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PATIENT CARE AND MAINTENANCE OF RECORDS IN A HOSPITAL

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Health Care

Health Care has been advancing rapidly the world over. In India, private charitable hospitals have contributed enormously to the primary, secondary and tertiary care of the common man, who cannot afford costly medicare. India being a highly populated country the Government alone cannot cater to the medical needs of the masses. Hospital have launched a series of schemes to promote health awareness in the country by conducting a number of free medical camps and highlighting the importance of taking preventive care against various diseases. Although rise in disposable income and better availability of health insurance have made health services more accessible the industry still faces a number of challenges. One of the major stumbling blocks is the acute shortage of trained personnel ranging from doctors, nurses, technicians to healthcare administrators. A hospital administrator is usually an individual responsible for the day to day operational running of the health care institution. In addition, the administrator participates in and coordinates the setting of strategic priorities for the direction of the hospital. Specific duties include recruitment and retention of physicians, overseeing quality, improvement of processes for efficient delivery of patient care, setting standards, oversight of budgets, creating financial and business strategies to assure fiscal viability and health. The hospital administrators also become involved in press relations, public and community affairs, grants management, billing, collections, purchasing of equipment and meeting regulatory standards.

Hospitals have been changing in shape, size and functions to adopt themselves to the advancements in the medical field and socio-economic changes around them.

New realities are placing pressures on the healthcare industry, and how patient care is delivered. Rising hospital management costs, an aging population, a shortage of healthcare workers, challenges in accessing services, timely availability of information, issues of safety and quality, and rising consumerism are some of the facts of today's healthcare system. The industry has reached a point of chasm, where they need to decide how services could be delivered more effectively to reduce costs, improve quality, and extend reach.

Patient care is an area, which needs utmost attention in the healthcare arena. Laboratory services are an essential component of healthcare services. They constitute the support system of healthcare and there is no specialty in healthcare that does not require laboratory investigations, no matter how basic they are. As a result, laboratory investigations play a vital role in the treatment of disease conditions.

The continuing surge in noscocomial infections in hospitals today, have brought out the underlying importance of the role played by Central Sterile Services Department (CSSD)

in combating Hospital Acquired Infections (HAI). Many hospitals in the country have a CSSD; others are soon to follow the trend.

Today, the upcoming advanced sterilizers are all computer controlled with a backup that leaves no margin for error. Theoretically, one can achieve 100 per cent sterility, but practically achievement of true sterility is a factor that follows the law of chance. Hence achieving 99.99 per cent log kill of bacterial spores is considered good enough to pronounce the material as sterile.

Hospitals today, apart from being centers for medical treatment, are also driven by forces of increasing competition, and the need to channelise their specializations and administrative data. However, with foreign patients streaming into the city, the primary focus is mainly on quality healthcare and streamlined patient-sensitive services. To bring about quality healthcare and prompt service under one umbrella, hospitals have now initiated HIS which today has become the backbone of almost all the private hospitals in the city.

With the advancements of technology over the past years, physicians, especially those who practice in intensive care setting, are faced with patients who are not going to recover, however they are not going to die. This is due to modern treatments and technology.

Recent advances in fully digital imaging technology have dramatically affected the planning and design of diagnostic and interventional radiology facilities. Requirements for image display and multidisciplinary consultation have created new criteria for lighting, acoustics, workstation ergonomics and telecommunications. Moreover, as imaging has developed as a critical element of patient diagnosis and treatment, state-of-the-art imaging departments have become a competitive advantage in attracting patients, as well as recruiting and retaining qualified staff. Indeed, in many ways, imaging has become the heart of today's hospital.

Planning and design of interventional imaging facilities also pose unique challenges. In particular, the convergence of interventional imaging and surgery is having major effects on facility design.

A look at the evolution of imaging from the traditional imaging department to today's fully digital department reveals major changes in key characteristics of these facilities. The traditional film-based department (circa 1990) contained a dark room, large file room, large central technical work area, and a minimal preparation and recovery area. The hybrid digital and film-based department (circa 1993) eliminated the dark room, stored files in a remote archive, had a large central work core for daylight or digital image reading, and enlarged the preparation and recovery area

In fact, today's picture archiving communication systems, or PACS, require a telecommunications infrastructure capable of rapid transmission of large data files to

workstations throughout the hospital, physicians' offices in the community and even consulting radiologists halfway around the world.

