THE STUDY ON MEDICAL RECORD DEPARTMENT

CARRIED OUT AT

FORTIS HOSPITAL ANANDPUR

SUBMITTED BY

MONU ANAND

REG. NO. : 151541310014 OF 2015-2018

ROLL NO. : 15403315014

DATE:-

Fortis

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Date- 14th May 2018

TO WHOM IT MAY CONCERN

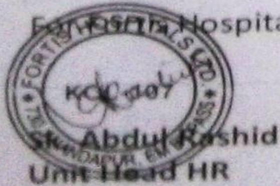
This is to certify that **Mr. Monu Anand** bearing Reg. No- 151541310014 has successfully completed his internship (18th January 2018 – 14th May 2018) from **Fortis Hospitals Ltd, Kolkata Anandpur Unit**, under the **Medical Record Department**.

This internship is for partial fulfillment of his curriculum **Bachelor of Hospital Management** which he is undergoing from the **Dinabandhu Andrews Institute of Technology and Management, Patuli Kolkata.**

During his internship, **Mr. Monu Anand** has been diligent on his assignments. His attendance was full as desired throughout the tenure of his internship. He is found to be honest, sincere and hardworking. We wish his all the success in all his future endeavors.

Yours faithfully,

For Fortis Hospitals Limited



Sk. Abdul Rashid
Unit Head HR

DECLARATION

I do hereby declare that this project work " A Study on Medical Record Department ", at FORTIS HOSPITAL ANANDPUR at Kolkata for 3 months (18TH JANUARY to 18APRIL), submitted by me in practical fulfillment for the requirement of Bachelor Degree in Hospital Management (BHM) from Dinabandhu Andrews Institute of Technology and Management with the collaboration of West Bengal University of Technology (WBUT) is the result of my original and independent research work carried out under the supervision and guidance from Dinabandhu Andrews Institute of Technology and Management .

I further declare that this project work or any part of this has not been submitted by me any where for the award of any degree or other similar title before .

Monu Anand

(STUDENT OF HOSPITAL MANAGEMENT)

ACKNOWLEDGEMENT

I am using this opportunity to express my gratitude to everyone who supported me throughout the course of this training. I am thankful for their aspiring guidance, invatualualy constructive criticism & friendly advice during my training & the project work.

I express my warm thanks to MS. SANJUKTA NANDI (PRINCIPAL MAM) , MR. SUROJIT SARKAR(HOD), MS. MOUMITA AKULI ROY AND MS. PARAMITA BANERJEE (INTERNAL GUIDE OF OUR COLLEGE) ,
MR. SUJAN DHAR (HOD OF MEDICAL RECORD), MR. SOUGATA PAUL & KOUSHIK GHOSH (ASSISTANT OF MEDICAL RECORD) AND MR.PRASANT SIR(HR) for their support & guidance
& all the faculties who provided me with the facilities being required & conductive conditions for my projects.

THANK YOU

MONU ANAND

(HOSPITAL MANAGEMENT 6TH SEM)

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EXECUTIVE SUMMARY:-

I have done this " summer training project on Medical Record department" at Fortis Hospitals Anandapur for 3 months under the guidance of Mr. Sujan Dhar (HOD).

The department observed by me :-

Medical record

INTRODUCTION:

Patient care includes a systematic and chronological record of care and treatment which necessitates the establishment of medical records department in hospitals. The medical record is a storehouse of knowledge concerning the patient.

Today technology is transforming the4 way healthcare is delivered ,managed ,and assessed with a continued shift from record management to data management so MRDs are moving from surveillance and archival functions to prospective functions and process intervention.

