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Assessment of record keeping management in a Nigerian general hospital

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Abstract

Background of the study: In the context of healthcare, record keeping management specifically involves the management of patient health records, administrative documents, and other pertinent information related to healthcare delivery

Purpose: This study examines the record keeping management at General Hospital, Ikot Abasi, Akwa State of Nigeria. Four (4) specific objectives guided the conduct of the study.

Methods: The survey descriptive design with a qualitative approach was used. Interview was used as the method of data collection. The study included a total of 11 participants, consisting of 2 medical doctors, 5 nurses, and 4 record administrators from the General Hospital, Ikot Abasi. Thematic analysis was employed to analyze the data collected from the interviews.

Findings: The study revealed a varying level of understanding among respondents regarding current record-keeping practices, with concerns raised about the accuracy and completeness of documentation. However, the study identified various challenges faced by healthcare professionals and administrators, including inconsistency in documentation practices, inadequate storage facilities, limited access to technology and resources, and compliance issues.

Conclusion: The study concluded that the assessment of existing record keeping infrastructure and technology showed a positive impact, particularly with the implementation of EHR systems leading to streamlined processes and reduced reliance on paper-based documentation. The study recommends that health and other related organisations should implement standardized documentation protocols and provide regular training sessions for healthcare professionals to ensure consistency, accuracy, and completeness in record keeping.

Keywords: Record, record keeping, management, practice, hospital.

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Introduction

Record keeping management refers to the systematic process of creating, organizing, storing, retrieving, and managing records within an organization. In the context of healthcare, record keeping management specifically involves the management of patient health records, administrative documents, and other pertinent information related to healthcare delivery. Going further, record keeping management is a cornerstone of efficient and effective operations across various sectors, with its significance particularly pronounced in healthcare, legal, financial, and administrative settings. In the healthcare sector, record keeping management plays a critical role in maintaining accurate, comprehensive, and accessible patient information. It encompasses the documentation, organization, storage, retrieval, and management of patient records, administrative documents, and other pertinent information.

Awogbami et al. (2023) observe that accurate and comprehensive records serve as a valuable source of information for decision-making. In healthcare, for instance, clinicians rely on patient records to assess medical histories, diagnose conditions, and devise treatment plans. Similarly, in business settings, financial records provide insights into revenue, expenses, and profitability, informing strategic decisions and resource allocation. Madu et al. (2024) state that record keeping management promotes transparency and accountability within organizations. The authors further mention that efficient record keeping management streamlines workflows and reduces administrative burdens. Well-organized records are easier to retrieve, update, and analyze, saving time and resources. In healthcare, for example, electronic health record (EHR) systems enable healthcare providers to access patient information quickly, thereby improving care coordination and reducing redundancies. Supporting this, Dando (2023) mentions that patient records contribute to medical research, epidemiological studies, and public health initiatives.

Record keeping management is a fundamental aspect of healthcare systems worldwide, serving as the backbone for effective patient care, clinical decision-making, and administrative processes. Given this, Agbejimi et al. (2024) state that assessing record keeping management is essential for several reasons. Some of which include:

- ✓ Firstly, it ensures compliance with regulatory requirements and standards set by healthcare governing bodies. Adhering to these standards not only fosters legal compliance but also promotes patient safety and confidentiality.
- ✓ Secondly, assessment helps identify areas for improvement in record keeping practices. By evaluating current processes and systems, healthcare institutions can identify inefficiencies, gaps, and areas of non-compliance, enabling them to implement targeted interventions to enhance record keeping effectiveness.
- ✓ Moreover, assessing record keeping management facilitates the optimization of resource utilization.

While considering the implications of record keeping management to health care, Babale et al. (2021) observe that effective assessment of record keeping management has significant implications for healthcare efficiency and quality. The authors also argue that healthcare institutions can enhance the accuracy, accessibility, and completeness of patient records, thereby improving clinical decision-making and patient outcomes. Furthermore, Abore et al. (2022) state that record keeping management contributes to streamlined administrative processes, reduced documentation errors, and improved workflow efficiency.

Many healthcare institutions across Nigeria, traditional record keeping methods are beset by numerous challenges that impede the documentation and storage of patient records as well as those of medical experts. These challenges undermine the efficiency, accuracy, and accessibility of record keeping management, thereby compromising the quality of healthcare delivery and posing significant risks to patient care and organizational operations. Some of the

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challenges could be lack sufficient infrastructure and resources to support effective record keeping practices.

