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Effects of Health Records Management on Health Service Delivery: A Case Study of the Prestea Government Hospital (PGH)

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Abstract

Background: The most crucial instrument when discussing patient healthcare are medical records. Both their management and their utilization are crucial for patient care management. Ghana has used many medical records management systems to aid in healthcare development. Retrospective and epidemiological investigations are slowed down by poor data quality, which inhibits research. As expectations have grown, more initiatives to capture and save patient records electronically are planned.

Aim: The purpose of the study is to investigate the perception of health worker about the EHRs use and impact on service delivery.

Materials and methods: The study's focus is on the health workers at Prestea Government Hospital (PGH), which include nurses, physicians, biotechnologists, Health Information Manager, pharmacists, midwives, etc. A sample size of 100 people from the intended audience was used. Standardized questionnaires were self-completed by respondent. The Completed questionnaires were given numbers to protect participants anonymity. Participants received sufficient information regarding their right to decline study participation and to withdraw at any time without repercussions. Data was entered into Excel and exported to SPSS for analysis. Descriptive and inferential analysis was performed and the outcomes were shown as tables, graphs, and figures.

Results: In all, out of 100 respondents, 35% of them were males and 65% were women. There were a lot of female replies since many of the respondents were nurses. Medical laboratory technicians comprised the smallest proportion of the workforce (5%) of all occupational groups. Prestea Government Hospital survey respondents overwhelmingly concur that electronic health records (EHRs) aid in the delivery of treatment. According to a survey, medical practitioners think the facility's EHR has all of the forms that are utilized there. The idea that the facility's EHRs help with data collection is accepted by few people. Medical professionals believe that the use of EHRs makes it simple to obtain historical patient data. This is so that all information may be easily accessed while undergoing medical treatment and kept securely saved. The system features alarms that play when erroneous data is entered. Although the system features pre-programmed commands that allow for uninterrupted navigation, there are frequently disruptions due to power fluctuations.

Conclusion: Access to patients' medical records via an electronic health information system platform is crucial for making medical decisions that will result in effective care delivery in healthcare facilities, lower the risk of treatment errors, decrease patient waiting times, and lower the number of medical errors, a study has found.

KEY WORDS: Records; Health records; Health record management.

Chapter 1
Introduction
1.0.Background

One of the most pressing issues that cannot be avoided when talking about the development of a country is Health (Afarikumah, 2014). Over the years, governments have put a lot of measures in place to help improve the living standards of people (Tajikistan, 2017). But this aim cannot be accomplished without considering the health of the population. According to WHO, health is defined as a state of complete physical, mental and social well-being and not a mere absence of infirmity. This goes a long way to explain that, the living standards of the people can be improved when patient healthcare is improved(Amin et al., 2020). Medical records are the most important tool when we talk about patient healthcare (Marutha & Ngoepe, 2017). Complete documentation of a patient's demographic information and medical history and procedures are all kept in a medical record (Asinor & Leung, 2016). One cannot talk about improving the healthcare of patients without considering the health or medical records of the patient and for that reason managing them is as important as its use(Amin et al., 2020). Many medical records management systems have been implemented in Ghana to help improve healthcare (Afarikumah, 2014).

Due to the negative repercussions of incomplete data and storage concerns that render a substantial number of records inaccessible, slowing down retrospective studies and hampering epidemiological research. It is therefore not unexpected to hear that old information systems are considered as "a restricted vehicle of communication that has been exceeded by modern digital technology," as said by Santos and colleagues. Expectations have grown as a result of the improvement of information technology systems and that attempts have be made to digitize and save patient records electronically to make handling them easier and more efficient to manage. Health policy analysts and decision-makers have recognized the promise of Information Technology in the healthcare industry, but it adoption and utilization have not been as powerful as seen in other industries. For this reason, not many hospitals in Africa employ Electronic Health Records (EHR) to deliver health to the patients who visit, with the Ghana not been an exception.