THE MEDICAL RECORD Consider that this is an INITIAL evaluation of the problem. A clinician will need to look at the progress notes for any changes in status or treatment.′ The primary MD may provide the initial dictation but then may consult other specialists (pulmonologist, endocrinologist, gastroenterologist, n nephrologist, psychologist, etc) to dictate their assessment′ This is the MD's or consulting MD's initial assessment of the patient and his/her problem when a patient is first admitted to facility or hospital. It may be several pages long and tends to be very thorough. RDs and DTRs should go here FIRST to review!′DICTATION:

1. This is where you will find quick pertinent info (vital signs) like daily weights, temperature, blood pressure, fluid intake, basic idea of pot intake (%), etc. Graphics are usually completed or logged by the nurse.′GRAPHICS:
2. This is where you find the daily orders for tests, procedures, labs, diets, medications, consultant lts, etc. *RDs/DTRs should go to the MD orders to verify and confirm the DIET ORDER as well as supplements!′PHYSICIANS OR MD ORDERS:
3. MD or other specialists follow up with patients daily (more or less frequently) and reassess the patient's progress usually AFTER the initial consultation or dictation. *The RD or DTR will read this section to receive the most up to date review of the patient's status. A patient's status or diagnosis can change′PROGRESS NOTES:
4. This section includes the RN/LDNs review of physical symptoms, patient's functional status, patient's or families' complaints or concerns, etc. *RDs/DTRs may go to this section to find more specific information about

the patient’s dietary intake, appetite, functional ability, orientation, affect, etc.′NURSING NOTES:

5. This includes all lab tests of serum, urine, sputum, stool. *RD/DTR would look here for the most current information (ie, Alb, Hgb, Hct, Chol, etc).′LABORATORY:
6. This will include updated lists of medications the patient is receiving orally and via IV fluids during the hospital stay. You will likely see a list of meds the patient takes at home and perhaps a discharge medication listing. This will also include nursing documentation of date/time the medication is administered.′MEDICATIONS OR MAR (MEDICATIONADMINISTRATION RECORD):
7. Allied health professionals (RDs, pharmacists, speech pathologists, social workers, etc) often include their full assessments and documentation in this section of the chart.′MULTIDISCIPLINARY:
8. This includes reports from radiology, MRIs, scans, EKGs, etc.′RADIOLOGY:
9. Documentation in the healthcare/medical records is crucial and necessary to ensure excellence in healthcare. The saying “if you didn’t document it, it didn’t happen” is common in the healthcare setting. Documentation is a legal record that must hold up in defense and justification of care. It is required!′MEDICAL RECORD DOCUMENTATION
10. 1. Documentation must be in black pen---no pencils or erasing should ever be used,2. If mistakes occur the practitioner must mark through the error with one line, add the word “error”, initial beside the error, and add the correction.3. Abbreviations must be approved by the facility---you are not allowed to make up your own!4. All documentation must be dated5. There should be no large gaps (blank space) between entries in a medical record6. Do not express your personal opinions or make criticisms of the patient or other caregivers. Remember that others are reading your notes!7. Date all entries---Sign all entries with your title8. Be BRIEF, be THOROUGH, be ACCURATE!9. Do not make a suggestion of medical diagnosis—that is not in your scope
11. There are various forms of medical record documentation. Regardless of the format the information included or reviewed is consistent in all forms.′TYPES OF MEDICAL RECORDDOCUMENTATION
12. A system of collection data that focuses on the primary client problems. A problem list is generated, updated, and continually reviewed. The plan addresses this problem list.′PROBLEM ORIENTED MEDICAL RECORD(POMR)

