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EFFECT OF OPERATIONAL POLICIES ON QUALITY HEALTHCARE SERVICE IN GBOKO DIOCESAN HOSPITALS, BENUE STATE, NIGERIA

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ABSTRACT

This study examined the effect of operational policies on the quality of healthcare services in healthcare institutions within the Catholic Diocese of Gboko, Benue State, Nigeria. The specific objectives were to investigate the effects of staffing policies, drug procurement and distribution policies, infection prevention and control policies, and health record management policies on the quality of healthcare services. A cross-sectional survey design was employed, and data were collected from 412 healthcare workers using a structured questionnaire validated through expert review. The reliability coefficients for the study instruments ranged between 0.78 and 0.86. Data were analyzed using descriptive statistics and multiple regression analysis. Findings of the study demonstrated that all four operational policies significantly affect healthcare quality. Staffing policy had the strongest effect ($B = 0.689$, $\beta = 0.580$, $t = 11.110$, $p = 0.000$), followed by drug procurement and supply policy ($B = 0.642$, $\beta = 0.550$, $t = 9.580$, $p = 0.000$). Infection prevention and control policy also exerted a strong positive influence ($B = 0.583$, $\beta = 0.520$, $t = 8.210$, $p = 0.000$), while health record management policy, though the least strong predictor, remained statistically significant ($B = 0.498$, $\beta = 0.445$, $t = 7.320$, $p = 0.000$). The study concludes that operational policies are critical determinants of healthcare quality in the Catholic Diocese of Gboko, with staffing, procurement, infection control, and record management practices all contributing significantly to service outcomes. It recommends strengthening human resource structures, improving procurement transparency and efficiency, enforcing infection control protocols, and standardizing medical record systems to enhance patient care quality.

KEY WORDS: Staffing Policies, Drug Procurement and Distribution Policies, Infection Prevention and Control Policies, and Health Record Management Policies, Quality of Healthcare Services

1.0 INTRODUCTION

1.1 Background to the Study

Healthcare delivery has remained at the center of global development debates due to its direct connection with human survival, social stability, and economic growth. In recent decades, countries across the world have intensified calls for improved operational frameworks in healthcare systems, as the demand for high-quality, safe, and efficient health services continues to rise. The COVID-19 pandemic further exposed the fragility of health systems globally, revealing how weak organizational and operational structures can compromise the quality service delivery (World Health Organization [WHO], 2021). From advanced nations to developing contexts, the need to strengthen operational policies has become a universal concern, with health institutions adopting structured policy interventions to guarantee patient safety, efficiency, satisfaction, and clinical effectiveness (Dahlgren et al.,

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2022; Nair & Sreeram, 2023).

Operational policies refer to structured institutional rules, procedures, and strategies designed to regulate day-to-day activities and ensure consistency, efficiency, and effectiveness in healthcare service delivery (Erasmus & Ekpo, 2022). They represent the institutional backbone that guides how human, financial, and material resources are mobilized to achieve set objectives. Four broad dimensions of operational policies are particularly relevant in healthcare systems. The first is staffing policies, which provide frameworks for recruitment, deployment, workload distribution, training, and motivation of healthcare workers. The second is drug procurement and supply policies, which guide the sourcing, storage, and distribution of medicines and consumables to ensure availability, affordability, and safety. The third is infection prevention and control (IPC) policies, which set standards for hygiene, sanitation, and biomedical waste management to minimize healthcare-associated infections. The fourth is health record management policies, which provide procedures for collecting, storing, and utilizing patient information for clinical and administrative purposes (Okoro& Ibrahim, 2021; Mwangi et al., 2023). Collectively, these policies provide the operational lens through which healthcare institutions can guarantee orderliness and efficiency in their daily operations.

Quality of healthcare service, on the other hand, is a multidimensional concept that describes the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (WHO, 2022). Scholars have identified four major measures of healthcare quality. Patient satisfaction captures the extent to which patients feel their expectations are met in terms of communication, timeliness, and dignity of care. Service efficiency and accessibility reflect the ability of the system to deliver care promptly and without unnecessary waste, while ensuring equitable access. Patient safety focuses on minimizing risks, errors, and harm during the delivery of care. Clinical effectiveness measures the degree to which healthcare interventions achieve desired health outcomes based on evidence-based protocols (Alhassan et al., 2022; Osei-Tutu et al., 2024). These measures provide a holistic framework for evaluating healthcare performance.

The interplay between operational policies and quality healthcare service has been well documented across regions, though with varying outcomes. In developed countries such as the United States, Canada, and the United Kingdom, structured staffing frameworks, digitalized medical records, and stringent infection control policies have contributed to reduced medical errors and enhanced patient outcomes (Johnson & Peters, 2022). In Asian contexts, including India and Thailand, effective drug procurement and supply policies have been instrumental in expanding access to affordable medicines, thereby boosting patient satisfaction and treatment outcomes (Singh & Verma, 2021). In Africa, countries such as Kenya and South Africa have shown that improvements in staff training policies and infection prevention guidelines directly translate into safer care environments and higher patient trust (Mwangi et al., 2023). Within Nigeria, however, health systems continue to grapple with inconsistent implementation of operational policies, weak procurement frameworks, inadequate staff welfare measures, and poor medical record systems, all of which compromise quality service delivery (Erasmus & Ekpo, 2022; Akinwale et al., 2023).

Faith-based hospitals, particularly Catholic health facilities, occupy an important place in Nigeria's health sector, accounting for a significant proportion of healthcare provision, especially in underserved rural areas. While Catholic hospitals are generally reputed for their commitment to compassionate care, studies indicate that they also struggle with operational challenges such as drug stock-outs, staff shortages, lapses in infection prevention, and weak patient record management (Uzochukwu et al., 2022). These gaps hinder the ability of Catholic facilities to fully meet patient expectations in terms of satisfaction, efficiency, safety, and clinical effectiveness. Despite the successes of operational policies in improving healthcare systems elsewhere in the world, there remains a paucity of empirical evidence within Nigeria, and in the Catholic Diocese of Gboko in particular, on the extent to which such policies affect the quality of healthcare delivery.

This lacuna forms the motivation for the present study. By systematically investigating the effect of operational policies on the quality of healthcare services in the Catholic Diocese of Gboko, this study seeks to bridge the knowledge gap and provide actionable insights for diocesan administrators, policymakers, and practitioners. Such evidence-based guidance is critical for strengthening Catholic healthcare institutions in Gboko and ensuring that they meet global standards of quality, safety, and effectiveness in service delivery.

1.2 Statement of the Problem

Healthcare facilities run by faith-based institutions, including the Catholic Diocese of Gboko, have long contributed to bridging the gap in healthcare access, especially in underserved communities. However, the quality of healthcare services within these facilities has increasingly come under scrutiny. Quality of care is often measured through patient satisfaction, service efficiency, patient safety, and clinical effectiveness. Evidence suggests that in many mission hospitals and clinics, including those under the Diocese, patient satisfaction, service efficiency, patient safety, and clinical effectiveness remain suboptimal.

Patient satisfaction is undermined by long waiting times, poor communication between staff and patients, and the frequent unavailability of essential medicines, which forces patients to seek services elsewhere. Service efficiency and accessibility are weakened by bureaucratic procurement processes, inadequate infrastructure in rural facilities, poor referral systems, and limited use of information and communication technologies in hospital administration. Patient safety remains a concern due to lapses in infection prevention, poor biomedical waste management, and medication errors arising from incomplete or manual records. Clinical effectiveness is further hampered by inadequate refresher training for staff, shortage of modern diagnostic equipment, weak follow-up mechanisms, and irregular application of evidence-based treatment protocols.

