Functioning of Medical Record Department in Rockland Hospital

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Dr.Pranav Shankar

International Institute of Health Management Research

New Delhi -110075

May, 2010

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RockLand Hospital

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under the guidance of

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International Institute of Health Management Research

New Delhi -110075

May, 2010

Certificate of Internship Completion

Date:……..

TO WHOM IT MAY CONCERN

This is to certify that Mr./Ms./Dr. has successfully completed his 3 months internship in our organization from February 1, 2010 to April 30, 2010. During this intern he has worked on …….(task performed) under the guidance of me and my team at …….(organsiation). …….(any positive/negative comment)

We wish him/her good luck for his/her future assignments

(Signature)
_____(Name)
_____Designation

Certificate of Approval

The following dissertation titled "**functioning of MRD at RocklandHospital.**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

Name	Signature
_____	_____
_____	_____
_____	_____

Certificate from Dissertation Advisory Committee

This is to certify that **Dr.Pranav Shankar** , a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He/She is submitting this dissertation titled " **Functioning of MRD in RocklandHospital** " in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been re-produced from any other dissertation, monograph, report or book.

Faculty Advisor:-Dr.Dharmesh Lal
Designation:- Asst.Professor
IIHMR
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Designation:-MS
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B-33,34 Qutab Institutional Area
Date 15-05-2010

Abstract: Medical Record forms one of the important componants of patient care and treatment. Accurate and adequate medical records are essential for clinical, legal, fiscal and research purposes and is based on the principle" people forget, but records remember". Medical Records Department (MRD) has become an essential department of every hospital. Printed performs developed by hospitals are widely used to achieve regularity and uniformity in the recording and presentation of information. A smooth and un interrupted supply of well-designed forms is a must for efficient medical record keeping. This study attempted to standardize the existing Medical Record Forms (MRF) used in a super specialty hospital. Analysis of the data revealed that forms are not standardized with regard to number, colour, content and size. Only the core forms bear numbers. Too many sizes are in use. Use of too many forms of the same colour may defeat the very purpose for introducing colour code, that of easy identification. There are multiple procuring agencies leading to multiplication of forms for same or similar purpose.The number of forms has seen doubled in nos. in the last two years. Several reasons could be described to this increase, like increase in the complexity and number of investigations to keep update with the developments in medical science; e.g., Discharge Summary, in an effort to include more details. Other reasons include lack of effort to eliminate forms which are no longer required; separate forms for investigation request and reporting which can be combined; lack of forms control and forms evaluation in the absence of regular meetings of the Medical Records Committee; and finally lack of automation. Standardization of paper-based records is the first step and this has been recommended in terms of number, size, content, layout, thickness, colour, paper quality and inventory

ACKNOWLEDGEMENT

While it is not possible to single out everyone concerned, I would like to thank all those who contributed so significantly to the making of this work possible.

I must acknowledge our greatest debt and extend our deepest thanks to **Vice President Medical Shri. Param Hans Mishra** who obliged me by kindly accepting my request to undergo training in their esteemed hospital and for assigning me an aspiring project work whereby I was unable to gain some practical experience and better understanding of concepts.

I am highly obliged and grateful to **Dr.Vijay Aggarwal (MS) Dr. Kausar Ali Shah (EX-MS) , Dr. Himali Sharma(DMS) Dr.Ritu Bassi (AMS)and Mehdi Hassan** (Medical Record Technician), who supervised me this work, provided continuous guidance and support in working.

Special mention must be made to a large number of employees of the hospital who spared time to respond to my queries.

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Dr.Pranav Shankar

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Abbreviations

1	CMO	Casualty Medical Officer
2	CT	Computerized Tomography
3	AMS	Assistant Medical Superintendent
4	HOD	Head of Department
5	IP	In Patient
6	ICD	International Classification of Diseases
7	ICP	International Classification of Procedures
8	ICU	Intensive Care Unit
9	MCD	Municipal Corporation of Delhi
10	MHC	Master Health Checkup
11	MLC	Medical Legal Case
12	MRI	Magnetic Resonance Imaging
13	MRD	Medical Record Department
14	MTP	Medical Termination of Pregnancy
15	NCT	National Capital Territory
16	OPD	Out Patient Department
17	PNDT	Pre Natal Diagnostic Techniques
18	BR	Birth Register
19	DR	Death Register
20	HSR	Hospital Statistic Report
21	OFMR	Onco File Movement Register
22	PDR	Patient Discharge Register
23	RSFF	Requisition Slip File Folder
24	SBFF	Snake Bite File Folder
25	CDFF	Communicable Diseases File Folder
26	MRFF	Morbidity Report File Folder
27	DCRFF	Dengue Cases Report File Folder
28	MCFF	Malaria Cases Report File Folder
29	HOTFF	Human Organ Transplant File Folder
30	CFF	Census File Folder

31	DCFF	Death Certificate File Folder
32	HIV.CFF	HIV Cases File Folder
33	FRR	File Return Register

About Rockland Hospital

Introduction:

Rockland Hospital has redefined the healthcare delivery system in India. Its motto ’Where caring is the way of life', is the guiding principal for the entire Rockland family.

Located in Qutub Institutional Area in the close proximity of the lush green Sanjay Van, Rockland Hospital is run by theTrust i.e ” Foundation For Applied Research in Cancer (FARC)” of which Shri Rajesh Srivastava is the Chairman.

Today, Rockland hospital is a multi-specialty hospital, with focus on specialization with perfection. A diligent team of professionals and highly qualified doctors renowned in their respective fields of specialty like Padmashree Prof. (Dr.) P.K. Dave (Orthopedics) , Prof. (Dr.) M.P. Sharma (Gastroenterology), Dr. KK Pandey (Oncology), Dr.R.P.Mathur(Nephrologists) andMaj(Gen.)Dr.R.P.Singh(H.O.D.Int.Medicine & Clinical Servics)are a part of the Rockland family.

Special attention has been given to the design and aesthetics of different categories of rooms for the patient. The breath taking view of Sanjay Van and Qutub Minar is a unique sight is unimaginable in a metropolis like Delhi. The ultra modern, technically advanced operation theatres with laminar airflow and

pneumatic instruments are well equipped to carry all sorts of sophisticated surgery. Post-Operative and Intensive-Care beds connected to a centralized gas supply and an advanced monitoring system are supervised by experienced and trained nursing staff.

Strategically designed health packages are a noteworthy feature of the hospital services. It has been planned and designed keeping economy and the highest standards of quality under consideration, with an aim to benefit each and every stratum of society.

The OPD services of the hospital were inaugurated by the Hon'ble Chief Minister of Delhi, Smt. Sheila Dikshit, on 19th June 2004.

The idea behind starting this hospital was to provide quality services to society at all times. The visionary behind the Rockland Hospital, Shri Rajesh Srivastava relentlessly strives to contribute to the growth and development of society keeping the cultural traditions intact.