In addition to technology, planning and design of imaging facilities must take into account staffing and patient care. Shortages of qualified physicians, nurses and technologists have heightened the need for health care facilities that aid in recruitment and retention, as well as enhancing productivity.

Both outpatient and inpatient acuity levels are expected to be higher today than in the past, and there is a growing need for sophisticated diagnostic and treatment services. At the same time, patients are becoming savvy health care consumers who demand state-of-the-art care, good communication and a comfortable environment. Facilities are being designed to enhance patient care and comfort at the same time they reduce facility operational costs and improve staff productivity.

Facilities must also be planned and designed for maximum flexibility. That is, they must be able to accommodate future changes in patient care models and imaging equipment, both economically and without significant disruption of operations.

Patient Care

Medical Records Department (MRD)

Medical record can be defined as an orderly written document encompassing the patient's identification data, health history, physical examinations findings, laboratory reports, diagnosis, treatment and surgical procedures and hospital course. When complete, the record should contain sufficient data to justify the investigations, diagnosis, treatment, length of hospitality, results of care and future courses of action.

Medical record is an important "patient forgets but records remember" the record is valuable to many individuals and groups: patients, physicians, healthcare institutions, research teams, teachers and students, national health agencies and international health organizations.

Objectives

- To meet all patient needs such as in helping them for insurance claims, union benefits, etc
- To meet all physician needs such as
  - Practice of scientific medicine based on recorded facts
  - Continuity of medical care
  - Retrieval for study and research
- To meet the institution needs such as generating hospital statistics, admission control, improving quality of care and safeguard in tort suits

Functions

The functions carried out in the MRD is listed below

- Receive the patients and entry is made for the new patients

- Maintains separate IP and OP records
- The process of assembling, checking, coding and indexing is done in the record office.
- Provides prompt record service at all hours of any in formation
- Properly organizes the records of each patient and file it.
- Ensures easy retrieval of the record or ready availability of other data pertaining to the patients.
- Keeping track when the record is withdrawn from the cabin or shelf
- The Medico Legal Case sheets are maintained separately.

Scope

- Proper maintenance of medical records.
- Maintenance of integrity and confidentiality of the medical records.
- Submission of requires data to the government authorities.

Process summary

S.No.	Process	Details
1	Maintenance of medical records	▪ Systematic maintenance of records ▪ Check deficiencies in the records and ensure proper assembling and filling according to IP.No. ▪ Coding as per I.C.D norms and entry in the system.
2	Birth and death certificates	Sending birth and death reports to the concerned corporation ward office.
3	Medico Legal cases	Maintaining hospital copy for all MLC intimations.
4	Retention of records	Retention of records as per hospital policy
5	Statistics	▪ Compiling daily hospital census and reporting to the authorized personnel. ▪ Updating statistics of al OP and IP census to monthly statistics.
6	Discharge summary	All discharged case sheet received from discharge summary department Discharge summary copy provided as requested by patients and doctors.
7	Others	Issue medical records to authorized personnel for audits/ research purpose. Issue certificate to patients/authorities as required.

Supplementary Chart

Assembling of Medical Records:

Assembling of Inpatient case sheets in the following order.

- Deficiency check list
- Discharge summary
- First information sheet
- Temperature chart

- Drug sheet
- Clinical notes (History and clinical examinations)
- Progress sheet
- Order sheet
- Consultant sheet
- Consent forms
- Pre-operative check list
- Anesthesia record
- Operation record
- Nurse's record
- Intake and out-patient chart
- Investigation reports. (X-ray, C.T scan and Lab reports)
- Physiotherapy record
- Referring letter
- ICU charts/ records
- Patient condition explanation chart
- Deficiency check list is kept each case sheet
- Keep incomplete records separately (according to treat consultants)
- Physiotherapy record
- Referring letter
- ICU charts records / records
- Patient condition explanation chart
- Deficiency check list is kept in each case sheet

Keep incomplete records separately (according to treating consultant) pending follow up and completion.

ICD Classification

All the in-patient case sheets (final diagnosis) are coded according to the International Classification of Diseases using 10th edition published by WORLD HEALTH ORGANIZATION, Geneva.

Verify the records to ensure that the codes have been entered.