Globally, studies have shown that well-designed operational policies can significantly enhance healthcare outcomes. For instance, in parts of East Africa and Asia, strong policies on staff training, drug procurement, and infection control have been linked with improvements in patient safety, satisfaction, and treatment outcomes. Similarly, in developed health systems, the adoption of electronic health records and structured staffing policies has demonstrably reduced medical errors and enhanced efficiency. These successes underscore the central role of operational policies in shaping healthcare quality.

However, there is a paucity of empirical evidence in Nigeria, and in Benue State and Gboko Diocese in particular, on how operational policies influence healthcare quality in faith-based facilities. While anecdotal accounts suggest both strengths and weaknesses, systematic studies that provide evidence-based insights remain

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limited. This knowledge gap has made it difficult for policy makers, diocesan health boards, and hospital administrators to identify which operational policies are most effective in enhancing service delivery. It is against this backdrop that this study seeks to examine the effect of operational policies on the quality of healthcare services in the Catholic Diocese of Gboko, with the aim of identifying policy gaps and recommending strategies for improved healthcare delivery.

1.3 Objectives of the Study

The main objective of this study is to examine the effect of operational policies on the quality of healthcare services in the in Catholic Diocese of Gboko. The specific objectives are to;

i. investigate the effect of staffing policies on the quality of healthcare services in Catholic Diocese of Gboko;

ii. assess the effect of drug procurement and distribution policies on the quality of healthcare services in Catholic Diocese of Gboko;

iii. determine the effect of infection prevention and waste management policies on the quality of healthcare services in Catholic Diocese of Gboko and

iv. evaluate the effect of patient record management policies on the quality of healthcare services in Catholic Diocese of Gboko.

1.4 Research Hypotheses

Ho_1: Staffing policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko.

Ho_2: Drug procurement and distribution policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko.

Ho_3: Infection prevention and waste management policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko.

Ho_4: Patient record management policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko.

2.0 REVIEW OF RELATED LITERATURE

2.1 Conceptual Framework

The conceptual framework for this study is built around the idea that operational policies are the institutional instruments that translate strategic goals into routine actions, and that the strength, coherence and implementation of those policies determine process performance and, ultimately, quality outcomes in health facilities. This section introduces the main concepts that will be used throughout the chapter: operational policies (and their practical dimensions), service quality (and its constituent measures), and the institutional characteristics of faith-based (Catholic) hospitals that mediate how policies are formulated and applied in practice.

2.1.1 Concept of operational policies

Operational policies have been described in multiple but complementary ways in recent health policy literature. One useful framing treats operational policies as the set of formal and informal rules that determine how resources are allocated and how day-to-day clinical and administrative activities are carried out within health organisations; from this perspective, operational policies are instruments for translating policy intent into routine practice and for ensuring predictable, auditable actions across the facility. This managerial/implementation view emphasizes procedures, standard operating protocols and managerial accountability (Maddox, 2024). This also means the governance instruments that set the bounds for decision-making within institutions, determining who may hire, purchase, prescribe, or discharge, and under what conditions. Under this governance definition, operational policies create the authority lines and approval workflows that reduce ambiguity and distribute responsibility across clinical and administrative roles (Omaghomi, 2024).

In the broader health sector, operational policies are commonly understood to include workforce rules (recruitment, rostering, supervision and continuing professional development), commodity management and procurement guidelines, clinical governance and safety protocols (including infection prevention and waste management), and information governance (medical record keeping, confidentiality and data use). These policy areas form the day-to-day "engine room" of a health facility: weaknesses in any of them typically show up as stock-outs, service delays, medical errors, or data gaps that impede continuity of care (Abdulkadir, 2024).

When applied to the Catholic diocesan hospitals of Gboko, operational policies must be read through both institutional capacity constraints and mission commitments. Diocesan hospitals usually operate in mixed funding environments (user fees, diocesan subsidies, donor grants) and often serve rural, low-income populations; their operational policies therefore reflect trade-offs between financial sustainability and equity of access, and between adherence to religious directives and the demand for modern clinical services. Reports and analyses of faith-based providers emphasise that, in many African dioceses, infrastructure limitations, intermittent supply chains and human-resource constraints complicate policy implementation even when policies are formally present (CUAMM, 2024). Although operational policies in healthcare are broad and varied, four dimensions stand out as central to the effectiveness of hospital service delivery: staffing policies, drug procurement and supply chain policies, infection prevention and control policies, and health record management policies. These four were selected for this study because they represent the most immediate and measurable operational levers that directly influence patient experiences and outcomes in Catholic hospitals.

i. Staffing Policies

Staffing policies are a cornerstone of operational efficiency in healthcare systems because they determine the adequacy, competence, and distribution of personnel who provide direct and supportive care. Scholars describe staffing policies as institutional frameworks that guide the recruitment, deployment, retention, and continuous training of health workers in alignment with service demands and patient needs (Okoroafor et al., 2022). This emphasizes that staffing is not simply about filling vacant posts but about ensuring that the right mix of skills is available in the right places at the right times. In another perspective, staffing policies are seen as mechanisms that balance organizational objectives with professional development, ensuring that employee welfare, workload distribution, and career progression are integrated into operational planning (Mwangi & Gachanja, 2023). A further interpretation underscores their role in equity and accessibility, as staffing frameworks must address urban-rural imbalances, mitigate migration, and guarantee that vulnerable populations are not underserved due to workforce maldistribution (Adebisi et al., 2023).

In the context of Catholic diocesan hospitals in Gboko, staffing policies must contend with both structural and contextual challenges.

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These facilities often rely on limited financial resources, which constrains the recruitment of specialists and increases dependence on general practitioners, nurses, and community health workers. The situation is compounded by migration of skilled health workers to urban centers or abroad, leaving rural-based mission hospitals with persistent shortages. Furthermore, the faith-based identity of these hospitals often requires balancing professional staffing needs with alignment to religious values, which sometimes narrows the recruitment pool. Despite these challenges, strong staffing policies can enhance service delivery by ensuring transparent recruitment procedures, fostering professional development, and creating an environment where staff feel valued and motivated to deliver compassionate care (Ezenwaka et al., 2024).

ii. Drug Procurement and Supply Policies

Drug procurement and supply policies form a critical dimension of operational policies in healthcare institutions. They regulate how medicines are sourced, distributed, and made available to patients in a timely, safe, and cost-effective manner. Scholars have defined drug procurement and supply policies in varied but complementary ways. One perspective sees them as a structured set of rules guiding the acquisition, storage, and distribution of essential medicines within health systems, emphasizing equity, transparency, and accountability (Yadav et al., 2022). Another view considers these policies as frameworks that ensure alignment of medicine procurement with public health priorities, focusing on the availability of quality and affordable drugs (Mwangi et al., 2023). More recently, they have been described as governance instruments that balance competing interests of affordability, sustainability, and accessibility while responding to dynamic health demands (Adeniran & Omole, 2024).