Location and Map:



Address:

Rockland Hospital,

B - 33-34, Qutub Institutional Area, New Delhi - 110016

Tel: 011- 41222222,41688752, Fax: 011-41688752

Email: info@rocklandhospital.com

Website: www.rocklandhospital.com

Specialties and Services:

Specialisation

Anesthesia	**Neurology**
Bariatric Surgery	**Non Invasive Cardiology**
Dietetics & Nutrition	**Onco Surgery**
Dental & Facio maxillary	**Obstetrics & Gynecology**
Dermatology	**Orthopaedics**
ENT & Ophthalmology	**Pulmonology**
Endocrinology	**Physiotherapy**
Gastroenterology	**Plastic & Cosmetic Surgery**
General Surgery	**Paediatrics**
Internal Medicine	**Psychiatry**
Nephrology	**Urology**

Round The Clock Services

ICU, KTU & NICU (17 beds)	**Blood Bank**
3 OTs , Day Care Emergency OT	**Routine & Specialized X-Rays**
Labour Room	**Ultrasound, ECHO Cardiogram, Doppler**
Dialysis unit	**CT scanMammography**

Location of Departments in Hospital:

I. Basement -- OPD(ONCOLOGY),OPD, Account Office

II. Ground Floor -- Front Office, Billing, OPD(Dental, Gastro),Day Care, Casualty, Maintenance Department, HR and Administration Office, Blood Bank, Store, Cafeteria

III. First Floor -- OT, ICU, NICU, Endoscopy, Labour Room

IV. Second Floor -- Patients Rooms, Nursing Station

V. Third Floor -- Patients Rooms, Nursing Station

VI. Fourth Floor -- MRD, Dialysis, Seminar Room, Marketing Department, Purchase Office, Trustees Office

Organization:

Rockland Philosophy

Every Organisation, Every Society, Every Nation, Every Group Strives For Success And Recognition. Each Individual Member of the Group Endeavours to Be Held In Universal Respect and Esteem; To Gain Prosperity, Wealth, Personal Fulfillment and Dignity.

The Rockland Logo

- Blue : symbolises security and trust

- Red : epitomises energy and dynamism

- The Rockland logo symbolises our commitment to provide world-class services while maintaining the highest standards of excellence.
- The logo is dynamic and poly-symbolically imbued with emotive and conceptual values such as life and hope.

The arrow circling round to the point of origin is a symbol of continuity and integrity, as well as a personalised and holistic approach to individual care

Vision:

To use multidisciplinary approach with ethical practices by a team of highly responsive, caring and efficient professionals with a constant focus on excellence in delivering medical services in patient care, continuing medical education, scientific knowledge and deliver benchmarked quality medical care

Mission:

To use multidisciplinary approach with ethical practices by a team of highly responsive, caring and efficient professionals with a constant focus on excellence in delivering medical services in patient care, continuing medical education, scientific knowledge and deliver a benchmarked quality medical care.

The Board of Trustees:

Rockland Hospital, which is run under the aegis of FARC, is governed by a trust established in 1986. The trust is a subsidiary of the SB Group, and consists of the following members :



Shri Rajesh Srivastava

Chairman



Shri Prabhat Srivastava

Member Trustee



Shri Rishi Srivastava

Member Trustee



Smt Mala Srivastava

Member Trustee



Smt Sushmita Srivastava

Member Trustee

Advisory Board

The Hospital has a distinguished Advisory Board, consisting of the following:



Padmashree Prof. (Dr.) P. K. Dave

Chairman, Advisory Board

Former Director of All India Institute of Medical Sciences (AIIMS)

MEMBERS:

(Prof) Dr. M. P. Sharma

Prof. & Head of Deptt. Gastroenterology and chairman Hospital management board. Formerly at All India Institute of Medical Sciences (AIIMS)

Mr. Arun Gupta

Financial Consultant, worked in a leading nationalized bank for over 25 years in various capacities. The last posting being on deputation as Senior Financial consultant Vice President.

Mr. N. P. Singh

General Manager Administration, Delhi Transco Ltd. & Indraprastha Power Generation Company Ltd.



Mr. Umesh Upadhy

(Eminent Media Personality)



Mr. K. L. Chugh

Chairman, Emeritus ITC Ltd. and Chairman, Cosmos Consulting.

Mr. Rakesh Srivastava

Mr. Aditya Bhandari



Dr. K. S. Bhimwal

MBBS, DHA, MHA

INTERNATIONAL PATIENTS SERVICES:

We have a separate division for International Patients. This takes care of fixing appointments, corresponding and receiving patients, conducting them through out the hospital for their treatment.

The concerned staff is trained in their mannerism, grooming, language and hospitality skills. All the activities are done in a seamless manner and an escort sees off the patient and the family at the airport.

Medical Expertise:

We have a panel of highly experienced and qualified doctors who have gained national and international Recognition.

Food:

You could choose from menu of Indian, Continental, and vegetarian food.

Recovery: Hospital has two motels where the patient has the facility to stay.

Transportation: The hospital has in house travel desk for facilitating the transportation of patients and their attendants.

Payment Options: International Insurance, Credit card facility and payment in international currency. Arrangements made by Rockland Hospital for International Patients:

- Travel Arrangements
- Airport pick-ups and drop
- Co-ordination of doctor's appointments
- Accommodation for relatives and attendants
- Locker facilities
- Provision of cuisine options
- Provision of interpreters

Arrangements with leading resort chains for post-operative recuperation

Internship Report:

I started work with Rockland Hospital,NewDelhi since May 2009 as an intensivist in ICU under chaiman ICU& Anaesthesia Dr. P.Mazumdar.I had work as intensivist till 20th December2010 than I was promoted as AMS after placement week at IIHMR.

Job Title:-AMS-Front Office

Department:-Administration

Reporting:-Medical Superintendent/ V.P.

Job Summary:-Responsible to the Medical Superintendent for the smooth functioning of the front office.

Duties &Responsibilities:-

- Ensure all front office protocols are implemented and followed properly
- Complete handling of TPA-pre authorization, queries, final approval, and Estimating amount of advance to be taken.
- Giving estimates to prospective patients.
- Issue of emergency certificates(CGHS)
- Ensuring in House recovery before patient is discharged, on daily basis.
- Screening Bed Allocation per Hospital policy.
- Coordinating anticipated vacancies/room bookings for admissions.
- Coordinating Ambulance Services.
- OPD Services
- IPD /OPD Billing
- Dispatch/ Back office
- Medical Record Deprtment.
- Auditing of given area.

Supervision Received:-Medical Superintendent

Supervision Exercised:-All staff of front office.

Two days after joining as a AMS, I have been shifted to Manesar to resolve the acute crisis of doctor due to resignation of Dr.Nitin.

From 22nd December 2009 to 9th Feburary2010 at Manesar:

- Working Hours:-9:00 AM to 5:00PM
- Responsible for clinical assessment of OPD Patients/ Emergency
- Health checkups of various corporate organization
- Pre-employment checkups.
- Organizing camps in different villages &companies.
- Organizing meeting with various companies CEO'S for empanelment.

On 10th February2010 I joined back to Rockland Delhi.

10/02/2010(Wednesday)

- Morning meeting at sharp 9:00 am with All HOD's, Trustees, Executive Director, VicePresident, Medical Superintendent on Monday, Wednesday, Friday Leaded by ED & Trustees
- Introduction with Advisory Board, Trustees, Medical director planning, and other associate members.
- Round of Wards and concerned departments.
- Handover from Dr.Naveen
- Organizing farewell for Dr.Naveen & Dr.Kausar.

11/05/2010(Thursday)

- Morning meeting With All HOD'S leaded by MS onTuesday,Thursday, Saturday
- Round of concerned department.
- Started learning to give estimate, Emergency certificate.
- Attestation of documents for reimbursement of various corporate/CGHS/DGHS/ECHS/ patients.
- Meeting with all concerned departments employees for eg. Front office,Billing,Dispatch,MRD,OPDstaff
- Monitoring of daily revenues from OPD & IPD
- Clinical Meets and paper presentation by DNB student.