Medical records are essential for improving patients' health (Asinor & Leung, 2016). Effective hospital record administration is vital to ensure hospitals' efficiency, accountability, openness, information security and overall, good governance. It must be noted that an effective records management system is required to ensure efficient management of patients' health records. Electronic Records Management Systems (ERMS) can be used to ensure easy access to information and efficient management of records for treatment (Oginga, 2017). However, due to the unwillingness of health professionals to use EMRs, records managers and clerks waste a lot of time looking for missing and/or misfiled records leading to delay in administering of healthcare to patients thus affecting the quality of care given to them. Patients generally have to wait a long time for health services due to ineffective records management systems (Oginga, 2017). Proper medical records management systems must be employed and used to help maintain and resolve data quality concerns as well as reduce patient waiting time and ensure quality healthcare delivery (Amin et al., 2020). This study investigates the attitude of health professionals at the Prestea Government Hospital towards the use of EHR to administer healthcare to the patients who visit the hospital.

Brief History of Prestea Government Hospital

The Prestea Government Hospital was constructed in 1929 by the then state gold mine company to cater for the health needs of the workers but was taken over by government following the collapse of the company in 1996.The hospital provides healthcare for the entire Prestea Huni valley district and other adjoining communities. The hospital is situated in a valley which is about 1km from the main Prestea township with patients having to climb a steep hill and travel an untarred road before accessing healthcare. The facility has migrated from paper records to electronic medical records. Initially, the facility started with HAMS in 2015 after they changed into using LMHS this year.

1.1. Problem Statement

Prior to the use of digital health systems, health workers rendered services to the patient using the paper-based medical record system. Digital health systems, such as EHRs which have come to replace the paper-based record, promise a lot of benefits such as reduction in medical errors, improvement patients 'safety, improvement in data collation and storage, and also, improvement in the overall outcome of health of patient. However, health workers have varying perceptions about the EHRs, its usefulness and impact on the service they deliver to patients. This study seeks to investigate the perception of health workers about the use of EHRs and its impact on health service delivery in Prestea Government Hospital.

1.2. Main objective

The purpose of the study is to investigate the perception of health worker about the EHRs use and impact on service delivery.

1.3. Specific Objectives

1. To determine the perception of health workers about the EHR use at PGH.
2. To investigate the perception of the health workers about the usefulness of the EHRs at PGH
3. To determine how the use of the EHRs affects the quality of health service delivery at PGH.

1.4. Research questions

1. What is the perception of health workers about the EHRs at PGH?
2. What is the perception of the health workers about the usefulness of the EHRs at PGH?
3. How does the EHRs use affect the quality of health service delivery at PGH?

1.5. Significance of study

The purpose of this study is to conduct an investigation on the perception of health worker about the EHRs use and impact on service delivery. This research will also aid the facility in identifying, recognizing, and suggesting the necessary current record management practice system that will allow the health facility to provide quality health care services. The study's results and recommendations might also be utilized by the health facility to help them develop an effective records management system.

1.6. Scope of Study

The perception of health worker about the EHRs use and impact on service delivery. This will include their perception about the current system in use, its usefulness as well as the impact it has on the service they deliver to patients.

1.7. Organization of Study

This dissertation has five chapters in total. Chapter One covers the background of the study, the problem statement for the identified issue, and its importance. The literature review in chapter two examines the findings of numerous academic studies on health records management. It also outlines the steps taken to analyze the data that was collected. The survey results are presented in chapters four and five, which deal with analysis, limitation, conclusion, and suggestion. The data will be presented in tables and figures for ease of interpretation. Before drawing conclusions and making recommendations, Chapter 5 makes a number of observations that are compared to the survey results.

Chapter Two
Literature Review

Data is being produced in ever-increasing quantities by businesses, both on paper and electronically (Asinor & Leung, 2016). Records management ensures that information is easily accessible and that it is disposed of when no longer required (Elikwu et al., 2020). Organizations must ensure the accuracy of their records by ensuring the authenticity of the data; records must be able to be proven to be what they claim to be (Marutha & Ngoepe, 2017) . Records managers must ensure that their organizations' decision-makers are drawn to them (Scholl et al., 2011). Records serve as "evidence of human activities and transactions" to protect both the public and the government's rights (Afarikumah, 2014). The preserved records will allow the government to demonstrate their administrative process (Oginga, 2017). The government's implementation and achievement of goals such as the rule of law, accountability and state resource management require proper health record administration (Marutha & Ngoepe, 2017). Getting management's attention requires convincing them of the importance of records management (Amin et al., 2020). An accurate and complete hospital record leads to better patient care and fewer medical errors (Mosweu & Rakemane, 2020). If a patient's private doctor wanted to use the medical record for future treatment, he needs the records first (Mosweu & Rakemane, 2020). Without them, he would be hesitant to proceed for fear of prescribing the wrong therapy (Marutha & Ngoepe, 2017). It can be difficult for health care providers to keep up-to-date with their patients' medical records (Amin et al., 2020).