Within the Gboko diocesan hospitals, drug procurement and supply policies take on an additional layer of importance. These hospitals serve semi-urban and rural populations where access to essential medicines can be limited due to weak public supply chains and high costs in private pharmacies. A well-articulated procurement policy helps the hospitals to streamline purchasing processes, leverage collective bargaining, and ensure that drugs are affordable to patients. However, these institutions often face challenges such as irregular funding, dependence on donations, limited supplier options, and logistical barriers like poor road infrastructure, which complicate the consistency of drug supply.

iii. Infection Prevention and Control Policies

Infection prevention and control (IPC) policies form a fundamental component of operational policies in healthcare institutions. They are designed to reduce the risk of healthcare-associated infections (HAIs) by establishing systematic procedures and guidelines for preventing the transmission of pathogens in clinical settings. These are structured institutional frameworks that integrate hygiene protocols, sterilization practices, and protective equipment standards to safeguard both patients and healthcare providers (Ngugi et al., 2022). They are also seen as regulatory instruments that ensure compliance with global health safety standards such as those of the World Health Organization, emphasizing surveillance, outbreak response, and risk mitigation (Tadesse & Bekele, 2023).

In the healthcare sector broadly, IPC policies are indispensable to service delivery. HAIs remain a leading cause of morbidity and mortality globally, and poorly implemented infection control measures often exacerbate the burden of disease in already fragile health systems. Hospitals with strong IPC policies record fewer infection outbreaks, reduced antibiotic resistance, and improved patient trust (Mensah et al., 2023). Furthermore, in the wake of the COVID-19 pandemic, IPC policies have gained renewed prominence as instruments of resilience, ensuring continuity of care while protecting both frontline staff and vulnerable patients.

In the Catholic hospitals within Gboko Diocese, IPC policies carry particular significance. These hospitals often serve densely populated communities with limited resources, where infection outbreaks can spread rapidly. Common challenges include overcrowded wards, inadequate supply of personal protective equipment, insufficient training on standard precautions, and reliance on manual sterilization techniques. Weak surveillance systems and delays in reporting infectious diseases further exacerbate the risks (Ityav & Gberikon, 2023). Moreover, cultural practices and limited awareness among patients sometimes hinder strict adherence to IPC guidelines.

iv. Health Record Management Policies

Health record management policies constitute a pivotal operational domain because they govern how patient information is captured, stored, retrieved and protected within healthcare institutions. Different scholarly perspectives frame these policies in complementary ways. One view treats them as technical frameworks that prescribe standards for clinical documentation, coding, retention periods and interoperability so that medical information reliably supports clinical decision-making and continuity of care (Martins, 2022). Another perspective highlights their governance function, seeing record policies as instruments that define roles, responsibilities and access controls to safeguard confidentiality, ensure legal compliance, and enable audit and accountability (Chen, 2023). A further interpretation considers record management policies through a systems lens, emphasising the integration of health information systems with supply, staffing and clinical workflows to produce timely data for performance monitoring and feedback (Patel & Singh, 2024). More recently, researchers have stressed the patient-centred dimension of records policy, arguing that policies should also facilitate patient access to their own records and promote shared decision-making while protecting privacy (Rodriguez, 2022).

These perspectives underline that health record management is simultaneously technical, legal, organizational and ethical. In practice, well-crafted record policies ensure that clinicians have accurate histories, reduce duplication of tests, prevent medication errors, and enable reliable monitoring of outcomes, all of which contribute directly to clinical effectiveness and patient safety (Alvarez, 2023). Record policies that mandate standardized data elements and promote interoperable electronic systems also strengthen administrative efficiency by reducing retrieval time and improving referral processes. Conversely, weak or inconsistent record policies produce fragmented information flows, increase the risk of clinical errors, and limit the health facility's ability to learn from routine data.

2.1.2 Quality Healthcare Services

Quality of healthcare services has become a central concern in global health discourse as healthcare systems face growing demands from rising populations, emerging diseases, and constrained resources. The concept is multi-dimensional and contested, as different stakeholders; patients, providers, regulators, and policymakers attach varied meanings to what constitutes "quality." Nonetheless, there is broad consensus that quality healthcare involves providing services that meet established standards while addressing patient needs in a safe, effective, timely, and patient-

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centered manner (World Health Organization, 2022).

Quality of healthcare services is typically assessed through four interrelated measures that together capture the multi-dimensional nature of the concept. Patient satisfaction reflects the degree to which healthcare services meet or exceed patient expectations in terms of responsiveness, communication, and dignity (Njeru et al., 2023). Efficiency refers to the ability of healthcare systems to optimize available resources to achieve maximum output, including reduced waiting times, avoidance of unnecessary procedures, and cost-effectiveness (Onyango et al., 2022). Safety addresses the reduction of risks, errors, and harm to patients during care delivery, including infection control and adherence to treatment protocols (Okeke & Bello, 2023). Effectiveness denotes the capacity of services to achieve desired health outcomes in accordance with evidence-based standards, such as successful recovery rates, improved health status, and long-term management of chronic conditions (Chukwurah & Adetunji, 2024).

In the Catholic hospitals within Gboko Diocese, the concept of quality healthcare carries particular significance. As mission-driven institutions, they aim not only to provide clinical excellence but also to embody values of compassion, dignity, and community service. However, they are challenged by systemic constraints, including limited resources, high patient loads, and infrastructural deficits, which compromise their ability to deliver services that meet all dimensions of quality. Operational policies in staffing, drug supply, infection prevention, and record management therefore play a pivotal role in shaping how these hospitals can deliver care that is safe, efficient, effective, and satisfactory to patients.

2.1.3 Operational Policies and Quality Healthcare Service

The relationship between operational policies and healthcare service delivery has been widely acknowledged in contemporary health-systems research as both direct and systemic, highlighting the critical role of structured organizational rules in shaping the processes and outcomes of care. Operational policies such as staffing, drug procurement and supply management, infection prevention and control (IPC), and health records management constitute the core mechanisms through which health facilities translate institutional goals into routine practices. These policies influence not only how resources are mobilized and allocated but also how care is delivered, monitored, and improved. Studies increasingly show that the quality care patients receive is significantly dependent on the clarity, adequacy, and consistency with which such operational policies are implemented (Agyapong et al., 2023; Oleribe et al., 2022).

Evidence from high-income health systems demonstrates that strong operational policies create an enabling environment for safe, efficient, patient-centered, and clinically effective care. Countries such as the United Kingdom, Canada, and Sweden link improved patient outcomes to standardized staffing protocols, structured clinical workflows, streamlined drug-supply systems, and robust digital health-record infrastructures (Bianchi et al., 2022). The presence of standardized operational procedures reduces ambiguity in care delivery, minimizes avoidable variability, and enhances accountability across care teams. These systems also show that effective operational policies support integrated care pathways, reduce waiting times, strengthen continuity, and enable timely clinical decisions which are elements that strongly predict high performance on global quality-of-care indices.

In low- and middle-income countries (LMICs), operational policies are even more consequential due to the presence of pervasive structural challenges such as resource scarcity, staff shortages, weak supply chains, and infrastructural limitations. Research from India, Kenya, Ghana, Uganda, and South Africa shows that facilities with well-articulated operational policies perform substantially better in areas such as patient flow management, infection reduction, drug availability, treatment adherence, and patient experience compared to similar facilities lacking such policies (Moyimane et al., 2022; Okechukwu & Nyaribo, 2023). The function of operational policies in LMICs is therefore twofold: they compensate for structural weaknesses while providing the procedural discipline necessary to maximize limited resources.

2.2 Theoretical Framework

This study is underpinned by two key theories that explain the link between operational policies and quality of healthcare services: Donabedian's Quality of Care Model and Systems Theory. Among the two, Donabedian's model is adopted as the anchor theory, given its direct emphasis on healthcare quality assessment and its structured explanation of how institutional policies and processes translate into outcomes for patients. Systems Theory is used as a supportive lens because it helps in understanding how the interaction among various operational policies, such as staffing, procurement, infection prevention, and record management, collectively shapes healthcare performance.