12/05/2010(Friday)

- Morning meeting starts with discussion of Patients Feedback, complaints & Suggestions. Discussion on various top level decisions and its implementation on ground level.
- Change in OPD timing for CGHS/DGHS/ECHS (2:00pm to 4:00pm)
- Weekly Ward,OPD, Support services round with ED,V.P.on Friday
- After noon weekly meeting on Medical Records/ Death Cases/MLC Cases/ File completion etc
- Daily admission reports.
- Daily discharge reports.
- Daily admission refusal.

13/05/2010 (Saturday)

- Starts with Morning meeting as usual.
- Saturday, The toughest OPD day at Rockland Hospital due to weekly holiday in Govt. /empanelled organizations.

- Managing referral letters problems, expired validation of cards,Improper referral or mistakes in referral.

- Weekly Marketing meeting at 2:00pm, than weekly Billing meeting at 3:00pm.
- No. Of pending file(OPD & IPD) to dispatch according to listed corporate.
- Clearance of bill against outstanding bill amount.
- Reply of queries / justification raised by corporate while passing the bill.
- Discussion on TPA's bills and related issues.
- Billing Problems at OPD counter , IP billing, IT support in billing, undefined refund policy.

14/05/2010(Sunday)

- Has to present in hospital as a Day Administrator.
- Round with chief security officer to all the area of the hospital.
- Solve the patient / staffs problems, billing issues etc.
- Responsible for smooth functioning of all activities.

15/05/2010(Monday)

- Same working schedule as other days
- Reshuffling of inter departmental staff.
- Change in duty roster of staff.
- Assigned work to different level of staff like manager, Asst.Manager, Sr.executive, executive and given job responsibilities.

16/05/2010(Tuesday)

WEEK OFF

Dissertation on "MEDICAL RECORD DEPARTMENT"

INTRODUCTION

A chronological written account of a patient's examination and treatment that includes the patient's medical history , complaints, the physician's physical findings, the results of diagnostic tests ,procedures, medications and therapeutic procedures.

The medical record is a storehouse of knowledge concerning the patient. It is a yardstick by which the quality of work done by the physician and hospital personnel may be measured. Despite recent interest and innovation in medical record design and use, medical records have been deemed 'chaotic repositories of information' A medical record is a collection of record facts concerning a particular patient.

HISTORY:

Continuous development has taken place in the field of medical records over the period from the initial primitive form. The first medical records unit was established in **1667** at St. Bartholomew's Hospital in England and followed by the practice of maintaining ill Patient's register in Pennsylvania Hospital ,**USA** in 1752.

In India, medical record keeping has not developed in the same way as in western hospitals. In India Bhore Committee **(1946)** has stressed the importance of keeping adequate medical record.

PURPOSE[1]:

The medical record is indispensable from the standpoint of the patient, the doctor, the hospital and for medical education and research. The purposes of medical records to serve in relation to these aspects as under:

The patient:

The primary reason for medical record keeping is to improve the quality of care of the patient. It is essential for immediate diagnosis, treatment and for the future welfare of the patient. Every illness, however, minor involves study and examination to the extent that it is impossible for any individual to keep all details in mind. The written report is evidence that the patient's care is being done in a scientific manner. Other points in relation to this are:

- It serves the document of clinical history of the patient's illness and course of his disease.
- It serves to avoid omission or unnecessary repetitions of diagnostics test and treatment measures.
- It assists in continuity of care in the event of the future illness.
- It serves as evidence in the event of when the legal question arises.
- Provides necessary information for insurance, contributory health scheme or for the employment purposes.

The doctor:

- Assurance of quality, quantity and adequacy of diagnostic and therapeutic measures undertaken.
- An assurance of orderly continuity of medical care.
- Evaluation of medical practice.
- An aid in research and title continuing education of health professionals,
- A protection in the event legal question arises.

The hospital:

- Document:-the type and quantity of work undertaken and accomplished.
- Furnish proof of the type and quantity of care rendered to the patient.
- Evaluate the proficiency of the individual doctor, for administration and clinical purposes.

- Evaluate the services of the hospital in terms of accepted norm and standards.
- Protect the hospital in the event of legal matters
- Serve as an administrative record of personnel performance and staffing needs, for budget Preparation, justification for physical facility allocation and utilization, for statistical data for administrative use and evaluation, for estimating equipment and supply utilization and needs.
- Assist in future programme planning.

Medical education and research: Medical records can also be used for the medical education and research in following ways

- Recorded observations are the basis for all clinical research.
- Group ostudies of records by the medical staff serve them to further education of doctors and other health personnel.
- Medical records supply pertinent data for the use by public health authorities in control of the diseases.

Physical Facilities:

While planning physical facilities for a medical record department, Following to be taken into consideration:

Location

Central admission and inquiry office should be located near the main entry of the hospital in close proximity of the outpatient department and accident and emergency services as the majority of the patient in the hospital come to these departments and admitted through these areas. Outpatient record section should also be located in the outpatient department near its main entrance.

Central medical record office may form a part of administrative wing. Since this office deals with inpatient records, it should be in close proximity to the inpatient areas.

Space and General Facilities Requirement[4]

Admission and Inquiry Office: A space of 125-175 sq.ft. is considered adequate.Counter should be aesthetically made to facilitate easy communication between staff, Ptients, corporate client. General office equipment will mainly be required for the staff working here. Separate counters for admitting clerk, receptionist handling information and billing clerk should be provided. The room should have adequate waiting space with all facilities for eg comfortable chair , toilet for all staffs, patient and their attendants. Telephone with facility of local calls & STD must be made available,

Central Record Office[9]:

I) The space requirement depends upon the size of hospital. As a rough idea space of 2 to 3 sq.ft. per bed may be sufficient. The details are as under:

50 bed hospital-1 50-175 sq.ft.

100 bed hospital- 225-250 sq.f't.

200 bed hospital--450-500 sq.ft.

500 bed hospital-1000-1200 sq.ft.

ii) This area may be sufficient 10 store inactive medical records also. The space for this may be in the general record storage area or on a separate floor.

Space ranging from 120 sq.ft. to 500 sq.ft. with adequate shelves will be required.

iii) In addition to the computers if the functioning is computerized, general office equipment for the medical record technicians clerks will he required.

Adequate facility for holding meetings, medical staff/ trainees to pursue the record needs to be catered

c) **Out patient Record Section:** Average ***2-3*** feet per bed of space is required for out patient record section also. A space of 150 sq.ft. for the *50* bed hospital to 1200 sq.Ft. for a 500 bed hospital may be adequate for the out patient rec-

ords. Separate counters for the registration old and new, male and female patients are to be provided. Counter 24" wide, 4C)" high with file drawers beneath it is required. Wailing area adjacent to registration furnished with chairs, benches, announcement boards and health education visual aids need to be catered.

Storage:

Completed medical documents are stored in the main medical records by following a filing system. The following factors are considered for an effective filing system:

a) Compactness to reduce physical effort and cost of storage space.

b) Accessibility for speedy location and identification.

c) Simplicity for understanding of all concerned.

d) Economical both in the cost, installation and operation.

e) Elasticity to expand according to future requirement.

f) Tracer system for document in circulation.

System of Filing:

Any one of the following can be followed for filing:

a) Decentralized system: Under this system inpatient and outpatient department have their own individual records and file them independently within the department. If a patient is transferred from one department to another the file may be loaned to other department. This system is labour intensive and the operating cost are higher.

b) **Centralized system: In** the centralized system, medical records arc filed centrally in the medical records department. The centralized system is efficient, provides better control and followed in most hospitals.

Methods of Filing:

The various methods available are:

a) Numerical method

b**)** Alphabetical method

c) Chronological order

d) Terminal digit system

e) Mid digit system

Numerical method of filing is the commonest method is use. As already discussed in Section 2.6, each patient is given a unique number at the time of his registration/ admission and the filing is done in the numerical order. This method is most suitable for retrieval of files. The disadvantage of this system is that the files are added to one end of the system, which usually is the furthest from the working area and most active for retrieval and filing purpose.