Medical records contain documentation of policies and procedures that guide service delivery, such as who is accountable for completing the task, and what the prices are (Ikonne et al., 2021). The constant publishing of new information makes it challenging for providers to stay current (Mathioudakis et al., 2016). High productivity, profitability, and competitive advantage results from timely decisions (Marinič, 2015). To make wise decisions, many managers simply require an efficient records management system (Amin et al., 2020).

The patient has the right to the privacy of any information gathered about them while they are receiving consultation, examination, and treatment (Seniwoliba et al., 2017). The right to information is guaranteed by Article 21(f) of the Constitution of the Republic of Ghana within the parameters of the law. And as a company, we must make sure that these details are kept confidential (Janet, 2015). The objective of paperless trade is to replace paper-based corporate procedures with electronic ones (Adjorlolo & Gunnar Ellingsen, 2013). This entails scanning and indexing all paper records, as well as maintaining them through a company database (Marutha & Ngoepe, 2017). It has the potential to increase the quality of public services while also lowering costs and facilitating access to services (Marutha & Ngoepe, 2017). It as well helps to better secure information that are collected and stored and can easily be managed and monitored (Zali et al., 2018).

The Perception of Health Workers About the EHR Use.

Records management (RM) is the supervision and administration of digital or paper records, regardless of format (Elikwu et al., 2020). Prescriptions can be sent electronically to pharmacies from the point of care (Ikonne et al., 2021). This reduces the abuse and addiction rates of controlled substances, particularly opioids (Elikwu et al., 2020). Based on a patient's current medication and diagnosis, EHRs can automatically check for any possible drug-to-drug or drug/allergy interactions (Scholl et al., 2011).

The Perception of The Health Workers About the Usefulness of the EHRS.

Electronic health records are computer-assisted systems used in healthcare to collect, store, and combine a variety of patient medical data (Scholl et al., 2011). The primary purpose of medical records is to improve therapy, clinical decision-making, and research (Janet, 2015). Records management tasks include creating, receiving, maintaining, using, and disposing of records. Access to data continues to be restricted, resulting in inefficient and delayed treatment delivery (Marutha & Ngoepe, 2017). A simple and functional electronic filing system speeds up file or record retrieval, which influences the speed with which clinical and administrative decisions are made (Asinor & Leung, 2016). Electronic health records are the first step toward transformed health care (ASHT), according to the American Society of Health Technologists.

It provides more precise patient data (Marutha & Ngoepe, 2017). Electronic medical records were created initially to help with the storage and retrieval of patient information. Digital records update patient information in real time, providing other healthcare professionals with an up-to-date, accurate patient file (Elikwu et al., 2020). Continuity is especially important when a patient switches providers or sees a new physician. EHRs help providers manage patient care more effectively and provide better health care (Scholl et al., 2011).

It encourages interoperability. EHR communicates with other systems, such as EMR, allowing medical practices to improve continuity of care (Amin et al., 2020). When patients need to see specialists, manage chronic conditions like diabetes, or plan to transition to a home health care setting for recuperation or hospice, an interoperable EHR system is essential (Asinor & Leung, 2016).

It increased productivity (Afarikumah, 2014). Templates are included in EHRs to assist physicians in documenting common patient issues or complaints (Asinor & Leung, 2016). A few companies have also added voice recognition capabilities, allowing providers to interact with platforms through speech (Ikonne et al., 2021). Prescriptions can be electronically transmitted from the point of care to pharmacies. This lowers the rate of abuse and addiction to controlled substances (Marinič, 2015). EHRs can automatically check for potential drug-to-drug or drug/allergy interactions based on a patient's current medication and diagnosis (Marutha & Ngoepe, 2017). Electronic health records provide benefits such as increased safety, effectiveness, patient-centeredness, communication, education and timeliness, efficiency, and equity (Oginga, 2017).

