic record help in standardizing patient record because of the vital role it is playing in ensuring qualifies of patient's records with 37 respondents which are amounted to 62.71% of the respondents.
- Finally the research work revealed that there is impact of electronic patient record with 37 respondents which amounted to 62.71% of the respondents.

ISSN No:-2456-216

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

A. Introduction

This chapter summarises all of the research. Conclusions and recommendations.

B. Summary

This research work is divided into five chapters. Chapter one contains background, statement about the problem, study objective, significance, limitation, and scope. while chapter two reveled various authors opinion on assessment and validation of medical records system towers ensuring confidentiality with the research methodology. These include the research plan, population, sampling methods, source of data, method for data collection, and analysis.

The facts gathering from the study area were presented in chapter four analyzed while the final chapter is chapter five summaries, conclusion and made some recommendations.

C. Recommendation And Suggestions

- The hospital management should improve the welfare of the Heath Information Management professionals in other to avoid any circumstance that will lead to poor management of patient information in the hospital.
- The staff in health information department must be lenient to the patients in other to make them express their problems to the physician.
- The staff in the health information management department should make sure they abide by every code and conduct of the profession for effective practice in the hospital.
- The hospital management should embark on electronic health record because it contains all standards of managing patient information.
- The government should embark on electronic record system in Federal Medical Centre, Ebute-Metta; doing so will improve confidentiality of patient information and avoid damage due to environmental hazard.

D. Conclusion

In conclusion I haven carried out a good and comprehensive research on this institution (FMCEB), hence the need to assess and validate medical records system toward ensuring confidentiality of patient record that can ensure qualitative health care delivery in the Centre.

Which indicate that assessment and validation of medical records system toward ensuring confidentiality of patient record can be achieved by employing adequate trained staff, provision adequate working materials to the health information management department and the forms and format use in the hospital should renovated, provision of electronic medical record (EMR) for making patient medical information to be valid and confidentiality to patient.

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APPENDIX

QUESTIONNAIRE

Faculty of Sciences

Health Information Management Department

TBUGLEX USA,

1st March, 2019.

Dear Respondent,

I am a final-year student at the above mentioned institution, and I am currently doing research on the Assessment of Medical Records System towards Ensuring Confidentiality of Patients Records.

I hereby request your contribution to fill the space provided in this questionnaire to the best of your ability and as honest as possible.

I also assure you that all your information give will be treated confidentially.

Yours faithfully,

AdemohAbdulraheem

ISSN No:-2456-216

SECTION (A) DEMOGRAPHIC DATA

1. Sex: Male ( ) Female ( )
2. Age: 20 – 30 ( ) 31 – 40 ( ) 41 – 50 ( ) 51 – 60 ( ) 60 and above ( )
3. Marital status: Single ( )Married ( ) Widow ( )
4. Qualification:- HIT/ND ( ) HND ( ) PGD ( )

SECTION (B) RESEARCH QUESTION

Please tick in the appropriate categories (liker): Strongly Agreed (SA), Agreed (A), Undecided (UD), Disagreed (D), and Strongly Disagreed (SD).

5. Health information personnel are a key to provide accurate patient medical records?

SA ( ), A ( ) UD ( ) D ( ) SD ( )

6. Both the physician and patient have the vital role in provided accurate patient medical records? SA ( ), A ( ) UD ( ) D ( ) SD ( )
7. Provided adequate working material will enhance the production of accurate patient health information? SA ( ), A ( ) UD ( ) D ( ) SD ( )
8. Privacy should be maintained to ensure the secured patient medical information?
   SA ( ), A ( ) UD ( ) D ( ) SD ( )
9. Well-structured Medical record department will enhance the secure of patient record? SA ( ), A ( ) UD ( ) D ( ) SD ( )
10. Code and conduct should be follow and maintain to ensure the confidentiality of patient record? SA ( ), A ( ) UD ( ) D ( ) SD ( )
11. The form and format of maintaining patient record in Federal Medical Centre, Ebute-Metta is it satisfactory? SA ( ), A ( ) UD ( ) D ( ) SD ( )
12. Good inter departmental relationship will enhance the confidentiality of patient record in FMCEB? SA ( ), A ( ) UD ( ) D ( ) SD ( )
13. Electronic Medical Record plays a vital role to make the patient information to be confidential? SA ( ), A ( ) UD ( ) D ( ) SD ( )
14. Can Electronic Medical Record help with the standardization of patient record?

    SA ( ), A ( ) UD ( ) D ( ) SD ( )

15. Electronic Medical Records are having an impact?SA ( ), A ( ) UD ( ) D ( ) SD ( )