Filing Procedure:

Types of Files: It is useful to use files of different colours for different years for easy retrieval and identification. Files should be uniform standard size depending upon the size of forms in use in a hospital. For the most forms a standard size of **8.5"xll"** is

Preferable. The filing jacket should be 1/2 " bigger than the length and width of the biggest form in use.

Filing: File three types of filing procedure are generally used are as under:

i) Vertical

ii) Suspended

iii) Horizontal

The **vertical system** is universally used in which the the file are kept vertically on its spine or edge and supported by the other files or cards within the section storage steel racks with shelves of standard size are suitable for the storage. This system is economical, affords easy reference, adaptability and scope for extension.

In the **suspended system** especially made filing cabinets are required and the records are suspended from frames in drawers in the cabinet. The system is fairly costly and not easily adaptable but the securely of the documents is belter.

In **horizontal filing** the medical records are inserted in folders/files which are kept one upon another in a chronological order. The retrieval of records is difficult and storage in orderly manner cannot be maintained. Whenever any record is taken out, it usually upsets the other records.

Microfilming of Medical Records for Storage[7]:

In large teaching hospital the space for medical records storage may pose a big problem. Microfilming may be the only answer for inactive storage of medical records. The advantages of microfilming are:

a) **Saving of space: 90%** of the space can be saved if he records are microfilmed.

b) **Easy accessibility:** Due to easy storage in a smaller area, the accessibility of the records to students, faculty and staff become very easy.

c) Protection: Micro filmed records cannot be easily tempered.

d) **Elimination of misfiring:** Incorrect filing of the records is impossible after the same has been filmed. They can be easily classified and stored.

e) **Saving of time and manpower:** More economical in the long run because it reduces the waste of time and manpower.

Microfilming requires special equipment such as microfilming camera, processors, viewing machine, duplicating and photostating machine in addition to certain expendable items such as microfilming rolls, fixer and developer. Micro filming technicians will also be required for the purpose.

Computerization of Medical Records: Technological advances and decreasing cost of computerization have brought about revolutionary changes in the medical records system, their storage and retrieval. Key to the future is the computerization of medical records. Today it is possible to even store all types of images such as that of X-ray,CAT Scan and MRI. By networking the system throughout the hospital, it is impossible to give desktop access to doctors, nurses, techni-

cians and administrators and yet maintaining the confidentiality of the whole system.

Retrieval of the Medical Records[8]:

The retrieval of medical records is usually required for any of the following purposes.

a) When the patient attends to follow up

b) Patient is admitted in the ward or casualty for observation.

c When the files are issued to research workers for academic purposes

d) For medical reimbursement and

e) For producing in the court of law for medico legal purposes.

The method of retrieval will depend upon the system of storage being followed in an institution. In a conventional system where medical records have been stored in shelves, the file is traced by the number allotted. The file folder is taken out and a tracer card is placed in its place as marker. The tracer cad contains basic information regarding the recipient of the document such as the name of the borrower, purpose for which the documents are required, date of issue, identification data of the documents issued and the signatures of the individuals issuing and receiving the documents. The tracer card remains in its place until the file is returned.

The medical record should contain, sufficient information to clearly identify the patient support the diagnosis justify the treatment and to accurate result. It is a device for recording the significant characteristic in the course of professional care for the purpose.

And training of physicians, other medical and paramedical staff also basis clinical research. Research to be effective requires concentrically record. And the important of accurate records for legal purpose is well established.Need for many categories for patient for physician hospital, health authorities, accredita-

tion councils and insurance sector companies etc. It serves to documents the study of the patient, and it serves to avoid admission or unnecessary repetition of diagnostic and treatment measures. It assist in continuity of care in even future illness, it serves as legal evidence. It serves as a story of the passage though hospital, maintaining continuity in that story. Physicians now to not always have the time to get acquainted with the family life of the patient so written report of the family history and personal history necessary. The economic stand point use of medical record by other agencies representing insurance claims, union benefits unemployment, and industrial compensation is of paramount importance to the patient,

information contained in the medical record is often the determining factors in providing the patient with financial support of subsequent medical care for the remainder of his or her life,

medical record meets physician`s needs as practice of scientific medicine based on record facts, continuity, medical care, evaluation of his or her own capabilities and short comings and effective communication for the medical team. Frequently the physicians may wish to review all cases which her or she had in the hospital during a given time, also the physicians or hospital may need to refer to the record for medical legal purpose.

- Providing the best medical care/patient care
- Providing material for :
    I. Teaching and training
    II. Service statistic/Administrative statistic/Medical statistic
    III. Medical research, Medical legal purpose

LOCATION OF MEDICAL RECORD DEPARTMENT:

The medical record department at Rockland Hospital is located at the fourth floor, near trustee floor. IPD record are kept in the lockers and subsequently ar-

ranged as per patient's IPD Nos. and onco file are kept separately as per patients UHID number. IPD records are stored meticulously and it is managed by MRD Technician **Mr. Mehdi Hassan**. Who is available from 9.30 am – 5.30pm daily.

TYPES OF MEDICAL RECORD REGISTER[5]:

1)	Birth Register	- (BR)
2)	Death Register	- (DR)
3)	Monthly Hospital Statistic Report	- (MHSR)
4)	Patient Discharge Register	- (PDR)
5)	X-Ray Stock Register	- (X-ray SR)
6)	IPD File Movement Register	- (IPDFMR)
7)	Information Letter File Folder	- (ILFR)
8)	Requisition Slip File Folder	- (RSFF)
9)	Government Letter File Folder	- (GLFF)
10)	Circular File Folder	- (CFF)
11)	MTP Report File Folder	- (MTPRFF)
12)	Snake Bite File Folder	- (SBFF)
13)	Morbidity Report File Folder	- (MRFF)
14)	Dengue Cases Report File Folder	- (DCRFF)
15)	Malaria Cases Report File Folder	- (MCRFF)
16)	HIV/AIDS Cases File Folder	- (HIV CFF)
17)	MCD Birth Report File Folder	- (MCDBRFF)
18)	MCD Death Report File Folder	- (MCDDRFF)
19)	Still Birth File Folder	- (SBFF)
20)	Human Organ Transplant File Folder	- (HOTFF)
21)	Census File Folder	- (CFF)
22)	Death Certificate File Folder	- (DCFF)

23) HOD Report Register - (HODRR)

24) Attendance Register - (AR)

25) No. of Delivery File Folder - (N.D FF)

26) MLC Register - (MLCR)

1. BIRTH REGISTER:

All the information that is found on a birth certificate mention in the birth register. The report about birth send to the MCD online every 21st day.

Constitute of birth register:

- Date of birth
- Name of mother
- UHID No. num
- IP number.
- Address
- Doctor name
- Mode of delivery
- Sex of baby
- Time of birth
- Birth weight
- Pediatrician

2. DEATH REGISTER:

All Information about of any death included in this register. A death report sent to be MCD online as per government policy.