2.2.1 Donabedian's Quality of Care Model

Donabedian's model, introduced in 1966, remains one of the most influential frameworks for assessing quality of care in healthcare systems. The model conceptualizes healthcare quality through the triad of structure, process, and outcome. Structure refers to the resources, infrastructure, and institutional arrangements that support care delivery; process describes the actual delivery of healthcare services, including compliance with standards and protocols; and outcome reflects the consequences of care, such as patient satisfaction, recovery, and safety. The assumptions of Donabedian's model are central to its explanatory power. First, the model assumes that the quality of care is measurable and can be evaluated through the systematic observation of structures, processes, and outcomes (Sofaer & Firminger, 2021). Second, it presupposes that strong structures and processes inevitably lead to desirable outcomes, meaning that if Catholic hospitals in Gboko adopt effective operational policies, their patients will experience improved quality of care. Third, the model assumes that quality improvement is continuous, requiring regular evaluation and revision of policies to align with evolving healthcare standards (Akinyemi & Hassan, 2022). Finally, the model assumes that quality is multidimensional, encompassing technical, interpersonal, and systemic aspects of care, which correspond to the measures of quality service used in this study.

In relation to this study, Donabedian's model offers a strong theoretical foundation because it directly connects operational policies with quality outcomes in healthcare. For instance, staffing policies represent the structural dimension, drug supply and infection control policies reflect both structure and process, while health record management strengthens the process dimension. These, when effectively implemented, lead to better outcomes in terms of patient satisfaction, service efficiency, patient safety, and clinical effectiveness. The model thus justifies the central argument of this research that operational policies in Catholic hospitals within Gboko Diocese significantly influence the quality of healthcare services delivered.

2.3 Empirical Review Focused on Operational Policies

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Osei and Boateng (2021) conducted a study in Ghana with the general objective of evaluating how staffing policies, a major component of operational policies, influence healthcare service delivery in mission hospitals. Their specific objectives focused on examining how workload distribution policies affect patient waiting time, how recruitment policies shape staff responsiveness, and how job description clarity impacts service efficiency. The researchers adopted a descriptive cross-sectional survey design involving a population of 512 staff, from which a sample of 346 was selected using stratified random sampling, with the sampling frame drawn from hospital HR lists. A structured questionnaire served as the instrument for data collection, while the data were analyzed using descriptive statistics and multiple regression. The findings revealed that hospital staffing policies significantly improved waiting time management and boosted patient satisfaction, with recruitment transparency particularly strengthening the quality of interactions between patients and staff. A critique of the study is that it relied solely on staff-reported information without validating staffing practices through document review or observational evidence, which could compromise the internal validity of the results.

Adegoke and Salami (2023) examined drug procurement and supply chain policies, which form a critical aspect of hospital operational policies, and their influence on healthcare service delivery in faith-based hospitals in southern Nigeria. The general objective was to determine the effect of drug procurement policies on service delivery, while the specific objectives involved assessing how procurement guidelines influence drug availability, how supplier selection policies affect continuity of treatment, and how stock monitoring policies affect timely service provision. Using a mixed-methods design, the researchers studied a population of 1,042 staff and sampled 402 respondents through multi-stage sampling. The sampling frame comprised departmental staff registers, and data collection was conducted using a structured questionnaire and interview guide. Quantitative data were analyzed using chi-square tests and regression, while qualitative data underwent thematic analysis. The study found that adherence to procurement policies increased drug availability and improved treatment continuity, whereas weak procurement processes caused stock-outs that compromised patient outcomes. The critique of the study is that procurement records were not independently audited, reducing the robustness of policy compliance assessment.

Mwangi, Wanjiru, and Kilonzo (2022) explored the influence of infection prevention and control (IPC) policies, another vital area of operational policies, on healthcare service delivery in Catholic hospitals in Kenya. Their general objective was to evaluate IPC policy compliance and its impact on service delivery. Specifically, they examined how hand hygiene policies affect patient safety, how waste management policies influence service quality, and how environmental sanitation protocols reduce hospital-acquired infections. The study applied a correlational design with a population of 860 nurses and clinicians, from which 289 participants were selected through stratified sampling. The sampling frame was drawn from departmental attendance registers. A structured IPC compliance questionnaire was administered, and Pearson correlation and regression analysis were used for data analysis. The findings indicated that strong IPC policies significantly reduced infection incidences and improved patient outcomes, especially in maternity and surgical wards. However, the critique lies in the fact that the study used a purely quantitative approach that did not incorporate observational audits, which are essential in assessing the realism of IPC compliance.

Nambasa and Okello (2024) carried out a study in Uganda focusing on health record management policies, which constitute a foundational dimension of hospital operational policies, with the general objective of determining how these policies influence continuity of care in mission hospitals. The specific objectives evaluated how documentation standards affect clinical decision-making, how confidentiality policies shape patient trust, and how digital record management improves efficiency of care. A survey research design was used, involving 975 health professionals and a sample size of 312 selected through systematic sampling. The sampling frame consisted of staff rosters from outpatient, inpatient, pharmacy, laboratory, and administration units. Data were collected using a structured questionnaire addressing policy adherence and service delivery outcomes, and analyzed using ANOVA and logistic regression. Findings showed that strong record management policies enhanced communication among healthcare staff, reduced clerical errors, and supported accurate clinical decisions. The critique is that the study did not evaluate the quality of actual records, relying instead on staff perceptions, which may not accurately reflect documentation quality.

Yakubu and Suleiman (2020) investigated the combined effect of major operational policies—staffing, drug procurement, IPC, and record management policies—on healthcare service delivery in northern Nigerian faith-based hospitals. Their general objective was to determine how operational policies jointly predict patient satisfaction, efficiency, safety, and treatment outcomes. The specific objectives examined the influence of each policy type on these service delivery measures. The researchers adopted a cross-sectional explanatory design with a population of 1,670 healthcare workers and a sample of 518 selected through multistage sampling. The sampling frame was obtained from staff lists across 20 hospitals. A structured operational policy adherence questionnaire served as the instrument for data collection, while structural equation modelling (SEM) was used for data analysis. The study found that operational policies collectively accounted for 64% of the variance in healthcare service delivery, with staffing and drug supply policies being the strongest predictors. The critique of this study is that although SEM provides strong statistical modelling, the study did not incorporate patient-level data to validate service delivery outcomes, limiting triangulation.

Martinez and Alvarez (2025) conducted a study in Spain with the general objective of assessing how staffing policies, particularly nurse-to-patient ratio guidelines, influence quality of healthcare services in public hospitals in Madrid. Their specific objectives included determining how workload allocation affects efficiency, how scheduling policies influence patient satisfaction, and how clinical role assignments affect treatment outcomes. Using a descriptive-explanatory survey design, the researchers studied a population of 2,240 healthcare workers, selecting a sample of 612 through stratified random sampling based on ward categories. The sampling frame was drawn from the human resource registry of Madrid's three largest hospitals. Data were collected using a standardized Staffing Policy Effectiveness Questionnaire and analyzed using hierarchical regression. The findings revealed that hospitals with clearly defined staffing policies demonstrated significantly higher patient satisfaction and reduced error rates. The critique, however, is that the study relied primarily on self-report measures from staff, without incorporating objective patient-level quality indicators, which may limit the robustness of the findings.

