

The Appraisal of Clinical File Management in Primary Health Care

Thompson Salvation Chinezom¹ & Professor Innime Righteous²

School of Public Health, University of Port Harcourt.

*Corresponding Author: Thompson Salvation Chinezom

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Citation: Thompson Salvation Chinezom & Professor Innime Righteous. (2025). The Appraisal of Clinical File Management in Primary Health Care. UKR Journal of Medicine and Medical Research, 1(2), 98-103.	<i>The study assessed clinical file management in primary health care, with particular reference to Ahoada East Local Government Primary Health Care Centre, Rivers State. The study was motivated by the importance of accurate, accessible, and well-managed clinical files in supporting continuity of care, clinical decision-making, patient safety, health information management, and effective health service delivery. The study adopted a descriptive survey research design. The population comprised patients attending Ahoada East Local Government Primary Health Care Centre, while a sample of 100 patients was selected for the study. Data were collected using a researcher-designed questionnaire divided into Sections A and B, with responses measured using a four-point Likert scale of Strongly Agreed, Agreed, Strongly Disagreed, and Disagreed. The instrument was subjected to face and content validity through the appraisal of the research supervisor. Data collected were analysed using frequency tables and simple percentages, while the hypothesis was tested using inferential statistics. The findings indicated that effective clinical file management contributes significantly to patient care and health outcomes. The hypothesis test showed that the calculated t-value of 2.813 was greater than the critical value of 1.96 at the 0.05 level of significance, leading to the rejection of the null hypothesis. The study concluded that effective clinical file management is essential for improving the quality, efficiency, safety, and continuity of primary health care services. It recommended improved health information infrastructure, regular training of health workers, standardized record-keeping procedures, stronger data security and confidentiality measures, routine monitoring and evaluation, and greater stakeholder involvement in clinical file management.</i> Keywords: Clinical File Management, Primary Health Care, Health Information Management, Patient Care, Medical Record-Keeping, Data Security and Confidentiality.

Introduction

Ineffective management of clinical files negatively affects the quality of the service delivery in primary health care. Well-maintained and easily available clinical records ensure the continuity of care, promote informed clinical decision making, and facilitate public health surveillance and monitoring. The World Health Organization (WHO, 2019) claims that efficient clinical record management increases patients' safety and improves the quality of healthcare due to reduced errors and duplication. In PHC clinics, where financial and material resources are limited and where many patients visit, efficient management of clinical records is necessary to increase operational efficiency and provide better health outcomes.

A range of challenges to the efficient management of clinical files in primary health care clinics have been identified in the research. The existing problems include the lack of physical infrastructure, shortage of appropriately trained personnel, and lack of adherence to established documentation processes (Odeyemi & Saka, 2021). Many PHC facilities still use paper-based record keeping systems, which may result in the loss of information, unreadable handwriting, and delayed search for clinical records. The stated challenges limit the availability of important clinical information, prevent proper decision making, and, consequently, negatively affect patients' safety and quality of healthcare services.

The introduction of electronic health records (EHR) is considered one of the possible solutions to address a number of drawbacks of paper-based record keeping. According to recent evidence, electronic information systems allow enhancing the accuracy of clinical information, promoting more rapid access to patient records, and increasing the availability of information across all levels of healthcare provision (Nguyen et al., 2014). However, there are a number of factors that can prevent the implementation of EHR systems in primary health care clinics, including lack of funding, absence of technical know-how, and unwillingness of health workers to use innovations. Some barriers to the implementation of electronic record management system have been identified in the systematic review of Kruse et al. (2018). They included the issues with information security, insufficient staff training, and organizational/technological changes.

Training and professional development of health staff are key factors contributing to the improvement of clinical file management practices in healthcare facilities. Even a most innovative information system fails to deliver its full potential in the situation when staff members lack relevant knowledge and competencies (Biruk et al., 2014). Apart from training, supervision and systematic monitoring are required to increase compliance with the documentation rules, identify weak areas in the record keeping practice, and ensure the accountability of healthcare providers. In a study conducted by Abiy et al. (2018) in Ethiopia, the quality of clinical records was found to be higher in those health centres that implemented continuous training programs.