Constitute of death register:

- Name of patient
- Name of father/husband

- Age
- Caste & Religion
- Sex
- D.O.A
- Nationality/Occupation
- Date &Time of death
- Cause of death
- Consultant name

3. <u>Monthly Hospital Statistic Report:</u>

In this register the data mention about the

- Total functional bed
- Total patients admitted
- Available bed per days
- Numbers of patient discharge
- Total death in hospital
- Death under 48 hour
- Death over 48 hour
- Total Birth
- Total surgeries
- MLC
- Anesthesia

To use of these data we make the following monthly report in a hospital

1) **<u>Average length of stay:</u>** Average length of stay is the average number of days of service rendered to each discharged patient during the given period of time. Patient days are compiled from

the discharge summary of discharged patient. The formula is :

$$\frac{\text{Total patient days during given period}}{\text{Total discharges (including deaths) during the same period}}$$

2) **Bed occupancy rate:** Bed occupancy rate indicates the relationship between availability and utilization of hospital beds and facilities.

$$\text{BOR} = \frac{\text{Average daily census}}{\text{Bed complement}} * 100$$

3) **Bed complement:** Bed complement is the number of hospital beds normally available for use by in patient.

4) **Average daily census:** Average daily census is the average number of patients at given time per day and expressed as:

$$\frac{\text{Sum of daily census or a given period}}{\text{Number of calendar days in the period}}$$

5) **Bed turnover rate:** Bed turnover rate gives the number of discharges per hospital bed over a given period

$$\frac{\text{Total number of patient discharged including death}}{\text{Bed complement}}$$

6) **Bed turnover interval:** It is also called 'T' interval. BTI is the average period in days a bed remains vacant between one discharge and another admission. BTI should be around 0.5 days

The maximum patient days – Actual patient days a given period

No. of discharges including deaths a given period

7) Gross death rate:

Total num.of hospital deaths during a given period * 100

Total discharges including deaths during the same period

8) Net death rate:

Total deaths of inpatients after 48 hr. of admission during a given period * 100

Total discharges including deaths during same period

4. PATIENT DISCHARGE REGISTER:

In this register the information of discharge patient mention. e.g IP No., patient name, room no., D.O.A, D.O.D, department.

5. X- RAY STOCK REGISTER:

All information about the patient the patient x-ray receives is mention in this register.

6. INFORMATION LETTER FILE FOLDER:

In this folder, if any file of patient is not received after discharge within 48 hrs, then MRD a letter to nursing superintendent to look that file and do the needful. The letter constitute are:

- IP Num.
- Patient name
- D.O.D and Room num.

7. REQUISTION SLIP FILE FOLDER:

In this folder the requisition slip contain. If any department need any patient file that a requisition slip fill and give to MRD and take a file. Format as below:

- Name of patient
- IP num.
- Date & Time
- Location of department
- File receiving purpose for
- Dr. Name & sign

8. GOVERNMENT LETTER FILE FOLDER:

In this folder the letter kept which is send by the government to the hospital regards dengue report, communicable disease report, institutional delivery, morbidity report.etc.

9. CIRCULAR FILE FOLDER:

In this folder, the hospital related events, training program, meeting etc. information kept. The circular letter goes to the every department of hospital.

10. MTP REPORT FILE FOLDER:

In this folder the monthly report of MTP cases, which is done in the hospital maintain. The monthly reports send to the CMO of that area.

11. SNAKE BITE FILE FOLDER:

In this folder monthly report of deaths due to the snake bite are kept and the monthly report send to the Directorate of Health Services.

12. MORBIDITY REPORT FILE FOLDER:

The monthly report of morbidity kept in this folder and monthly report send to the Directorate of Health Services.

13.DENGUE CASES REPORT FILE FOLDER:

Total cases of dengue in a month are found are recorded in this folder. After diagnose the case of dengue hospital has to report within 24 hr. to the MCD.

14.MALARIA CASES REPORT FILE FOLDER :

Total cases of malaria in a month are found are recorded in this folder. After diagnose the case of malaria hospital has to report within 24 hr. to the MCD.

15.HIV/AIDS CASES FILE FOLDER:

The reports of the HIV patients are kept in this folder. After diagnose the case the report send to the Directorate of Health Services within 24 hr.

16.MCD BIRTH REPORT FILE FOLDER:

All birth report which is send to the MCD, kept in this folder for record purpose. It is useful for making the birth certificate.

17.MCD DEATH REPORT FILE FOLDER:

All death report which is send to the MCD, kept in this folder for record purpose. It is useful for making the death certificate.

18.STILL BIRTH FILE FOLDER:

This folder contains report about the foetus dead before delivery.

19.HUMAN ORGAN TRANSPLANT FILE FOLDER: In this folder, the report about any organ transplant which is done in hospital kept. It is also mention the whole information of donor and recipient.

20.CENSUS FILE FOLDER:

In this folder the information about total preserved bed, new admission, total transfers in and out, total discharge, and total beds are being used.

21.MLC REGISTER:

If any patient case becomes MLC then it becomes the property of court. The report mention in this folder. A case become MLC when police involve. e.g Accident, Patient file the case against the hospital, Suicide.

RETENTATION PERIOD OF MEDICAL RECORDS

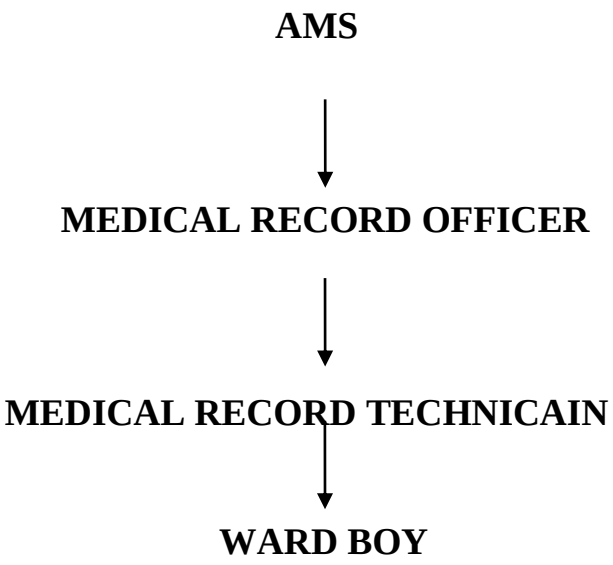
S.No.	Name of the departments	Retention period
1.	Outpatient medical records	5 Years
2.	Inpatients medical records	10 Years
3.	Medico-legal Registers	Life time
4.	X-Ray: Outpatient department In patient department Medico-legal	 5 Years 10 Years Life time
5.	Registers: Admission Delivery Surgery Death Log books	 Permanent Permanent Permanent Permanent 2 Years
6.	Statistical Reports	Permanent
7.	Floor census	2 Years
8.	Admission & Discharge report	2 Years

REPORTS TO GOVERNMENT AGENCIES[7]

S.No.	Report	Agency
1.	Communicable diseases report	State health intelligence bureau

2.	MTP report	Directorate of family welfare
3.	Morbidity report	State health intelligence bureau
4.	Snake bite report	State health intelligence bureau
5.	Birth & death report	Zonal birth & death registrar

ORGANOGRAM[7]



MEDICAL RECORD FORMS

In hospital there are various types of forms used. Majority of the forms are white, however forms of other colours are also available. Weight of medical forms should be 75 GSM(grams per square meter) and cards type medical forms 200 GSM. There are two types of section of medical records

I. **Identification section:** This section fills up the patient identification data at the time of registration /admission. Following particulars should be recorded.
    - Name of patient
    - UHID no.

- Father's name/Husband's name
- Age & Sex
- Marital status
- Address
- Contact number.
- Nationality
- Company/Organization/TPA
- Medico legal case if any

II. Medical section: The medical section is filled up by resident doctor /attendant consultant. Following particulars should be recorded.

- Physician notes
- Progress and treatment notes
- Different investigation report form
- Activity sheet
- Consent forms
- Anesthesia record form
- Operation record form
- I.C.U charts
- KTU charts
- Medication chart
- Intake Output chart
- Discharge summary

ICD 10 CODING

Coding is done based on final diagnosis with all complication given in the discharge summary/face sheet of the patient.