Haruto and Megumi (2025) conducted a study in Japan examining drug procurement and supply chain policies and their effect on

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service continuity in urban teaching hospitals. The general objective was to evaluate how procurement policy reform improved the availability of essential medicines. Specific objectives examined the influence of supplier vetting criteria on service reliability, the impact of digitalized procurement tracking on drug stock levels, and the role of emergency procurement protocols in minimizing treatment disruption. A longitudinal research design was adopted, involving a population of 1,730 procurement and pharmacy staff, with 487 participants sampled using purposive sampling. The sampling frame consisted of pharmacy and procurement departments in Tokyo's five largest teaching hospitals. Data were collected using policy audit checklists and electronic survey instruments, and analyzed using time-series regression. Findings indicated that digital procurement policies reduced stock-out frequency by 43% and significantly improved continuity of care. The critique is that the study focused only on large hospitals, leaving out rural or smaller facilities where supply chain complexities may differ significantly.

Thompson, Riley and Carter (2025) investigated the role of infection prevention and control (IPC) policies in improving patient safety within regional hospitals across the United States. Their general objective was to determine the extent to which IPC policies reduce hospital-acquired infections (HAIs). Specific objectives assessed the effect of hand hygiene compliance policies, sterilization guidelines, and isolation protocols on patient recovery outcomes. A quasi-experimental design was used, involving a population of 3,600 clinical workers, from which 740 were sampled using cluster sampling. The sampling frame included staff lists from 12 hospitals participating in a national HAI reduction initiative. Data were gathered using an IPC compliance observation tool and self-administered questionnaires, and analyzed using multivariate ANOVA. Findings showed that hospitals with strict IPC policy enforcement recorded a 29% reduction in HAIs over six months. The critique is that the quasi-experimental design did not fully control for external influences such as community infection trends, which may have affected HAI rates.

Singh and Verma (2025) examined health record management policies and their effect on clinical decision-making in tertiary hospitals in New Delhi. The general objective was to determine how digital record management policies enhance quality of care. Their specific objectives focused on analyzing how accuracy of documentation affects diagnostic decisions, how confidentiality policies influence patient trust, and how record retrieval procedures impact service efficiency. They employed a cross-sectional survey design with a population of 1,520 clinicians and record officers, from which 504 were selected using systematic random sampling. The sampling frame consisted of electronic attendance logs from five major teaching hospitals. A Health Information Management Policy Questionnaire was used to collect data, and analysis was performed using logistic regression and correlation analysis. Findings showed that effective record management policies significantly improved diagnostic accuracy and shortened patient waiting times. However, the critique is that digital literacy differences among staff were not controlled for, which might have influenced perceptions of policy effectiveness.

3.0 METHODOLOGY

This study adopted a correlational survey design to examine the relationship between operational policies (staffing, drug procurement and supply, infection prevention and control, and health record management) and the quality of healthcare services (measured by patient satisfaction, efficiency, safety, and effectiveness) in Catholic hospitals within Gboko Diocese. The population comprised 480 staff across St. John's Hospital Gboko, St. Monica's Hospital Adikpo, and St. Thomas Hospital Ihugh, categorized into management, medical, and non-medical staff. A census approach was used due to the manageable population size, ensuring comprehensive coverage. Primary data were collected using structured questionnaires administered to staff in key units such as administration, procurement, finance, stores, quality control, and operations, while secondary data from hospital records complemented the analysis. A total of 412 questionnaires were successfully retrieved and analyzed. The instrument utilized a five-point Likert scale and was validated through expert review, ensuring face and content validity. Construct validity was confirmed using KMO (0.9815) and Bartlett's Test ($\chi^2 = 532.146$, $p < 0.001$), indicating strong inter-item correlations and suitability for multivariate analysis. Reliability testing using Cronbach's Alpha showed high internal consistency across all constructs, ranging from 0.894 to 0.951, confirming the instrument's stability and coherence.

Data collection followed ethical procedures, including institutional approval, informed consent, and confidentiality. The study specified a functional model: QHS = f(SP, DPS, IPCP, HRMP), where healthcare service quality depends on the four operational policy dimensions. Data were analyzed using descriptive statistics (frequencies, means, and standard deviations) and regression analysis to determine the strength and direction of relationships between variables. Regression was appropriate for estimating the effect of operational policies on healthcare quality and aligning with the correlational design. The decision rule was based on a 95% confidence level: hypotheses were rejected where t-values exceeded 1.96 and p-values were less than 0.05, indicating statistical significance.

4.0 ANALYSIS AND DISCUSSION OF FINDINGS

4.1 Regression Analysis

Multiple regression analysis was adopted to achieve the study objective of examining the effect of operational policies on quality of healthcare services in healthcare institutions in Catholic Diocese of Gboko, Benue State as presented under model summary, analysis of variance and regression coefficients.

Table 4.1: Model Summary

Model	R	R Square	R square adjusted	Std. error of the estimate	Durbin Watson
1	0.837[a]	0.701	0.684	0.452	1.980

a. Predictors: (Constant), Health record management policy, Infection prevention and control policy, Drug procurement and supply policy staffing policy

b. Dependent Variable: Quality of healthcare services

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Source: Author's Computations using SPSS 2026.

The regression model in Table 4,1 produced an R value of 0.837, indicating a very strong positive relationship between the combined operational policies (staffing policy, drug procurement and supply policy, infection prevention and control policy, and health record management policy) and the quality of healthcare services. The R Square value of 0.701 shows that 70.1% of the variations in the quality of healthcare services are explained by the four operational policies included in the model. The adjusted R Square of 0.684 further confirms the robustness of the model, showing that even after adjusting for sample size and predictors, the explanatory power remains very high at 68.4%. The standard error of estimate (0.452) indicates that the prediction errors around the regression line are small, suggesting good model accuracy. The Durbin–Watson value of 1.980 falls within the acceptable range of 1.5–2.5, indicating no autocorrelation problem, and confirming that the residuals are independent. This means the model is statistically valid and suitable for interpreting the effect of operational policies on healthcare quality.

Table 4.2: Analysis of Variance

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	68.451	4	17.113	83.945	0.000[b]
	Residual	29.124	407	0.448		
	Total	97.575	411			
a. Predictors: (Constant), Health record management policy, Infection prevention and control policy, Drug procurement and supply policy staffing policy						
b. Dependent Variable: Quality of healthcare services						

Source: Author's Computations using SPSS 2026.

The ANOVA output in Table 4.2 shows a regression sum of squares of 68.451 and a residual sum of squares of 29.124, with a total of 97.575. The resulting F-value of 83.945 is very high, and the significance value (p = 0.000) is well below the 0.05 threshold. This result means that the model is statistically significant. In other words, the set of operational policies used in the model jointly have a significant effect on the quality of healthcare services. There is less than a 1% probability that this relationship occurred by chance. Therefore, the ANOVA confirms that the regression equation is meaningful and reliable for explaining variations in healthcare quality in the Catholic Diocese of Gboko.

Table 4.3: Regression Coefficients

Model		Unstandardized coefficients (B)	Standardized coefficients (Beta)	t	P-Value
1	(Constant)	0.521		3.520	0.000
	Staffing policy	0.689	0.580	11.110	0.000
	Drug procurement and supply	0.642	0.550	9.580	0.000
	Infection prevention and control	0.583	0.520	8.210	0.000
	Health record management policies	0.498	0.445	7.320	0.000

a. Dependent Variable: Quality of healthcare services

Source: SPSS Output of Field Survey, 2025.

The regression coefficients in Table 4.3 provide detailed insights into how each operational policy contributes to predicting the quality of healthcare services. These indicators—B (unstandardized coefficient), Beta (standardized coefficient), t-value, and p-value—collectively show the strength, direction, and statistical significance of the relationship between each independent variable and the dependent variable.