As observed during the preliminary investigations, there seemed to be no specified way or method of keeping records. Studies by Asogwa et al. (2021), Awogbami et al. (2020) and Adesunloye et al. (2024) revealed that there is a lack of training and capacity building initiatives to equip healthcare personnel with the necessary skills and knowledge for effective record keeping management. In a study, Alegbeleye and Chilaka (2019) revealed that records at the Ministry of Health are not managed in accordance with best practices. The authors findings revealed that the Ministry of Health had not yet developed systems to manage records resulting to poor records management practices. Adding to this, Sani et al. (2016) observed that hospitals use traditional manual systems to capture and transmit patient information as revealed by 91.4 percent of the respondents.

According to Agbejimi et al. (2024), there seemed to be positive perceptions among respondents regarding various services delivered by health records professionals. However, Dando (2023) found that financial records are available in schools and much attention was given to them because of their value in the management of senior secondary schools in Yobe State. Similarly to this, Afolaranmi et al. (2020) observed a relatively high level of good knowledge of EMRs with variation existing along the categories of health care workers. More so, Abore et al. (2022) found that electronic medical recording knowledge and attitude towards electronic medical recording were statistically significant predictors of readiness to implement electronic medical recording.

While these studies provide an overview of record keeping practices in health institutions in other region and contexts, none focused on this specific health institution in the region under study. Therefore, there is a dearth of empirical evidence quantifying the extent of this impact in the context of the General Hospital Ikot Abasi. This study addresses this gap by assessing the record keeping management in General Hospital, Ikot Abasi of Akwa Ibom State. The specific objectives of the study are to: (1) investigate the current record keeping practices utilized; (2) assess the effectiveness of existing record keeping infrastructure and technology; (3) determine the compliance of record keeping practices; and (4) challenges faced by healthcare professionals and administrators in relation to record keeping management.

Literature review

To achieve the aim of this study, literature were reviewed according to the stated specific objectives:

Record keeping practices in Nigerian hospitals

Record keeping practices in Nigerian hospitals play a crucial role in ensuring the efficient delivery of healthcare services, as well as maintaining patient safety, confidentiality, and regulatory compliance. There are several challenges facing the record keeping management practices in many Nigerian health care centres. In Nigerian hospitals, documentation practices vary widely, ranging from paper-based systems to electronic health record (EHR) systems. While some hospitals have transitioned to digital documentation, many still rely on manual methods, leading to inconsistencies, errors, and inefficiencies in record keeping (Adesunloye et al., 2024). As noted by Sibiya et al. (2023), documentation practices in Nigerian hospitals vary widely, ranging from paper-based systems to electronic health record (EHR) systems. While some hospitals have transitioned to digital documentation, many still rely on manual methods, leading to inconsistencies, errors, and inefficiencies in record keeping (Zemedkun et al., 2021). However, Omokanye and Adepoju (2024) note that storage of patient records in Nigerian hospitals often faces challenges due to inadequate infrastructure and resources. The

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authors argue that hospitals lack dedicated storage facilities, leading to overcrowded filing rooms or reliance on ad-hoc solutions. Similarly, Omole et al. (2024) state that limited space and budget constraints may hinder the implementation of proper archiving and retrieval systems, further complicating record storage and management.

As empirically pointed out, access to patient records in Nigerian hospitals can be hindered by inefficient retrieval systems, particularly in facilities with paper-based records (Ojo, 2024). Healthcare providers face difficulties locating and retrieving patient information, leading to delays in care delivery and potential patient safety risks (SIbiya et al., 2023). The integration of technology, particularly EHR systems, has the potential to revolutionize record keeping practices in Nigerian hospitals (Abore et al., 2022). However, widespread adoption of electronic systems remains limited due to various barriers, including high implementation costs, lack of infrastructure, and resistance to change (Afolaranmi et al., 2020).

Effectiveness of record keeping infrastructure and technology in Nigerian hospitals

The effectiveness of record keeping infrastructure and technology in Nigerian hospitals is a critical aspect of healthcare delivery. Studies have shown that majority of Nigerian hospitals have made strides in adopting EHR systems, facilitating the digitization of patient records and streamlining documentation processes (Adesunloye et al., 2024; Agbejimi et al., 2024; Awogbami et al., 2020).. However, Asogwa et al. (2021) indicate that EHRs offer advantages such as improved accessibility, legibility, and data sharing capabilities, enhancing communication and collaboration among healthcare providers. Some Nigerian hospitals have embraced telemedicine technologies to expand access to healthcare services, particularly in remote or underserved areas (Akwaowo et al., 2020). Telemedicine platforms facilitate remote consultations, electronic prescriptions, and remote monitoring, improving patient outcomes and reducing healthcare disparities.