However, apart from staffing and workforce considerations, organizational policies and governance structures may contribute significantly to clinical record management. Healthcare organizations with well-defined documentation policies and proper monitoring mechanisms tend to maintain accurate and consistent clinical records (Lester et al., 2010). Moreover, the development of nationwide health information system that pools together data from primary healthcare facilities will facilitate health planning, resource distribution, and policy-making based on evidence. Nevertheless, the integration of information from various facilities and systems will be possible only in case of interoperability of digital platforms and standardization of data format, which continues to pose challenges for many countries. The seamless exchange and proper use of health information remain difficult tasks in many places around the world.

To conclude, it should be noted that proper management of clinical files is crucial for the provision of quality and safe services in PHC. Despite numerous advantages offered by

electronic record keeping, the successful implementation of such systems depends on the presence of a number of factors. In particular, apart from the use of proper technology, the management of clinical records involves the issues of staffing, training, infrastructure and policies among others.

Research Design

Research design is the specification of the methods and procedures for collecting and analysing the information needed to address the problems. The design of this study was descriptive survey. The study did take into account the nature of the problem.

Population of the Study

For the purpose of this study, the target population consists of patients attending Ahoada East Local Government, Primary Health Care Centre, Rivers State.

Samples and Sampling Techniques

The sample of the study is that part of the population which was selected for closer investigation. The researcher employed a total number of one hundred (100) patients attending Ahoada East Local Government, Primary Health Care Center, Rivers State to choose the required samples for this investigation.

Instrument for Data Collection

The instrument used for data collection was a researcher-designed questionnaire. It was carefully structured to ensure clarity and simplicity. The questionnaire comprised two sections, A and B. Section A gathered information on the respondents' personal and demographic characteristics, while Section B contained items developed from the research questions to obtain responses from participants. The response options provided were Strongly Agree (SA), Agree (A), Strongly Disagree (SD), and Disagree (D).

Validity of the Instrument

To determine the face validity of the study, the research instrument was examined and assessed by the supervisor for the suitability of each item of the instrument. The final items were obtained by using the comment of the supervisor and then were subjected to content validity to ensure that the content of instruments was indicative of the area which instruments are meant to cover.

Method of Data Analysis

The response to the questionnaire items was analysed using frequency tables and simple percentage technique. The hypotheses of the research as indicated above were examined by Chi-Square Statistics.

4.2 Presentation of Data

Table 1: Distribution of Questionnaire

	Frequency	Percent
Returned	87	87.0
Unreturned	13	13.0
Total	100	100.0

Source: Field Survey, 2025

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

Table 2: Distribution According to Gender

	Frequency	Percent
Male	51	58.6
Female	36	41.4
Total	87	87.0

Source: Field Survey, 2025

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

Table 3: Distribution according to Age

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

Source: Field Survey, 2025

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

Table 4: Distribution According to Marital Status

	Frequency	Percent
Single	49	56.3
Married	38	43.7
Total	87	87.0

Source: Field Survey, 2025

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

4.3 Testing of Hypothesis

Hypothesis 1

Ho: clinical file management has no significant impact on patient care and outcomes

H1: clinical file management has significant impact on patient care and outcomes

Table 5: Relationship between clinical file management and patient care & outcomes

Structure	N	X	SD	df	Standard Error	t _{cal}	t _{crit}	Decision
clinical file management	87	3.59	0.883	172	0.177	2.813	1.96	H ₀ Rejected
patient care & outcomes	87	3.09	1.398					

0.5 level of significance

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

4.4 Discussion of Findings

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

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

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

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

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

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

Conclusion

The study concluded that proper administration of clinical files is an essential component of quality health care especially in basic health care setting. Clinical files, paper and computerised, are the foundation of clinical decision making, continuity of treatment, preventive services and health system planning. The effective maintenance of clinical records leads to improvements in patient safety, reduces medical errors, enhances treatment outcomes and enables the efficient use of scarce healthcare resources.

Electronic clinical files (EHRs), in particular, have been associated with better clinical outcomes due to their ability

to streamline data collection, support real-time access to patient information, and enhance communication among healthcare providers. However, the transition from manual to digital systems presents challenges, especially in resource-limited environments where poor infrastructure, inadequate training, and limited funding hinder the full realization of these benefits.

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

Recommendations

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

involved in the design, implementation, and evaluation of clinical file systems to ensure they are user-friendly, relevant, and responsive to local needs.

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