How The Use of The EHRS Affects the Quality of Health Service Delivery.

Health record management systems have a significant impact on the delivery of high-quality health care services (Janet, 2015). Quality healthcare service delivery is impossible without a standard health records management system (Seniwoliba et al.,2017). Without a doubt, these systems have received insufficient attention from the government and health agencies. It has a significant impact on the improvement and sustainability of high-quality health care services across health facilities (Elikwu et al., 2020).In Ghana, Asinor and Leung (2016) conduct an exploratory study titled health records management practices.

According to the findings of their empirical study, good health record management is critical to improving health service delivery in developing countries such as Ghana. (Austin et al., 2010)investigated the effect of records management on service delivery at Kisii Teaching and Referral Hospital in Nairobi. According to the study's findings, records management practices include record creation/receipt, maintenance, use, and disposal. The study also revealed that due to a lack of effective and efficient records management practices, health workers in public health institutions, such as medical doctors and nurses, as well as pharmacists, are frequently unable to provide timely and effective health services to citizens. (Janet, 2015)conducted an empirical study of records management practices in Ghana's Upper Denkyira West District health facilities. Poor records management practices, according to the findings, have a significant impact on the responsiveness, effectiveness, and quality of health care service delivery. (Elikwu et al., 2020)conducted an empirical study of medical record management for healthcare services at the Victoria Public Hospital.

Chapter Three
Methodology

3.1. Study Design/Setting

For this study, a cross-sectional survey design was used. This design provided a numeric description of trends, attitudes and opinions of the sample; hence, it helped measure sample elements selected from the population of interest at a single point in time. The research focuses on health workers at the at the Prestea Government Hospital (PGH). The health workers include nurses, doctors, biotechnicians, HIM, pharmacists, midwifes, etc.

3.2. Sample Size Calculation

A confidence interval of 95% and error margin of 5% was used when calculating the sample size. Random sampling was used to select the respondents in order to avoid bias of the researcher. A sample size of 100 participants were used for this research from the targeted population.

3.3. Ethical Considerations

Written permission was sought and obtained from the administrative authorities at the facility. To ensure anonymity completed questionnaires were assigned numbers to hide the identity of the participants. No identifiable personal information such as name, designation or position held by respondent was collected in order to ensure anonymity and confidentiality. Participants were adequately informed about their rights to refuse to participate in the study and opt out at any time without consequences.

3.4. Data Collection Instrument/Procedure.

A structured questionnaire was used to collect the data from the healthcare providers. The questionnaires contained Likert scale (1 to 5) type questions. The questionnaires were distributed to the potential respondents to complete after which it was collected.

3.5. Data Analyses

The quantitative data was entered into Excel and then exported into SPSS for analysis. Descriptive and inferential analyses was done on data collected and the results were presented as table, graphs and figures.

Chapter Four
Results & Discussion

Table 1: Demographic Characteristics of the respondents

Variable	Frequency (N)	Percentage (%)
Gender		
Male	35	35.0
Female	65	65.0
Age		
18-29	34	34.0
30-39	53	53.0
40-49	12	12.0
50-59	1	1
Educational Background		
Masters	3	3.0
Bachelor's Degree	23	23.0
HND/Diploma	61	61.0
Others	13	13.0
Current position/Job title		
Administrative officer	10	10
Record Officer	13	13
Medical Laboratory Technician	5	5
Medical Assistant	17	17
Nurse	45	45
Midwife	10	10

Table 1 shows the demographic characteristics of the respondents. Out of the 100 respondents, 35(35%) of them were males and 65(65%) were females. The high number of females was as a results of a lot of respondent being Nurses. A total number of 34 respondents representing 34% were between the ages of 18-29, 53 representing 53% were between the ages of 30-39 and 12 respondents representing 12% were between 40-49 and one respondent was between 50-59 years. The respondents had varying educational qualifications as shown in Table 1. Out of the 100 respondents, 3 (3%) had a Master's Degree and 23 (23%) also had a Bachelor's Degree, HND and Diploma holders were 61 (61%) and 13 (13%) had other certificates. Most of the respondents in the study were from the nursing department which constitutes the majority of the category of staff. 45 nurses and 10 midwifes took part in the study representing 45% and 10 respectively. Medical assistants were the next largest category of staff who respondent to the questionnaire. They represent 10% of the respondents. Medical laboratory technicians were the least category of staff representing 5%.