SYSTEMS USE IN MEDICAL RECORD DEPRTMENT

There are two systems use in hospital

1. Hospital Information System (HIS)
2. International Classification of Diseases-10 (ICD-10)

CHARACTERSTIC OF GOOD MEDICAL RECORD[8]

The problem of completing record is very real one for the overburdened physician not withstanding that of physician and other in the medical record must be.

1. **Complete: -** sufficient data to identify patient, justify diagnosis, treatment follow and outcome.
2. **Adequate**: - with all necessary forms, clinical information.
3. **Accurate: -** the all information about patient should be accurate.

DUTIES & RESPONSIBILITY:

1. **AMS In charge Medical Records:**
   Dr.Pranav Shankar

   - The HOD medical record report to VP medical.
   - Responsible for day-to-day functioning of the department.
   - Responsible for the planning, organizing and coordinating inter and intradepartmental policies in regard to the management of patient record.
   - All staff of the department report to him.
   - Responsible for detailing staff for court case as and when subpoena pertaining to medical record is received.

- The authorized signatory of medical record pertaining to day-to-day functioning of medical record.
- Responsible for timely submission of reports to directorate of health services as per their notifications.

2. MRD Technician:

(Mr.Mehndi Hasan)

- Responsible for record keeping of all OPD/IPD patient related files.
- Responsible for easily retrieval of medical record.
- Checking medical record for missing files.
- Filling of medical record of discharge patients.
- Compliance of data for research from record
- Responsible for preparation statistical reports.
- Reviewing of all medical record to ensure presence of all component parts.
- Preparation of daily census.
- Making analysis of record of discharge patient and of all admission.
- Maintaining of birth and death register.
- Scrutiny of birth and death report received from the wards.
- Issue of medical records files required by the patient/patient attendant from time-to-time.
- Follow up with patient record file which are issued to the OPD/IPD and not received back in medical record department in time.
- Responsible for proper indexing and file numbering to all new patients file.

3. **Ward Boy:**

(Mr.Deepak)

- Department cleaning and mopping.
- Organizing of IPD file.
- Delivery and collecting case sheets/IPD files to and from different department.
- Any other work assigned by the in charge/technician.

CHRONOLOGICAL ORDER/CHECK LIST FOR IPD PATIENT FILE

UHID/IP NO:-……

PATIENT NAME:-……

Dr. NAME:-……...

I. Face sheet ……..
II. Discharge& Discharge summary.....……..
III. Death certificate…….
IV. Initial assessment form……...
V. Clinical chart……..
VI. Investigation chart……..
VII. chart……..
VIII. Blood sugar chart……

IX. Intake/output chart……..

X. Nutritional assessment……

XI. Surgeon physician notes…….

XII. Nurses notes……

XIII. New born baby sheet……...

XIV. Consent form……...

XV. Pre-operative nurses evaluation chart…….

XVI. Anesthesia notes…….

XVII. Operation notes……...

XVIII. ICU chart…….

XIX. Investigation chart……...

XX. Referral …….....

XXI. OPD card…….

AIM & OBJECTIVES

General Objective:-

- To Study the functioning of MRD in Rockland Hospital, for quality assurance in medical record department.

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Specific Objectives:-

- To study the various substitute of MRD in Rockland Hospital.
- To analyze the qualitative aspects of MRD .
- To suggest certain measures to improve the functioning MRD in Rockland Hospital.

METHODOLOGY

There are two way of collecting of data are follows as:

1. **Primary Data:** Primary data is collected originally by using tools like questionnaires, observations, diaries &etc.
2. **Secondary Data:** Secondary data is collected from the books, journals and internet.

OBSERVATION AND DISCUSSION

Two Hundreds file were selected randomly from the 10th February2010 to 31st March 2010.During studies of those files various important document were missing. Files were not properly filled; Discharge summary, initial assessment form, doctor's notes with time and proper signature etc were missing in many files.

	% OF INCOMPLETE FILES	% OF COMPLETE FILES
IPD care plan is document-ed and coun-ter-signed by the HOD	17	83
	%OF **NA** NOT AVAILABLE	% OF **NA** AVAILABLE

Nutritional Assessment	84	16
	% OF **DS** NOT AVAILABLE	% OF **DS** AVAILABLE
Discharge Summary	3.5	96.5
	% OF **IA** NOT AVAILABLE	% OF **IA** AVAILABLE
Initial Assessment	2	98
	% OF CONSENT NOT AVAILABLE	% OF CONSENT AVAILABLE
Medical Record having incomplete/In proper Consent	3.5	96.5