13. Often a brief notation as a followup to an original assessment. This note will review the problem, evaluate the effectiveness of plan, and indicate change. Progress notes are documented at pre-established intervals (daily, twice a week, monthly, etc).′PROGRESS NOTE:
14. Many physicians and health care providers document in this format and it is easy to follow. Some facility use pre-printed forms and practitioners fill out the blanks. Others simply provide lined sheets that the provider will simply write out S: then info, O: then info, on so on.′ Acronym for Subjective, Objective, Assessment, Plan (see handout on Basics of Soap Documentation).′SOAP:
15. The provider writes out information about the patient in an organized way (similar data clustered together). Often this is in long phrases or sentences reviewing the patient's problems.′NARRATIVE FORMAT:
16. Similar to SOAP but without the subjective component (all data, whether subjective or objective is clustered together)′DAP (DATA, ASSESSMENT, PLAN):
17. Intervention: the "actions" to address problem (food delivery, education/counseling, coordination of care)′ Diagnosis: Includes a PES statement that is "pulled" from 3 domains (intake, clinical, behavorial /environmental)′ Assessment: ABCD and pertinent client history′ADIME: This type of charting follows the Nutrition Care Process steps. Facilities may decide to order notes in this format OR address the initial problem of the patient (in acute care).
18. Evaluation: Have desired outcomes been achieved? How will this be tracked? On what time farm ′ Monitoring: what will be "tracked" or followed— loop back to the Assessment data terms (but not all are selected!)′CONTINUED. . .

OBJECTIVES OF THE PROJECT:

- To get overview of the entire system prevailing in the hospitals.
- To study the workflow and functions of various departments of the hospital.
- To know the procedures followed in the hospital.
- To record the staffing pattern and gather information about the responsibilities of the personnel.
- To find the drawback or deficiencies (if any) of the department.
- To suggest few recommendation for the existing problems; an approach for addressing and dealing with loop holes with efficiency and effectiveness.

METHODOLOGY:-

The methodology of my assignment is purely based on personal observation on the working activities of the Human Resource Department and other department.

NATURE OF DATA:-

Primary data

The primary data has been collected through personal observation.

Secondary data

The secondary data has been collected from t hospital information system.

HOSPITAL PROFILE:-

Fortis Hospital Anandapur

Fortis Hospital, Anandapur, Kolkata is a world-class super-specialty NABH accredited tertiary care healthcare hospital. The 10-storied, 400 bed hospital is built on a 3 lakh square feet area, equipped with the latest technologies in the medical world. This state-of-the-art facility specializes in cardiology and cardiac surgery, urology, nephrology, neurosciences, orthopedics', digestive care, emergency care and critical care. Among the various amenities, the hospital has a 24-hour accident and emergency service including trauma treatment, critical care ambulance service, blood bank, cardiac operation theatre, preventive health check, diagnostic and catheterization laboratory, critical and emergency care, diet counseling, physiotherapy and rehabilitation, laboratory and microbiological services, stress management, 24x7 pharmacy, endoscopy unit and emergency room.

The intensive care unit (ICU) is well-equipped with over 70 beds that include a Medical Intensive Care Unit (MICU), Coronary Care Unit (CCU), and recovery and isolation beds, with separate high-dependency units. The hospital also has a nephrology department with over 28 advanced dialysis units. The hospital,

governed by integrated Building Management System (IBMS), has a pneumatic chute system, for quick vertical and horizontal transportation between floors, facilitating speedy transfer of patient specimens, documents, reports, and medicines to the concerned departments. This saves time for rendering effective and efficient healthcare to the patients.

VISION

"Saving & Enriching Lives

MISSION

"To be a globally respected healthcare organisation known for Clinical Excellence and Distinctive Patient Care"

PURPOSE

“To create a world-class integrated healthcare delivery system in India, entailing the finest medical skills combined with compassionate patient care”