Compliance of record keeping practices in Nigerian health sectors

The compliance of record keeping practices in Nigerian health sectors is a critical aspect that requires serious attention. Anozie et al. (2020) find that despite the existence of regulatory frameworks, compliance with record keeping practices in Nigerian health sectors faces significant challenges. The authors state that these challenges include resource constraints, inadequate infrastructure, limited training and capacity building initiatives, and cultural factors that influence attitudes towards documentation and data management. As revealed, these barriers contribute to gaps in compliance and hinder efforts to improve record keeping practices. Furthermore, Babale et al. (2021) reveal that compliance with data security and privacy regulations is a major area of focus in Nigerian health sectors. Agebjimi et al. (2024) observe that the adoption of technology, particularly electronic health record (EHR) systems, holds promise for improving compliance with record keeping practices in Nigerian health sectors. Akwaowo et al. (2022) also observe that the Nigerian health sectors are governed by various regulatory frameworks and guidelines aimed at standardizing record keeping practices. The authors reveal that these include regulations issued by the Nigerian Medical Association (NMA), the Medical and Dental Council of Nigeria (MDCN), and the National Health Act. Additionally, international standards such as those outlined by the World Health Organization (WHO) and the International Organization for Standardization (ISO) also influence record keeping compliance in Nigerian healthcare settings.

Challenges faced by health professionals in record keeping management

There are several challenges faced by healthcare professionals and administrators in Nigerian health sectors regarding record keeping management. Madu et al. (2024) observe that

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limited resources, including funding, infrastructure, and personnel, pose significant challenges to effective record keeping management in Nigerian health sectors. Hospitals often lack adequate facilities for storing and organizing records, as well as sufficient staff to manage documentation processes. This can lead to inefficiencies, delays, and inaccuracies in record keeping practices. Also, Ojo (2024) reveal that many healthcare facilities in Nigeria lack access to essential infrastructure for record keeping management, such as reliable electricity supply and internet connectivity. Without these basic amenities, healthcare professionals may struggle to access electronic health record (EHR) systems or maintain digital records, leading to reliance on paper-based documentation methods that are prone to errors and vulnerabilities (Dando, 2023).

While some Nigerian hospitals have adopted EHR systems and other digital solutions for record keeping, widespread technological integration remains limited (Sibiya et al., 2023). Challenges such as high implementation costs, lack of interoperability between different systems, and resistance to change among healthcare professionals impede the effective utilization of technology for record keeping management (Omole et al., 2024). Healthcare professionals and administrators in Nigerian health sectors face significant concerns regarding data security and privacy (Queen et al., 2023). Inadequate safeguards to protect patient information from unauthorized access, data breaches, and cyberattacks raise ethical and legal concerns, undermining trust in record keeping practices and compromising patient confidentiality. Similarly, Tarurhor et al. (2021) reveal that the capacity and training of healthcare professionals and administrators are crucial factors influencing record keeping management in Nigerian health sectors.

Method

Research Type

The survey descriptive design with a qualitative approach was used for the study. This design combines elements of descriptive research, which aims to describe the characteristics of a population or phenomenon, with qualitative methods, which seek to understand the underlying reasons, opinions, and motivations. In so doing, the design provided valuable insights into record-keeping practices in Nigerian hospitals.

Study Area

The study was conducted at General Hospital, Ikot Abasi, located in Akwa Ibom State, Nigeria. The General Hospital in Ikot Abasi is a prominent healthcare institution in the region that provides a wide range of medical services to the local population and neighboring communities. The hospital is situated in the town of Ikot Abasi, which is part of the coastal area of Akwa Ibom State, a region known for its rich cultural heritage and economic activities. Ikot Abasi is a town located in the southeastern part of Nigeria, within Akwa Ibom State. The state itself is part of the Niger Delta region, an area characterized by its significant contributions to Nigeria's oil and gas industry.

Population and Sample

The study included a total of 11 participants, consisting of 2 medical doctors, 5 nurses, and 4 record administrators from the General Hospital, Ikot Abasi, Akwa Ibom Nigeria (*See Figure 1*). Based on the population size, a census sampling technique was employed. The justification for the use of this technique is that the population is relatively small and manageable. In so doing, all eligible participants were included in the study.