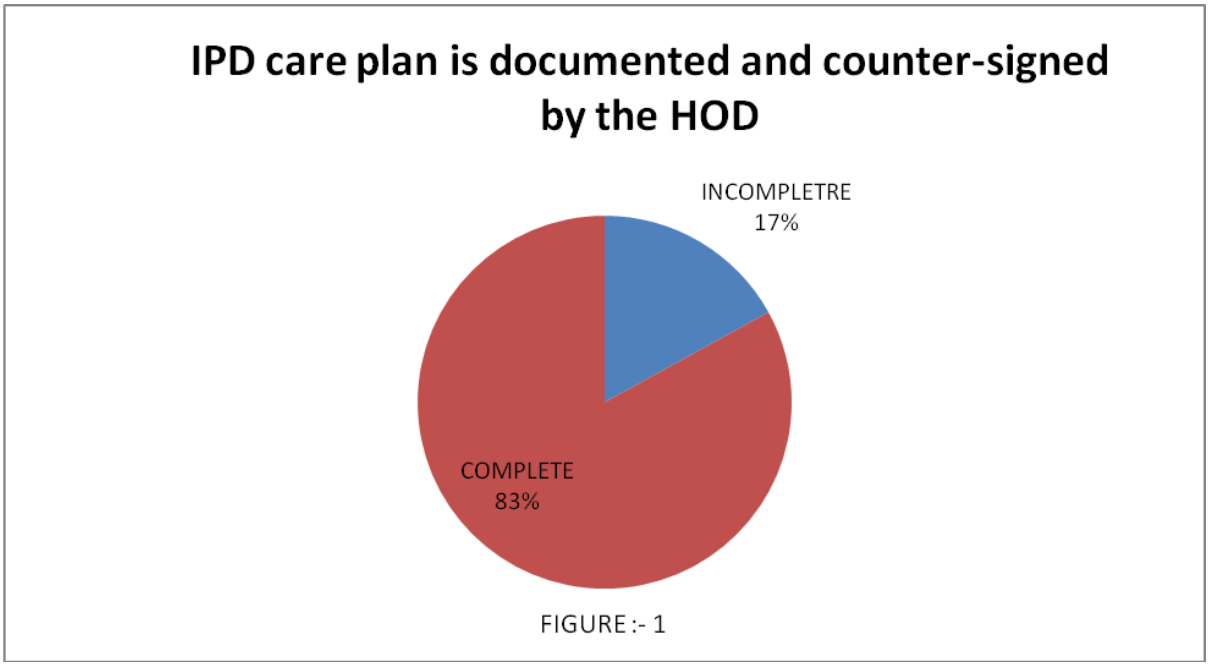


FIGURE :- 1

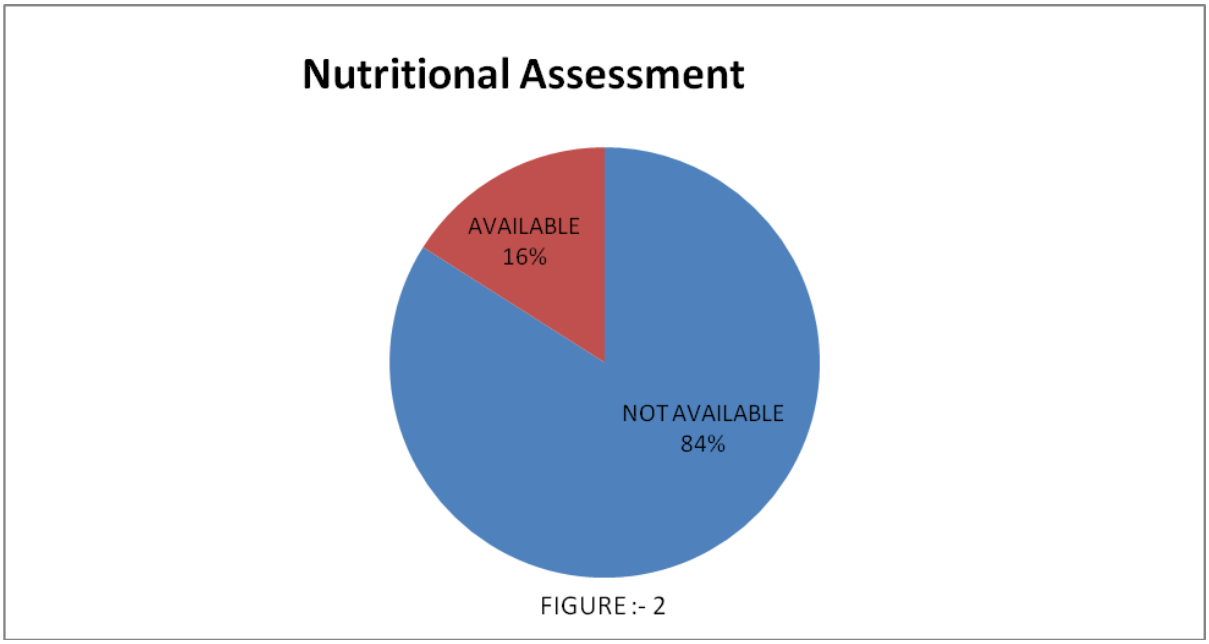


FIGURE :- 2

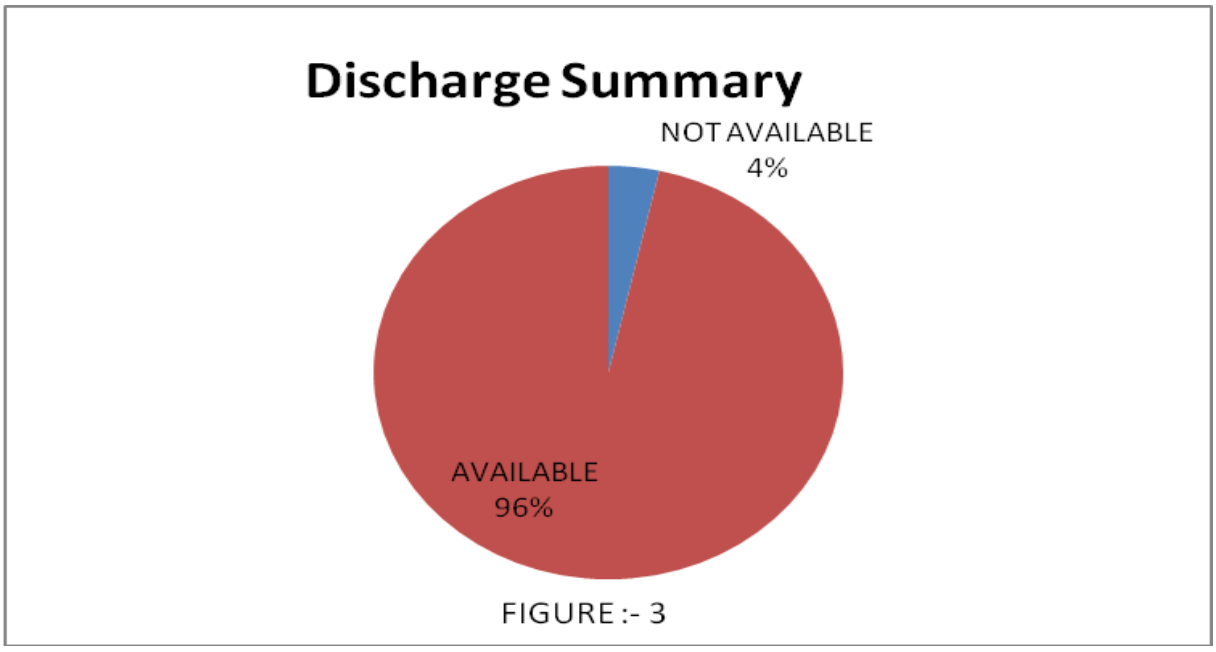


FIGURE :- 3

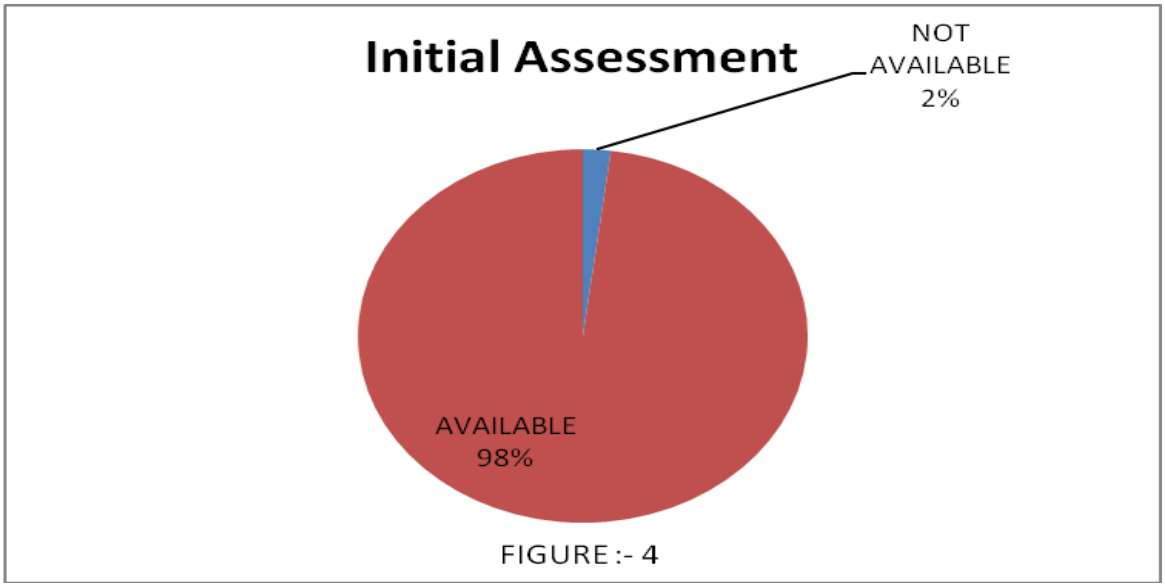


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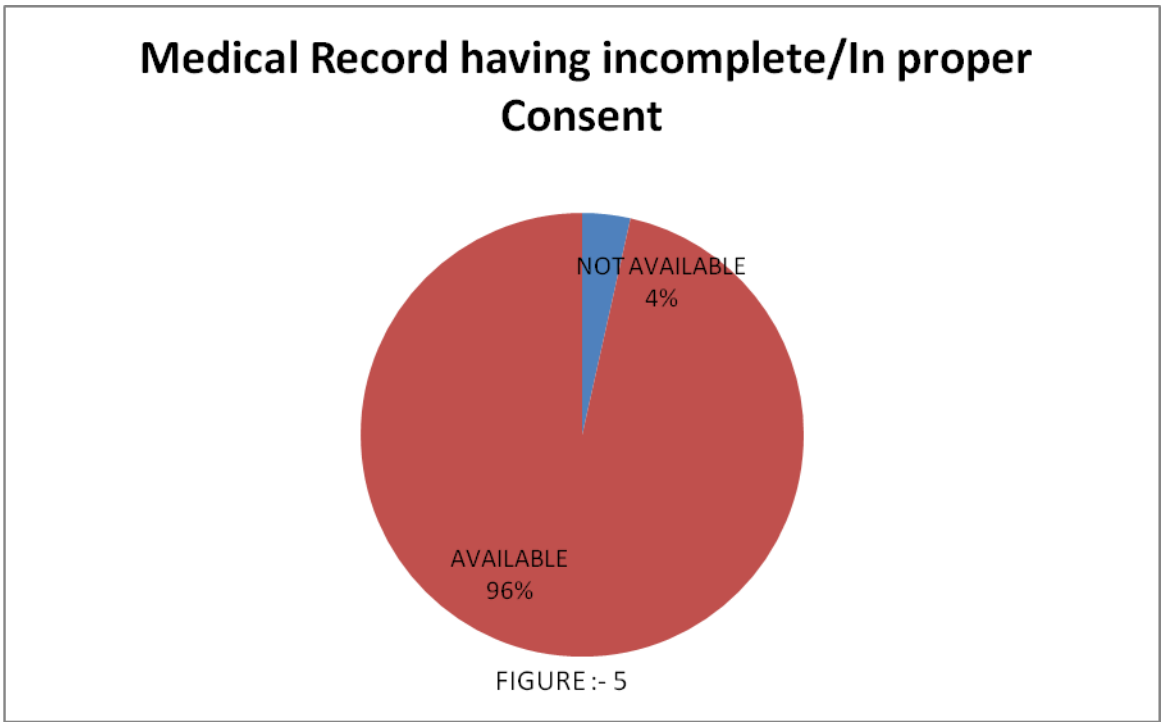


FIGURE :- 5

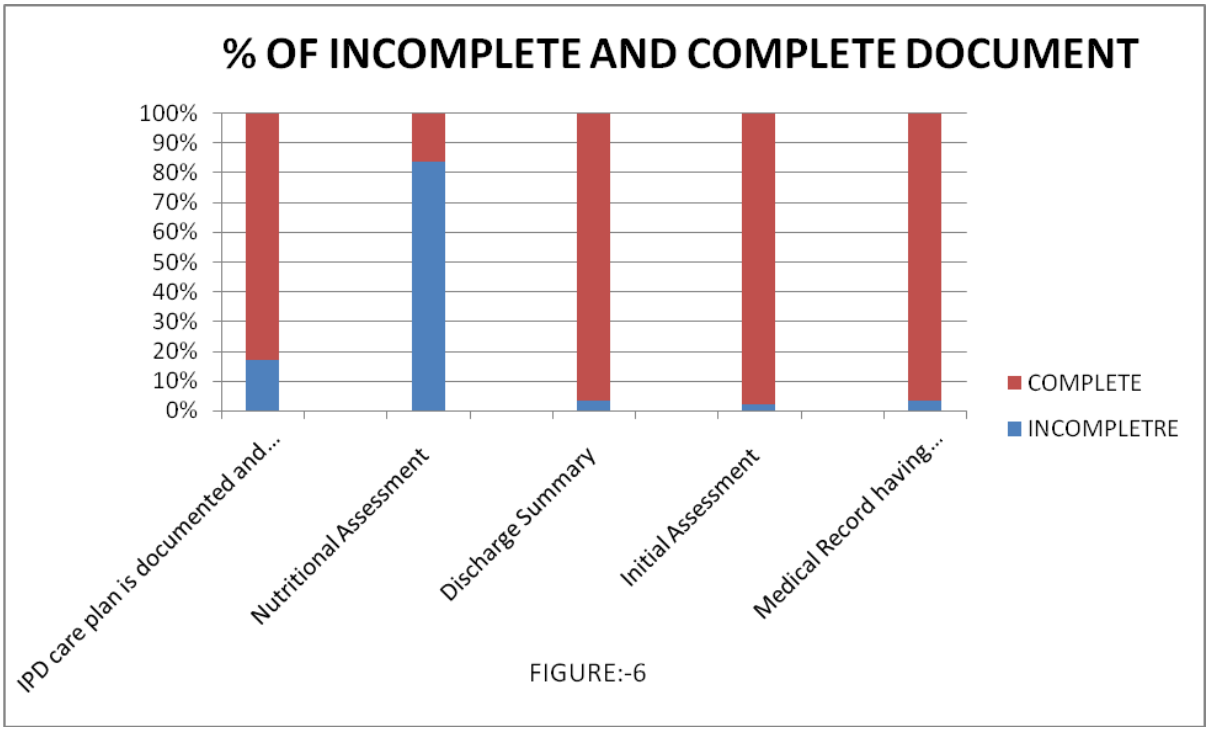


FIGURE:-6

In MRD of Rockland Hospital the all registers are maintain in proper manner and keep in rack. The Onco files are kept according to the UHID No. and IP files according to the IP No. I observed that there is no enough space in MRD and only one ward boy is there.

The location of MRD at fourth floor it is not a suitable for movement of patients file. The computer system is not upgraded and it is too slow which affect the work of MRD work e.g monthly report which is send to the MCD /Directorate of Health Services, delay.

SUMMARY AND CONCLUSION

After study of MRD in Rockland Hospital the following information may be drawn:-

(1)Nutritional assessment by dietician for IPD Patient is not being done properly, Only for those who are very sick or for VIP patient.

(2)In few cases it has been noticed the IPD case sheet does not counter signed by clinician or HOD'S

(3)In some cases discharge summary and initial assessment paper were missing.

(4)Location of MRD should be ground floor or first floor. It will save the time of file movement. There should be enough space in MRD. Because it has to maintain the huge amount of medical records of patient and there is no color coding of file.