The staffing policy variable shows an unstandardized coefficient (B) of 0.689, which indicates that for every one-unit improvement in staffing policy practices, the quality of healthcare services increases by 0.689 units. This is a strong and positive effect, meaning improvements in staffing levels, scheduling, role clarity, and staff development directly enhance service delivery. The standardized coefficient (Beta) is 0.580, showing that staffing policy is the strongest predictor among all the variables. The Beta expresses the effect in standard deviation units, meaning that a one standard deviation increase in staffing policy leads to a 0.580 standard deviation improvement in the quality of healthcare services. This confirms that staffing is the most influential operational factor. The t-value (11.110) is very high, indicating a strong statistical contribution of staffing policy to the model. Higher t-values mean the predictor is making a meaningful individual contribution. The p-value (0.000) shows the effect is statistically significant at the 0.05 level and even at more stringent thresholds. This means the likelihood that this effect occurred by chance is almost zero. Staffing policy significantly predicts the quality of healthcare services.

Drug procurement and supply policy has an unstandardized coefficient (B) of 0.642, meaning that a one-unit improvement in procurement systems increases healthcare quality by 0.642 units. This positive and sizable coefficient shows that efficient drug procurement processes have a major impact on hospital performance. The standardized Beta of 0.550 indicates that drug procurement is the second strongest predictor of healthcare service quality. A one standard deviation change in procurement processes produces a 0.550 standard deviation improvement in service quality. The t-value (9.580) shows strong individual significance. Any t-value above 2 is generally considered meaningful, so 9.580 confirms that drug procurement contributes powerfully to the model. The p-

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value (0.000) indicates that the effect is statistically significant. There is virtually no chance that this relationship is random. Therefore, drug procurement and supply policy significantly predicts the quality of healthcare services.

Infection prevention and control show an unstandardized coefficient (B) of 0.583, meaning that improving infection control practices by one unit increases service quality by 0.583 units. This result highlights the substantial impact of infection prevention on patient outcomes and safety. The standardized Beta of 0.520 reveals that infection control is the third strongest predictor. Although slightly lower than staffing and procurement, it still shows a powerful influence. A one standard deviation improvement in infection control boosts healthcare quality by 0.520 standard deviations. The t-value (8.210) again confirms the variable's strong contribution. This high value shows that the effect is not only meaningful but also very stable. The p-value (0.000) shows the effect is statistically significant. Thus, infection prevention and control policy significantly predicts the quality of healthcare services.

Health record management policy has an unstandardized coefficient (B) of 0.498, which indicates that a one-unit improvement in record-keeping increases the quality of healthcare services by 0.498 units. While slightly lower than the other variables, it still represents a strong positive effect. The standardized Beta of 0.445 shows that health record management is the least strong predictor among the four variables. Even so, a 0.445 standard deviation increase in healthcare quality for every one standard deviation improvement in record systems remains a significant contribution. The t-value (7.300)—though lower than the other variables—is still far above the threshold indicating significance. This confirms that health record management has a meaningful and statistically stable effect on healthcare quality. The p-value (0.000) demonstrates that the effect is statistically significant. Thus, health record management policy significantly predicts the quality of healthcare services.

4.2 Test of Hypotheses

This section presents the test of the four hypotheses formulated for the study using multiple regression results earlier reported. The decision rule guiding the test is that a hypothesis will be rejected where the p-value is less than 0.05 and the t-value is significant; otherwise, it will be retained. The analysis relies on the regression coefficients obtained from the field data to determine whether each operational policy significantly affects the quality of healthcare services.

Ho_1: Staffing policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko

This hypothesis assumes that staffing policies such as adequacy of staff, scheduling, professional development, and role clarity do not significantly influence the quality of healthcare services provided in the hospitals. However, the regression result clearly contradicts this position, as staffing policy recorded a very high t-value of 11.110 and a p-value of 0.000. Because the p-value is far below the 0.05 threshold, the result shows strong statistical significance. Based on the decision rule, the null hypothesis is rejected. The conclusion drawn is that staffing policies significantly and positively affect the quality of healthcare services in Catholic Diocese of Gboko, meaning improvements in staffing structure directly enhance service delivery.

The implication of this finding is that staffing practices are fundamental determinants of service responsiveness, error reduction, and patient satisfaction across mission hospitals in the diocese. Strong staffing policies enhance service efficiency, reduce waiting times, and ensure that patients encounter competent and well-positioned health personnel. The result aligns fully with Donabedian's model, which emphasizes structure as the basis for improved process and outcomes. Staffing represents a structural element that shapes how care is delivered. Systems Theory also supports this finding by suggesting that the human resource subsystem directly affects the functioning of all other subsystems in a hospital.

Empirically, this finding is consistent with the work of Osei and Boateng (2021), who found that staffing policies significantly improved waiting time management and patient satisfaction. The current study also corroborates Martinez and Alvarez (2025), who showed that defined staffing policies lead to higher patient satisfaction and reduced error rates in Madrid hospitals. Additionally, the finding aligns with Yakubu and Suleiman (2020), who reported staffing as one of the strongest predictors of healthcare performance in faith-based hospitals in northern Nigeria. This convergence reinforces the claim that staffing policies are central to healthcare quality improvement.

Ho_2: Drug procurement and distribution policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko.

This hypothesis suggests that drug procurement and distribution processes do not meaningfully influence healthcare service quality. The regression results, however, reveal a t-value of 9.580 and a corresponding p-value of 0.000, demonstrating very strong significance. Since the p-value falls well below 0.05, the position of the hypothesis is empirically unsupported. Based on the decision rule, the null hypothesis is rejected. The study therefore concludes that drug procurement and distribution policies significantly influence the quality of healthcare services, implying that effective procurement procedures, supplier management, and inventory control are essential for ensuring safe, timely, and reliable service delivery.

The implication is that strong procurement policies ensure drug availability, continuity of treatment, and reduction of stock-outs which are factors that directly influence patient outcomes, confidence in care, and service reliability. When drugs are consistently available, treatment plans proceed without interruption, and clinicians are able to deliver timely and adequate care. This result fits well within Donabedian's framework, which positions resource availability as a key structural determinant of care quality. Systems Theory further explains that procurement functions interact with clinical and administrative units, meaning that weaknesses in procurement can disrupt the entire care delivery system.

The finding aligns with several empirical studies. Adegoke and Salami (2023) found that adherence to procurement policies significantly improved drug availability and treatment continuity in southern Nigerian mission hospitals, a pattern echoed in this study. The result also aligns with Haruto and Megumi (2025), who reported that digital procurement systems in Japan reduced stock-out frequencies and improved continuity of care. It further aligns with Yakubu and Suleiman (2020), who ranked procurement policies among the strongest predictors of healthcare performance. These consistencies reinforce the conclusion that procurement policies matter profoundly for quality healthcare delivery.

Ho_3: Infection prevention and waste management policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko.

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This hypothesis presumes that infection control procedures and waste management practices do not significantly determine the quality of healthcare services. The regression output contradicts this assumption, revealing a t-value of 8.210 alongside a p-value of 0.000, indicating a statistically significant effect. Since the p-value is below the accepted 0.05 threshold, the null hypothesis is rejected in line with the decision rule. The conclusion drawn is that infection prevention and waste management policies significantly improve the quality of healthcare services by reducing risk exposure, enhancing patient safety, and ensuring adherence to professional health standards.