Table 2.1: EHRs USE		
Indicators	**Responses Mean**	**Standard Deviation**
Contains all forms used at the facility	3.80	0.765
Supports clinical decisions	4.01	0.577

Helps to collect data more effectively	4.48	4.041
Helps to analyze data efficiently	4.14	0.623
Helps to effectively retrieve records.	4.16	0.647
Safeguard patient information	4.31	0.677
Helps save time	4.05	0.757
Overall EHRs Use	**4.14**	**1.155**

Concerns of healthcare professionals regarding the use of EHRs at the Prestea Government Hospital are shown in table 2.1 above. The majority of respondents (Mean= 4.14, SD= 1.155) concurred that EHRs assist them in providing care at the facility. According to the survey, health professionals feel that the facility's EHRs contain all of the forms that are utilized there (Mean = 3.80, SD = 0.765). This demonstrates how the EHRs assist in patient care in terms of the numerous records that should be used at the facility. This demonstrates that the majority of the healthcare professionals concur that the EHRs contain the majority of the forms utilized in the facility. Additionally, it supports clinical decisions (Mean = 4.01 SD = 0.577). They contend that the EHRs provide sufficient patient data and built-in technologies to support decisions on patient care.

Additionally, it aids in more efficient data collection (Mean = 4.48, 4.041). Few people do not support with the fact that the EHRs at the facility aid in data collection, despite the fact that more health professionals hold this opinion. Furthermore, they feel that the EHRs facilitates effective data analysis (Mean = 4.14, SD = 0.623). In their opinion, the statistics are better arranged and presented. Once more, EHRs are helpful in efficiently retrieving records (Mean= 4.16, SD= 0.647). They hold the opinion that the EHRs enable them to quickly and accurately retrieve patient records, facilitating the provision of services to patients. Health professionals also think that EHRs protect patient information (Mean = 4.31 SD = 0.677). Regarding safeguarding patient data from unauthorized parties, they feel that the EHRs is safe and secure. Finally, they assert that it facilitates the reduction of documentation time (Mean = 4.05 SD = 0.757). The majority of the data acquired at one point may be accessible at another place, which the health workers say has saved them a lot of paperwork.

Table 2.2: EHRs USEFULNESS

Indicators	**Responses Mean**	**Standard Deviation**
Provides easy access to past medical records	4.11	0.751
Helps to improve the quality of decision-making	4.08	0.646
Allows for safe exchange of information.	4.09	0.653
Helps to improve efficiency and productivity	3.98	0.710
Helps reduce medication errors	3.92	0.787
Helps to provides quality data	4.11	0.549
Ensures confidentiality of patient’s information	4.16	0.692
Ensures more legibility of data	4.08	0.580
Overall EHRs Usefulness	**3.57**	**0.671**

Table 2.2 above illustrates the healthcare professionals' concerns on the usefulness of EHRs at the Prestea Government Hospital. In general, respondents (Mean= 3.57, SD= 0.671) believed that EHRs are valuable

in some way when providing services at the facility. According to the study's findings, medical professionals believe that EHRs make it simple to obtain previous patient records (Mean = 4.11 SD = 0.751). This is due to the fact that all records are securely kept on a device that allows for simple accessibility during patient care. They also think that the EHRs contribute to the production of high-quality data (Mean = 4.08 SD = 0.646). They disclosed that when data is entered wrongly, the system contains prompts that sound alarms.

Additionally, the EHRs guarantee patient information confidentiality (Mean = 4.16 SD = 0.692). They disclosed that each health professional uses a different pin to access patient records, prohibiting unauthorized individuals from accessing the records, and that they are only permitted access to portions of patients' records that are relevant to their job description.