RECOMMENDATIONS

I would like to recommend some points which can improve the quality and save the time are follows as:

(1)Dietary Services needs improvement, need to improve nutritional assessment and proper documentation.

(2)Case sheet should properly conter signed by the clinician or HOD'S

(3)Every case sheet must have attached initial attachment as well as discharge summary before sending the fie to MRD.

(4)There should be enough space for MRD and the location should be at ground floor or basement.

(5)Color coding of files as:

MLC and Death files	--	Red
IP Files	--	Green
Onco Files	--	Blue
OPD Files	--	Orange

- There should be two/three ward boy.
- The computer system should be upgraded.

- The files of patients which are coming from nursing station should be in chorological order and complete.

REFERENCES

1)Cashless transaction and receivables mgmt by Dr. Biswendu Bardhan & Dr Aanshu Sharma.

2) A new approach to acute hospital bed management a case study by author Eugene R.Boyer.

3) Tackling teething TPA problem by Priti Pathak.

4) Article on cashless health insurance more pain than gain.

5)Journal of the Academy of Hospital Administration.

(Vol. 17, No.1&2, Jan & June-December 2005.)

6) www.e-gyankosh.com

7) Principles of Hospital Administration and Planning.

(BM Sakharkar)

(8) Quality manual of Rockland Hospital, 2009

(9) Modules on supportive services, IIHMR, Delhi.