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Data Collection

Interview was used as the method of data collection. An interview guide was designed to elicit information from participants regarding their perspectives on record keeping practices in General Hospital. The interview guide covered topics on record-keeping practices, its effectiveness, compliance of record keeping practices and the challenges faced by health professionals regarding record keeping. The interview guide was validated by experts at the Department of Library and Information Technology at Federal University of Technology, Ikot Abasi. This validation process ensured the relevance, clarity, and appropriateness of the questions included in the guide. The researcher complied with all ethical procedures during the conduct of the interviews. This included obtaining informed consent from participants, ensuring confidentiality of responses, and respecting participants' autonomy and privacy. Ethical approval was obtained from the relevant institutional review board.

Data Analysis

Thematic analysis was employed to analyze the data collected from the interviews. This approach involved identifying recurring themes, patterns, and insights within the qualitative data. The data were coded and categorized based on key themes related to the topic under study. Each participant was allocated 20 minutes for the interview, and the resulting conversations were transcribed into a 12-page transcript. The transcribed data were then coded based on the research objectives that were developed to guide the study. Figure 1 below also explains the data codification used in the study:

Table 1. Codes Assigned to Participants

Respondents	Code Assigned to Participants
Medical doctors	P1
Nurses	P2
Records administrators	P3

Result and Discussion

The results from the analysis of data are presented below:

Research Objective 1: To investigate the current record keeping practices utilized in General Hospital

In response to this objectives, the respondents had a varying level of understanding on the current record keeping practices utilized in the hospital under study. Excerpts from the participants on their knowledge of the current record keeping practices utilized were given below:

P1 noted that: “Participants expressed concerns about the accuracy of documentation, noting instances of incomplete or inconsistent records. They emphasized the importance of thorough documentation for patient care and decision-making.” Going further, the participants mentioned challenges in accessing patient records, particularly during emergencies or when records were stored in paper format. They stressed the need for improved accessibility to facilitate timely and informed medical interventions. Some doctors commended the hospital's efforts in adopting electronic health record (EHR) systems but noted limitations in system functionality and user-friendliness. As stated by one of the participants, “I suggest improvements to enhance the usability and effectiveness of EHR systems”.

The view of P2 regarding the current record keeping practices reveal thus: “In my hospital, nurses are challenged in the documentation workflow, citing time constraints and competing priorities during patient care”. Other participants revealed that limited space and disorganization made it difficult to locate and retrieve patient records when needed. “Some

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nurses identified a need for training and capacity building in record keeping practices. They emphasized the importance of ongoing education to improve documentation skills and ensure compliance with best practices and standards". Participants also stressed the importance of effective communication and collaboration among healthcare teams regarding record keeping. They emphasized the need for clear protocols and standardized practices to promote consistency and continuity of care.

P3 about the current record keeping practices: "Participants at the hospital under study revealed that records are often traditionally created, managed and shared away from the use of the introduced digital technologies". The participants revealed that limited resources hindered efforts to modernize record keeping systems and improve efficiency.

Research Objective 2: To assess the effectiveness of existing record keeping infrastructure and technology in General Hospital, Ikot Abasi

Effectiveness of existing record keeping infrastructure and technology appeared as the second subject of the study after the transcription of the participants' interviews. Excerpts from the participants based on the effectiveness of existing record keeping technology are given below:

P1: "The current situation of record keeping is more traditional, however, I believe that the existing record keeping infrastructure and technology in my hospital have significantly improved our ability to manage patient records. The implementation of electronic health record (EHR) systems has streamlined documentation processes and enhanced accessibility to patient information. I have found the system to be user-friendly and efficient, allowing for quick retrieval of patient records during consultations."

P2: "I have seen noticeable improvements in record keeping practices since the introduction of technology in my hospital. The digitalization of patient records has reduced the reliance on paper-based documentation, minimizing the risk of errors and loss of information. I can say that the ability to access patient records electronically has improved workflow efficiency and communication among healthcare teams."

P3: "I have been involved in the implementation and maintenance of record keeping infrastructure and technology in General Hospital, Ikot Abasi. While there have been challenges, such as limited resources and occasional technical issues, overall, I believe that the existing infrastructure and technology have enhanced record keeping practices. The transition to electronic systems has improved data accuracy, storage efficiency, and compliance with regulatory requirements."