The implication of this finding is that IPC policies serve as protective mechanisms that enhance clinical outcomes and reduce healthcare-associated infections. Hospitals with strong IPC compliance tend to deliver safer, more reliable, and more hygienic services, reducing complications and improving patient satisfaction. Donabedian's model explains this outcome through its emphasis on process quality; how care is delivered. IPC policies directly shape clinical processes that determine patient outcomes. Systems Theory also supports this finding because IPC functions interface with all clinical departments, influencing safety across the hospital ecosystem.

Empirically, this finding is consistent with Mwangi et al. (2022), who reported that strong IPC policies significantly reduced infection incidences in Catholic hospitals in Kenya. It also aligns with Thompson, Riley, and Carter (2025), who recorded a 29% reduction in hospital-acquired infections due to strict IPC policy enforcement. Additionally, it corresponds with Yakubu and Suleiman (2020), who identified IPC policies as significant predictors of patient safety and treatment outcomes. These alignments strengthen the conclusion that IPC policies are critical to improving quality of healthcare services.

Ho_4: Patient record management policies have no significant effect on the quality of healthcare services in Catholic Diocese of Gboko

This hypothesis assumes that patient record management including documentation systems, confidentiality, controlled access, and record retrieval does not significantly contribute to healthcare service quality. The statistical evidence refutes this assumption, as the variable produced a t-value of 7.320 with a p-value of 0.000. Given that the p-value is well below the 0.05 threshold, the null hypothesis cannot be sustained. In accordance with the decision rule, the hypothesis is rejected. The study therefore concludes that patient record management policies significantly enhance the quality of healthcare services by supporting efficient clinical decisions, safeguarding patient information, and facilitating continuity of care.

The implication of this finding is that hospitals with stronger record management policies are better positioned to ensure accurate clinical decision-making, maintain comprehensive patient histories, enhance coordination among healthcare workers, and build patient trust through confidentiality assurance. These elements collectively strengthen the quality of care delivered by the hospitals. This finding aligns with Donabedian's model, as proper documentation is an essential process component that shapes outcomes. Systems Theory also supports the finding, showing that information flow is a backbone of all hospital subsystems, meaning that disruptions in record management affect the entire healthcare delivery chain.

Empirical evidence supports this result. Nambasa and Okello (2024) found that strong record management policies improved communication, reduced clerical errors, and supported accurate clinical decisions in Ugandan mission hospitals. This finding is also consistent with Singh and Verma (2025), who showed that digital record policies improved diagnostic accuracy and reduced patient waiting times. Furthermore, Yakubu and Suleiman (2020) demonstrated that record management policies significantly predict service delivery outcomes. The convergence of evidence reinforces the importance of record management policies for quality healthcare provision.

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

This study examined the effect of operational policies on the quality of healthcare services in Catholic Diocese of Gboko. The major findings of the study revealed that staffing policy, drug procurement and distribution policy, infection prevention and control policy and patient record management policy all have positive significant effect on quality of healthcare service delivery in Catholic Diocese of Gboko. Based on the findings, the study concludes that operational policies constitute a critical foundation for delivering high-quality healthcare services in Catholic Diocese of Gboko. The results demonstrated that staffing policies, particularly those relating to personnel adequacy, role clarity, and workload distribution, serve as essential structural elements that shape the efficiency and responsiveness of healthcare delivery. Drug procurement and distribution policies were also shown to be vital, as hospitals with transparent procurement procedures and efficient supply chains experience fewer drug stock-outs and provide more reliable treatment services. The findings further affirm that infection prevention and control policies are indispensable to patient safety. Adherence to IPC protocols, including hand hygiene, sterilization, and waste management, contributes significantly to reducing infection risks and enhancing clinical outcomes. Additionally, patient record management policies remain a cornerstone of quality healthcare, given their influence on clinical accuracy, continuity of care, data security, and overall coordination within the health system.

5.2 Recommendations

Based on the major findings, the following recommendations are made:

i. The Catholic Diocese of Gboko should prioritize regular staff audits, ensure adequate staffing levels, and implement clear and fair workload distribution policies to maintain high-quality healthcare delivery.
ii. The diocese should adopt transparent procurement procedures, digitalize supply monitoring systems, and engage credible suppliers to guarantee consistent availability of essential medicines.
iii. Hospital administrators should strengthen IPC policy compliance through continuous staff training, provision of IPC materials, regular audits, and strict enforcement of hygiene protocols.
iv. Hospitals should upgrade digital record systems, enhance staff capacity in data management, and enforce strict confidentiality policies to promote accuracy, continuity of care, and patient trust.

5.3 Contribution to Knowledge

The study reinforces Donabedian's Quality of Care Model by empirically demonstrating that structural elements such as staffing, procurement, IPC, and record management policies directly influence healthcare outcomes. It also strengthens Systems Theory by showing how different operational subsystems collectively shape

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overall healthcare quality in mission hospitals. Practically, the study provides evidence-based guidance to healthcare administrators, policymakers, and mission-owned hospitals on which operational policies most strongly influence service quality. The findings equip managers with actionable insights for improving staffing arrangements, procurement processes, IPC compliance, and record management systems to enhance patient outcomes.

5.4 Suggested Areas for Further Studies

Future studies should explore the longitudinal effects of operational policies to determine how variations over time influence healthcare quality. Researchers should also replicate this study in other dioceses, public hospitals, and private facilities to enhance generalizability. Additionally, further studies should incorporate observational audits of staffing practices, procurement systems, IPC compliance, and record quality to complement self-reported data and deepen understanding of operational policy effectiveness.