They added that the EHRs guarantee greater data readability (Mean = 4.08 SD = 0.580). Because paper records are not to be utilized, the system's set font size and style restricts the use of handwriting that is difficult to read. EHRs also help to improve the quality of decisions (Mean = 4.08 SD = 0.646). They believe that the system's decision-making is of high caliber if it has saved time and provided high-quality information, including past medical history. Furthermore, EHRs enable for the secure sharing of information (Mean = 4.09 SD = 0.653). This is due to the system's high level of security when in use. It restricts access to the patient information to those who are supposed to see it. Despite the fact that EHRs help to improve efficiency and productivity (Mean = 3.98 SD = 0.710), this is not fully reflected in the system. They believe that the system still has to be enhanced in order to provide more efficient patient care. They do not completely dispute that EHRs help to prevent medication errors (Mean = 3.92 SD = 0.787) in the EHRs, even though they believe the EHRs help a little with these concerns.

Table 2.3: EHRs EFFECT ON SERVICE DELIVERY

Indicators	**Responses Mean**	**Standard Deviation**
Support clinical decisions	4.19	0.615
Control the growth of records	4.11	0.737
Assimilate new records management technologies	4.12	0.624
Helps management make better decisions.	4.18	0.702
Keeps employees motivated.	3.98	0.974
Reduced patient waiting time	3.41	1.245
Prevent issues with data integrity	3.97	0.797
Reduce redundancy in records	4.11	0.815
Overall EHRs Effect on Service Delivery	**4.01**	**0.814**

Table 2.3 above illustrates the impact EHRs has on service delivery at the Prestea Government Hospital. In general, respondents (Mean= 4.01, SD= 0.814) believed that EHRs are place a role when it comes to providing services at the facility. According to the study's findings, medical professionals believe that the EHRs supports clinical decisions (Mean = 4.19 SD = 0.615). This is because the system provides patient information as well as prompts and reminders to assist health care providers in implementing evidence based clinical guidelines at the point of care.

They also think that the EHRs helps to assimilate new records management technologies (Mean = 4.12SD = 0.624). they believe that the system limits the generation of records or copies that are not required as well as destroying useless records or retrieving inactive records which helps to stabilize it growth.

Additionally, the EHRs guarantee that management make better decisions. (Mean = 4.18 SD = 0.702). They disclosed that the systems give complete data as well as well analyzed data for easy interpretation which helps them to make inform decisions.

They added that the EHRs do not really keep employees motivated. (Mean = 3.98 SD = 0.974). even though the system has set or predefined commands that aids in smooth navigation as well as reduce time used in documentation, the system is mostly interrupted as a result of power fluctuation. EHRs also help to reduced patient waiting time (Mean = 3.41 SD = 1.245). They do not really believe that the system has reduced patient waiting time because they feel the systems' connectivity is low which makes entry take time. They also stated that patient will have to go through a lot of procedures since when skipped the service cannot be rendered.

Furthermore, they believe the EHRs somehow prevent issues with data integrity (Mean = 3.97 SD= 0.797). This is due to the fact that the records can be accessed by only those that are directly providing service to the patient and also data entered at one point can only be edited at the same point which helps to keep the data intact. Lastly, the EHRs has helped reduce redundancy in records (Mean = 4.11 SD = 0.815). They believe that the system does not accommodate repetition in records. They stated that records such as demographics of a patient, taken at one point is being accessed at every point in the care to prevent taking conflicting data at another point. Each patient is given a unique identification number which helps prevent duplicate of records.

DISSCUSSION

In a paper titled "Healthcare Providers Intention to Use Technology to Attend to Clients" (Boadu et al., 2021). EHRs use, usefulness, and impact on service delivery concerns of healthcare workers using EHRs. The majority of LHIMS users had a favorable opinion of ease of use, with both a nice interface and clear instructions, according to research by Boadu et al. (2021) on the use, usefulness, and influence of EHRs on service delivery issues of healthcare personnel. Respondents said it was simple for them to be skilled, and they also thought the interface was easy to use. Overall, 3 out of 4 HP thought LHIMS was a very helpful technology for managing electronic patient records.

With regards to the utilization of EHRs, (Boadu et al., 2021) noted that it is thought that adequate training will make users more at ease using the system, hence improving their favorable attitude toward usage. The survey showed that the vast majority of HP had a positive attitude on utilizing the LHIMS. This exceptional performance might be attributable to HP's opinion of how simple LHIMS usage is. When they believe a new technology is simple to use, people often have a positive attitude about it.