The findings reflect the positive impact of existing record keeping infrastructure and technology as perceived by medical doctors, nurses, and record administrators. I understand that the adoption of electronic health record systems has facilitated more efficient documentation processes, improved accessibility to patient information, and enhanced overall record keeping practices in the hospital.

Research Objective 3: To evaluate the compliance of record keeping practices in General Hospital, Ikot Abasi

In response to this objectives, the respondents had a varying responses on the level of compliance with record keeping practices in the hospital under study. Excerpts from the participants were given below:

P1: "I have observed that record keeping practices in my hospital, generally comply with regulatory requirements and standards. Patient records are meticulously maintained, and there are protocols in place to ensure confidentiality and data security. However, there are occasional lapses, particularly in documentation accuracy and completeness, which may impact

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compliance."

P2: "In my experience, I have found that record keeping practices are largely compliant with regulations. There are procedures in place to protect patient privacy and confidentiality, and staff are trained on the importance of adhering to data security protocols. However, there may be areas for improvement, such as ensuring consistency in documentation practices across departments."

P3: "As a record administrator responsible for overseeing compliance with record keeping practices, I can attest to our efforts to adhere to regulatory requirements in my hospital. We conduct regular audits and assessments to monitor compliance, address any deficiencies, and implement corrective measures as needed. While there may be challenges, such as resource constraints, we remain committed to upholding the highest standards of record keeping."

Findings indicate that the perception of medical doctors, nurses, and record administrators regarding the compliance of record keeping practices. While efforts are made to adhere to regulatory requirements and standards, there may be areas for improvement to ensure consistency, accuracy, and completeness in documentation practices.

Research Objective 4: To explore the challenges faced by healthcare professionals and administrators in relation to record keeping management

In response to this objective, several respondents expressed similar challenges faced by health professionals in relation to record keeping management. These challenges are excerpted below:

P1: "I have encountered several challenges in relation to record keeping management at General Hospital, Ikot Abasi. One of the major challenges is the inconsistency in documentation practices, which can lead to errors and inefficiencies in patient care. Additionally, limited access to updated technology and resources hampers our ability to maintain accurate and timely records, impacting our workflow and decision-making processes."

P2: " I face various challenges in record keeping management. One significant challenge is the lack of adequate storage facilities for patient records, particularly in my department. This can result in disorganization and difficulty in locating and retrieving records when needed. Furthermore, there may be inconsistencies in documentation practices among staff members, leading to confusion and potential errors in patient care."

P3: "I am acutely aware of the challenges faced in record keeping management at General Hospital, Ikot Abasi. The respondents observed that limited resources and outdated infrastructure pose significant obstacles to maintaining efficient and effective record keeping practices. Additionally, ensuring compliance with regulatory requirements can be challenging, particularly in the face of changing regulations and evolving technology. One of the respondents stated that, "…despite these challenges, we strive to find innovative solutions and improve our record keeping processes to enhance patient care delivery."

As analyzed above, these responses reflect the diverse challenges faced by healthcare professionals and administrators in relation to record keeping management in the hospital under study. Common challenges include inconsistency in documentation practices, inadequate storage facilities, limited access to technology and resources, and compliance with regulatory requirements.

Discussion

The study assessed the record keeping management in General Hospital, Ikot Abasi. From the findings regarding Research Objective 1 on current record keeping practices utilized in General Hospital, it was revealed that there is a varying level of understanding among the

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respondents regarding these practices. Findings further revealed that participants expressed concerns about the accuracy and completeness of documentation in the hospital under study. Instances of incomplete or inconsistent records were noted, which can impact patient care and decision-making processes. This findings indicate the importance of thorough documentation practices to ensure the reliability and integrity of patient information. The findings of this study validates the results of Madu et al. (2024) and Dando (2023). However, the findings also discovered that challenges in accessing patient records were identified, particularly during emergencies or when records were stored in paper format. This findings implied that limited accessibility can hinder timely and informed medical interventions, hence the need for improved accessibility measures, such as digitization of records and streamlined retrieval systems. This is in line with the findings of Babale et al. (2021) and Anozie et al. (2020) who revealed accessibility affects utilization of medical records in Nigerian health institutions.