OBSERVED DEPARTMENT

MEDICAL RECORDS DEPARTMENT

NAME OF THE DEPARTMENT:-

Medical Record Department

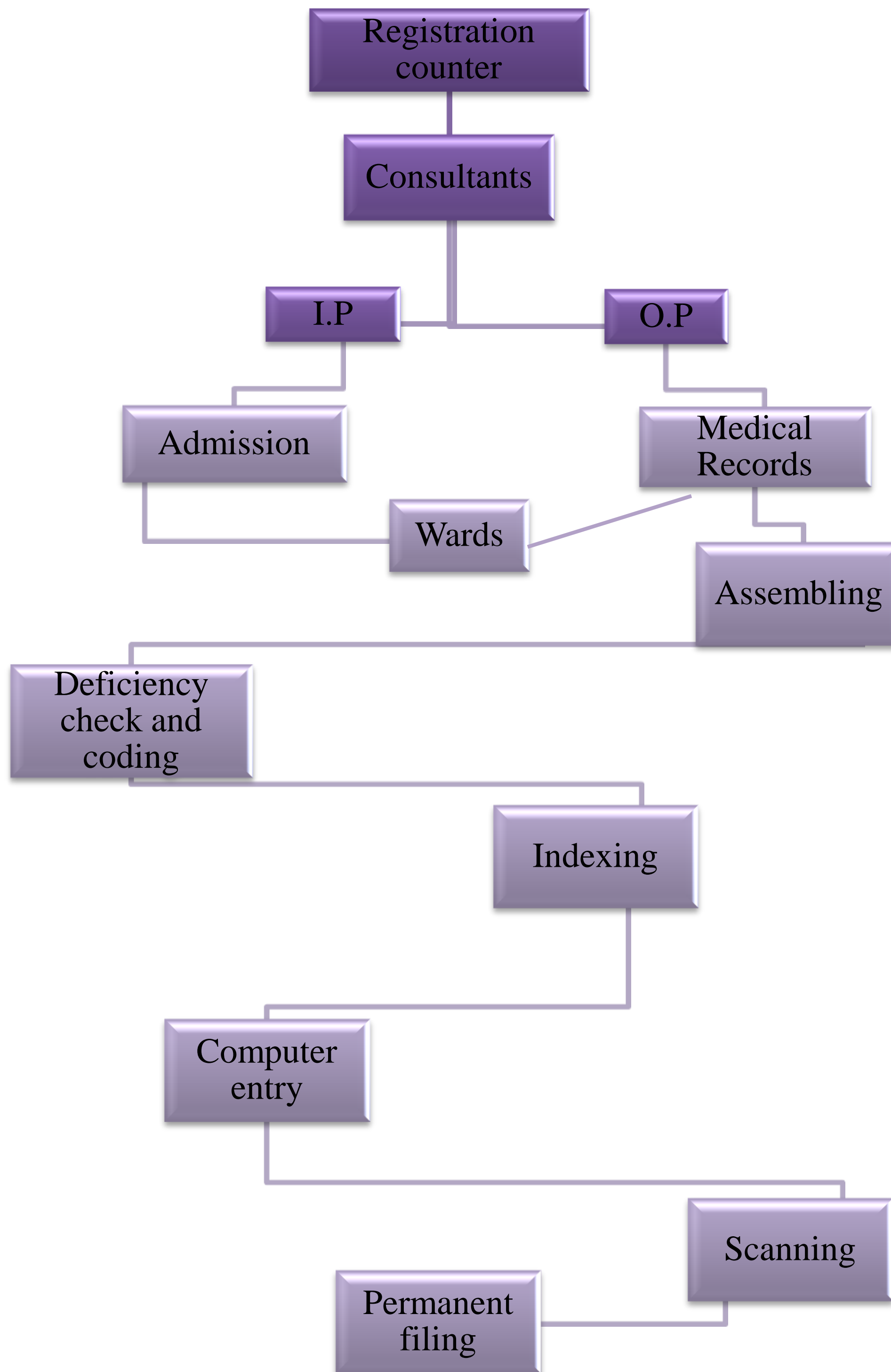
LOCATION OF THE DEPARTMENT:-

Medical Records Department is situated on 3rd level, side of administration block.

OBJECTIVES OF THE DEPARTMENT:-

- To study the functions of the record department of the hospital.
- To assess the daily TPA/CORPORATE/CASH PATIENT REPORT.
- To evaluate methods of the discharge file with proper filing (with ICD Code).
- To identify the gaps of the maintenance of the MR.
- To provide probable suggestions.