Departmental Policies

Policy: - storage of In-patient records:

- All in-patient records shall be maintained and stored by the MRD
- Annual numbering system will be maintained in the In-patient sheet
- Based on the IP number records will be stored in the Medical records room
- Only authorized persons can be view and retrieve the medical record
- Policy: Retention period of In-patient records

- Medico Legal case sheets. (Including expired case sheets) retained for 15 years.
- Expired cases sheets retained for seven years
- Ordinary case sheets retained for seven years
- Policy: destructions of In-patient records.
- Destructions of medical records will be carried out in accordance with the retention policy of the hospital
- The hospital chairman will authorize the destruction of medical records
- Policy: Audits for medical records:
- Audits of medical records of discharged in-patients will be carried out by the MRD staff within 2 days of receipt
- A quarterly audit of medical records will be carried out by a multidisciplinary team constituted for this purpose by the chairman.
- Results of the audit will be shared with the medical and nursing staff with a view to improve quality of the records.

Statistics

The following statistical data will be maintained by the MRD:

- Daily and monthly OP and IP statistics
- Month wise surgery statistics
- Average length of stay
- Consultant wise OP statistics
- Birth and death statistics
- Delivery statistics
- Dialysis statistics
- Scopy statistics
- MLC statistics

MRD will be preparing the statistics as per the management requirements.

Quality Plan

- To fill deficiency check list of discharged in-patients records within 2 days of receipt
- To rectify all deficiencies within a week of receipt of case sheet
- Coding of medical records as per international classification of disease within 10 days of receipt
- To send the birth and death reports to the corporation authorities within 7 days
- To send the infectious diseases weekly report to the corporation authority and the health department

Documents

Forms

- FORM-1 Live birth report
- FORM-2 Death report
- FORM- 3Still birth report
- FORM-4 Medical certificate of cause of death
- FORM-4A Medical certificate of cause of death

Registers

- Accident register and police intimation for medico legal cases
- Court register
- IP register.
- Loan register
- ICD-books Volume 1,2 and 3
- Post dispatch register.
- Case sheet receiving register
- Corporation delivery registers. (birth and death reports)

Files

- Summons file
- Government letter file
- Circular file
- Correspondence file
- Disability certificate file
- Wound certificate file
- Infectious diseases reports file
- Indent file
- Other certificates file

Medical Records Officer

- To prepare the infectious Diseases and notifiable diseases reports weekly and monthly.
- To prepare the statistical data's- like MLC< IP< OP< Surgery, Scopy, Dialysis and etc.
- To coordinate with health officer (DDHS) and Corporation ward officer (Birth and Death Register).
- To submit the Birth / Death and infectious diseases reports to the corporation ward office weekly once.
- To put Wound Certificate entry in the computer, modification and checking.
- Giving wound Certificate appointment to the Police and patient attainders.
- To visit the saravanampatty and trace out the old case sheet (when ever required)

- To prepare the world certificate pending list.
- To attend the patient and patient and attainders- Regarding their requirements from the department.
- To attend the management meeting.
- To get the infectious diseases report (positive cases) from the laboratory and wards. (like Dengue, Typhoid, Malaria and etc)
- To coordinate with medical officer regarding- departmental Improvements and work related problems.
- To check the MLC patients cases sheets and hand over the X-Ray, C.T.Scan films and reports, to the patient attainders, through the nursing staff.
- To prepare the court letter and received summons in the absence of medical records officer.
- To help the Subordinates whenever it is necessary.
- Manage and supervise the department
- Perform additional duties and responsibilities assigned by management from time to time.
- Shall update the consumables stock every week.
- Shall be responsible Biochemistry procedure file

Conclusion

Medicine is not the only thing that is practiced at. Hospital. Respect, Caring, Teamwork, Excellence and Commitment to Personal Best are guiding principles inherent in every professional. This is what motivates to deliver the highest level of quality health care service to the patients. Dedication to outstanding patient care and devotion to maintaining the highest standards of professionalism are the important characteristics of nursing. Through their integrated multispeciality group practice, they offer the most well-coordinated care possible to each patient and support innovation on the techniques and systems of caring for patients. The training in Hospital is of great help in understanding the intricacies involved in the Hospital. The training gives us elaborative idea about the patient care in each department and the functioning of the supportive services. On the whole the training is very informative and helps us towards bridging the gap between theory and practice.