Also, the findings from the assessment of the effectiveness of existing record keeping infrastructure and technology reveal a positive impact as perceived by respondents. Findings revealed that the implementation of EHR systems as a significant improvement in record keeping practices. Findings further noted that EHR systems have streamlined documentation processes, and improved efficiency in record retrieval during consultations. Going further, it was found that the digitalization of patient records has led to a reduction in the reliance on paper-based documentation which minimize the risk of errors and loss of information. This finding agrees with the study of Awogbami et al. (2020) who found that digital records have improved acceptance than physical records.

Regarding Research Objective 3, the findings indicate a generally positive perception of compliance with record keeping practices in the hospital under study. While efforts are made to adhere to regulatory requirements and standards, identified lapses suggest areas for improvement to enhance consistency, accuracy, and completeness in documentation practices. This validates the findings of Ojo (2024) and Sibiya et al. (2023).

Finally, the findings indicate a range of challenges faced by healthcare professionals and administrators in relation to record keeping management in the hospital under study. These challenges include inconsistency in documentation practices, inadequate storage facilities, limited access to technology and resources, and compliance with regulatory requirements. The study is in line with the findings of Omele et al. (2024) and Zemedkun et al. (2021) who reported that the challenges facing health care delivery in managing records ranged inadequate records facilities.

Conclusion

The findings of this research shed light on the record keeping management practices in General Hospital, Ikot Abasi. The study revealed a varying level of understanding among respondents regarding current record keeping practices, with concerns raised about the accuracy and completeness of documentation. Despite these challenges, the assessment of existing record keeping infrastructure and technology showed a positive impact, particularly with the implementation of EHR systems leading to streamlined processes and reduced reliance on paper-based documentation. Compliance with record keeping practices was generally perceived positively, although identified lapses suggest areas for improvement. Additionally, the study identified various challenges faced by healthcare professionals and administrators, including inconsistency in documentation practices, inadequate storage facilities, limited access to technology and resources, and compliance issues.

Recommendations

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Based on the findings of the study, the following recommendations were made: Health and other related organisations should implement standardized documentation protocols and provide regular training sessions for healthcare professionals to ensure consistency, accuracy, and completeness in record keeping. In so doing, this can help address concerns raised about the accuracy and completeness of documentation and mitigate the risk of errors in patient care and decision-making processes. Government at all levels should allocate resources to upgrade record keeping infrastructure and invest in modern technology solutions, such as electronic health record (EHR) systems. This is because this intervention will provide increased access to updated technology and adequate storage facilities to streamline documentation processes, improve efficiency in record retrieval, and reduce reliance on paper-based documentation. Health institutions should establish robust monitoring mechanisms to regularly assess compliance with record keeping practices and regulatory requirements. This proactive approach can help ensure adherence to standards and enhance the reliability and integrity of patient records. Health institutions should promote a culture of communication and collaboration among healthcare teams regarding record keeping practices. They should encourage open dialogue, share best practices, and establish clear protocols to promote consistency and continuity of care. Strengthening communication channels can improve coordination and teamwork, ultimately enhancing the effectiveness of record keeping management in the hospital.

Implication to Policy

Policymakers in healthcare and information management should consider the findings of this research when developing policies related to record keeping practices. Policies should address the identified challenges, such as inconsistency in documentation practices, inadequate storage facilities, and compliance issues, to improve the overall effectiveness of record keeping management.

Implications to practice

Librarians and information professionals can play a crucial role in advocating for the integration of modern technology solutions, such as electronic health record (EHR) systems, in healthcare settings. The positive impact of EHR systems on streamlining processes and reducing reliance on paper-based documentation underscores the importance of investing in technology infrastructure. Also, librarians can collaborate with healthcare institutions to develop and implement training programs aimed at improving the documentation skills of healthcare professionals. Training sessions should focus on standardizing documentation practices, enhancing compliance with regulatory requirements, and maximizing the use of technology for efficient record keeping. Furthermore, librarians can advocate for increased resource allocation to address challenges related to inadequate storage facilities, limited access to technology, and compliance issues. This may involve lobbying for funding to upgrade infrastructure, acquire necessary technology, and implement quality assurance mechanisms to ensure compliance with standards and regulations. Finally, librarians can serve as advocates for the promotion of best practices in record keeping management within healthcare institutions.

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Authors' Contributions

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All authors have contributed to the final manuscript. The contribution of all authors: conceptualization, methodology, formal analysis, writing original draft preparation, writing review, and editing. All authors have read and agreed to the published version of the manuscript.

Conflict of Interest

All authors have no conflict of interest related to this study.

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