REFERENCES

1. Abdulkadir, S. (2024). Strengthening operational frameworks in sub-Saharan healthcare facilities: Policy implications and practice gaps. *International Journal of Health Policy and Management*, 13(2), 115–126.
2. Adebisi, Y. A., Lucero-Prisno, D. E., Ekpenyong, A., Micheal, A. I., & Ilesanmi, E. B. (2023). Workforce distribution and equity in healthcare access in sub-Saharan Africa: Policy challenges and opportunities. *BMC Health Services Research*, 23(1), 1125.
3. Adegoke, F., & Salami, T. (2023). Drug procurement policies and healthcare service delivery in faith-based hospitals in southern Nigeria. *Nigerian Journal of Health Systems Research*, 11(1), 28–42.
4. Adeniran, F. O., & Omole, A. V. (2024). Governance and sustainability in pharmaceutical supply chains: Policy imperatives for African health systems. *Health Policy and Planning*, 39(1), 77–89.
5. Agyapong, R., Mensah, E., & Boateng, K. (2023). Operational systems and quality outcomes in sub-Saharan African hospitals: A systematic review. *BMC Health Services Research*, 23(1), 112–129.
6. Akinwale, O., Johnson, E., & Nnadi, C. (2023). Challenges of operational policy implementation in Nigerian healthcare facilities. *Journal of Nigerian Health Systems*, 15(2), 45–62.
7. Akinyemi, O. O., & Hassan, T. A. (2022). Quality of care in Nigerian hospitals: Policy implications of Donabedian's model. *International Journal of Health Policy and Management*, 11(12), 2381–2390.
8. Alhassan, R., Asante, F., & Aikins, M. (2022). Dimensions of healthcare service quality: patient satisfaction, safety, efficiency, and clinical effectiveness. *African Journal of Health Economics*, 8(1), 10–28.
9. Alvarez, R. (2023). Health information systems and clinical decision support: impacts on quality of care in low-resource hospitals. *International Journal of Medical Informatics*, 16, 104624.
10. Bianchi, A., Palazzesi, S., & Serra, F. (2022). Organizational policies and patient outcomes in European health systems: Evidence from cross-country administrative datasets. *International Journal of Health Policy and Management*, 11(9), 1840–1852.
11. Chukwurah, C., & Adetunji, F. (2024). Effectiveness of hospital services and patient recovery rates in Nigerian tertiary institutions. *African Journal of Health Economics*, 9(1), 55–68.
12. CUAMM. (2024). *Faith-based hospitals and operational realities in Africa: Annual report 2024*. Doctors with Africa CUAMM.
13. Dahlgren, G., Carlson, L., & Svensson, P. (2022). Strengthening health systems post-COVID-19: the role of operational policy reform. *Global Health Policy Journal*, 5(3), 120–137.
14. Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly*, 4(3), 166–206.
15. Erasmus, I., & Ekpo, U. (2022). Operational policy deficits and healthcare quality in Nigeria. *International Journal of Health Policy and Management*, 11(1), 30–39.
16. Ezenwaka, U., Ezumah, N., Obi, F., & Nwankwo, O. (2024). Human resources for health in faith-based hospitals: Challenges and innovations in Nigeria. *Journal of Global Health Reports*, 8, e2024021.
17. Haruto, S., & Megumi, Y. (2025). Drug procurement policy reform and continuity of care in Japanese teaching hospitals. *Asian Journal of Health Supply Systems*, 12(2), 88–103.
18. Ityav, D., & Gberikon, M. (2023). Barriers to infection control practices in Nigerian mission hospitals: Implications for patient safety. *Nigerian Journal of Clinical Practice*, 26(8), 1125–1134.
19. Maddox, R. (2024). Operational policies and healthcare governance: Linking procedures to patient outcomes. *Health Services Research*, 9(3), 321–334.
20. Martinez, L., & Alvarez, P. (2025). Staffing policies and quality of care in public hospitals in Madrid. *European Journal of Health Administration*, 18(1), 41–59.
21. Martins, A. (2022). Standards for clinical documentation: improving safety and continuity in hospital care. *Journal of Clinical Documentation*, 9(4), 301–318.
22. Mensah, P., Adjei, K., & Boateng, R. (2023). Infection prevention policies and patient outcomes in sub-Saharan African hospitals: Lessons from Ghana. *BMC Health Services Research*, 23(1), 1142.
23. Moyimane, M. B., Matlala, S. F., & Kekana, M. P. (2022). Experiences of nurses regarding the implementation of operational policies in district hospitals in South Africa. *Curationis*, 45(1), 1–10.
24. Mwangi, J., & Gachanja, P. (2023). Linking staff welfare and organizational performance in healthcare institutions. *International Journal of Health Policy and Management*, 12(1), 91–101.
25. Mwangi, J., Odhiambo, H., & Waweru, E. (2023). Infection prevention and staffing policy interventions in East African hospitals: outcomes and lessons. *East African Journal of Public Health*, 20(2), 75–92.
26. Mwangi, J., Odhiambo, H., &Waweru, E. (2023). Infection prevention and staffing policy interventions in East African hospitals: outcomes and lessons. *East African Journal of Public Health*, 20(2), 75–92.
27. Mwangi, P. M., Otieno, J., & Kamau, S. (2023). Aligning drug procurement policies with public health priorities: Evidence from Kenyan hospitals. *International Journal of Health Policy and Management*, 12(2), 150–161.
28. Nair, P., & Sreeram, V. (2023). Operational frameworks and quality improvement in hospitals: insights from Asia and beyond. *Asian Health Review*, 12(3), 105–118.

DOI: 10.5281/zenodo.20392256

29. Nambasa, R., & Okello, D. (2024). Health record management policies and continuity of care in mission hospitals in Uganda. *African Journal of Medical Informatics*, 5(1), 19–33.
30. Ngugi, A., Mwangi, M., & Kamau, S. (2022). Hygiene frameworks and infection control: Policy lessons from Kenyan referral hospitals. *Journal of Hospital Administration*, 11(3), 45–55.
31. Njeru, S., Waithera, S., & Kimani, P. (2023). Measuring patient satisfaction in Kenyan mission hospitals: A multidimensional approach. *BMC Health Services Research*, 23(1), 842.
32. Okechukwu, E., & Nyaribo, Y. (2023). Operational determinants of healthcare quality in Kenyan and Ugandan mission hospitals. *African Journal of Health Economics*, 12(2), 77–94.
33. Okeke, T., & Bello, R. (2023). Patient safety policies and their impact on healthcare quality in Nigerian teaching hospitals. *International Journal for Quality in Health Care*, 3(4), mzad023.
34. Okoro, D., & Ibrahim, S. (2021). Conceptualizing operational policies in health facilities: a managerial perspective. *Nigerian Journal of Health Administration*, 4(2), 50–64.
35. Okoroafor, S. C., Abimbola, S., & Ngobua, S. (2022). Human resource policies and the dynamics of staffing in Nigerian hospitals. *BMJ Global Health*, 7(5), e008921.
36. Oleribe, O., Momoh, J., & Robinson, C. (2022). Strengthening operational systems in African healthcare: Lessons from health-systems engineering. *Global Health Research and Policy*, 7(1), 23–38.
37. Onyango, E. O., Were, M., & Obuya, T. (2022). Cost-effectiveness and efficiency in hospital drug procurement: Insights from sub-Saharan Africa. *BMJ Global Health*, 7(12), e010221.
38. Osei, K., & Boateng, R. (2021). Staffing policies and healthcare service delivery in mission hospitals in Ghana. *Journal of Health Policy and Management*, 6(2), 44–57.
39. Osei-Tutu, E., Boateng, R., & Agyeman, Y. (2024). Assessing clinical effectiveness through health outcomes in Ghanaian hospitals. *Ghana Medical Journal*, 15(1), 15–26.
40. Patel, R., & Singh, V. (2024). Integrating health information systems into hospital workflows: a systems perspective. *Journal of Hospital Management*, 15(1), 39–58.
41. Rodriguez, M. (2022). Patient access to records and shared decision-making: ethical and operational implications. *Journal of Patient Experience*, 9, 23743735221082431.
42. Singh, R., & Verma, P. (2025). Health record management policies and clinical decision-making in tertiary hospitals in New Delhi. *Indian Journal of Health Informatics*, 14(1), 23–38.
43. Sofaer, S., & Firminger, K. (2021). Patient perceptions and Donabedian's model: A systematic review of recent evidence. *Quality in Health Care*, 3(4), 289–298.
44. Tadesse, F., & Bekele, A. (2023). Infection prevention and control policies in compliance with WHO standards: An Ethiopian case study. *American Journal of Infection Control*, 5(6), 678–686.
45. Thompson, J., Riley, K., & Carter, M. (2025). Infection control policy implementation and patient safety outcomes in U.S. regional hospitals. *Journal of American Health Quality*, 32(1), 77–92.
46. Uzochukwu, B., Nnebue, C., Onwujekwe, O., & Onyebuchi, J. (2022). Operational challenges in Catholic healthcare institutions in southeast Nigeria. *Journal of Faith-Based Health Services*, 6(1), 23–38.
47. World Health Organization. (2021). *Quality of care and COVID-19: making a difference*. Geneva: WHO Press.
48. World Health Organization. (2022). *Infection prevention and control policies and standards for healthcare facilities*. Geneva: WHO Press.
49. Yadav, P., Shah, N., & Hassan, M. (2022). Strengthening procurement systems for essential medicines: A global policy perspective. *The Lancet Global Health*, 10(7), e985–e993
50. Yakubu, H., & Suleiman, M. (2020). Operational policies and healthcare service delivery in faith-based hospitals in northern Nigeria. *Journal of African Health Management*, 7(4), 73–88.

DOI: 10.5281/zenodo.20392256