Chapter Five

Conclusion And Recommendation

Each patient is given a unique identification number, which helps to avoid duplicate records. Each health practitioner is issued a unique pin to access patient records. EHRs assist clinicians in making sound clinical judgments. This is because the system provides patient information as well as cues and reminders to health care staff. This demonstrates that the system has an impact on the services delivered to patients. The system used at the facility can determine whether the service provided to the patients is good or bad.

The hospital administration and government at all levels should prioritize the provision of necessary infrastructure in the health capital budget to support the adoption and implementation of the electronic health information system and electronic medical records management. This will promote prompt access to patients' records for medical care decision and improve healthcare service delivery quality, and lower high mortality rates from delayed treatments and preventable medical errors.

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APPENDIX A: QUESTIONNAIRES

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF ALLIED HEALTH SCIENCES
DEPARTMENT OF HEALTH INFORMATION MANAGEMENT

QUESTIONNAIRE ON "ASSESSING THE EFFECT OF HEALTH RECORDS MANAGEMENT ON HEALTH SERVICE DELIVERY: A CASE STUDY OF THE PRESTEA GOVERNMENT HOSPITAL (PGH), PRESTEA, GHANA."

This questionnaire has been developed to determine the effect of health records management on health service delivery at the Prestea Government Hospital (PGH) in the Prestea Municipality of Ghana. I kindly request that you complete the following questions. Please be informed that this study is purely academic and that all information obtained shall be kept confidential. The outcome of this research may be used for academic and general purposes such as research reports, conference papers or books.

Thank you in advance for your co-operation.

PART I
SECTION A: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF HEALTH PROFESSIONALS

Please tick (✓) the response applicable to you.

1. Gender: 1. Male ( ) 2. Female ( )
2. Age: 1. 18-29 ( ) 2. 30-39 ( ) 3. 40-49 ( ) 4. 50-59 ( ) 5. 60+ ( )
3. Marital Status 1. Married ( ) 2. Single ( ) 3. Divorce ( )
4. Current position/Job title: ……

5. Educational Background: 1. Masters ( ) 2. BSc ( ) 3. HND/Diploma ( )
4. SH( ) 5. Other Please specify……

PART II

In sections **C to D** below, the response to each statement is rated on a scale of 1, 2, 3, 4, and 5. Five (5) is the highest value on the scale; while 1 represents the lowest. Please tick (✓) the response as applicable to you and the hospital.

SECTION B: To determine the perception of health workers about the EHR use at PGH

	STATEMENT	RESPONSE (please, tick (✓))					
		1	2	3	4	5	Don't know
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
1.	The system contains all forms used at the facility						
2.	The system supports clinical decisions MAKING						
3.	The system helps to collect data more effectively						
4.	The system helps to analyze data efficiently						
5.	The system helps to effectively retrieve and dispose records.						
6.	The system helps to safeguard patient information						
7.	The use of the system helps save time, cost and efforts						

SECTION C: To investigate the perception of the health workers about the usefulness of the EHRs at PGH.

	STATEMENT	RESPONSE (please, tick (✓))					
		1	2	3	4	5	Don't know
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
1.	I believe EHR provides easy access to past medical records						
2.	I believe EHR helps to improve the quality of decision-making						
3.	I believe EHR allows for safe exchange of information.						
4.	I believe EHR helps to improve efficiency and productivity						

5.	I believe EHR helps reduce medication errors						
6.	I believe EHR helps to provides quality data						
7.	I believe EHR ensures confidentiality of patient's information.						
8.	I believe EHR ensures more legibility of data						

SECTION D: To determine how the use of the EHRs affects the quality of health service delivery at PGH

STATEMENT		RESPONSE (please, tick (✓))					
		1	2	3	4	5	Don't know
		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	
1.	Record keeping support clinical decisions						
2.	Records management helps to control the growth of records						
3.	Records management helps to assimilate new records management technologies						
4.	Records management helps management make better decisions.						
5.	Records management keeps employees motivated.						
6.	The system has reduced patient waiting time						
7.	The system has help prevent issues with data integrity						
8.	The system has helped reduce redundancy in records						