WORKFLOW OF MEDICAL RECORD DEPARTMENT:-



STAFFING:-

- Senior M.R.D Facilitator.
- Junior Facilitator.
- Trainees.

PHYSICAL FACILITIES:-

- Personal Computer
- Photocopy machine
- Printers
- Desk phone and intercom.

LAYOUT OF THE DEPARTMENT:-

Layout of Medical Record Department(3rd floor)

-

DAILY ACTIVITY OF MEDICAL RECORDS DEPARTMENT

⇒ Early morning during the work hours printouts of the previous day discharges list is taken from the 'HIS' system. The patient records are collected and taken to the Medical Record Department.

⇒ Medical Record Facilitator is the responsible person for performing the daily retrieval of Records. The Process is known as 'Internal' audit which includes:

∗ OPEN RECORD REVIEW (which may include 'Active Record Review' For special findings) (refer page no. 25)

∗ CLOSED RECORD REVIEW. (refer page no. 29)

⇒ Last days retrieved Patient's records are assembled in the specific order. Particular department is been informed if there are any missing papers, the Patient's document is been kept on hold until the rightful papers are been collected.

⇒ Records are been arranged in the following order referrer (PG No– 24) and only responsible persons are allowed access and make the appropriate entries.

⇒ After the files are documented then the diseases are Coded by ICD – X (System). (refer page no. 33)

⇒ Records are Filled in appropriate rack with According to the MRD received number.

⇒ All the rack are numbered serially.

⇒ The MRD Received numbers of the files in the rack are displayed on each shelf.

⇒ Medico-Legal files are marked with a green sketch pen with MLC (Medico Legal Case) written on it.

⇒ Expired patients files are filed in a separate rack with Ex written on it. Entry of expired patients files are maintain in a Death register. The copy of the Cause of Death certificate is kept with the nursing supervisor and once the book gets over the same is sent to the MRD. One copy of the Cause of Death certificate is also maintained in the indoor case file.

⇒ Municipal Death certificates are issued by the KMC (Kolkata Municipal Corporation).

- Statements are prepared for the expired patients of the previous moth.
- Same is been tallied with the wards register.
- After confirmation the Medical Records Death Register is been updated.

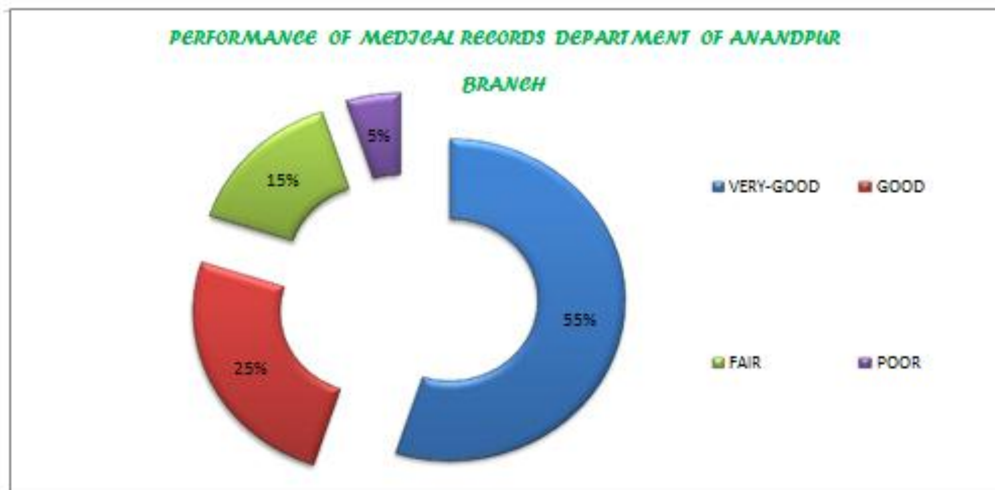
REGISTERS MAINTAINED IN M.R.D

REGISTER NAME	REGISTER CODE
Pathology Register (IP) -	FHL-A-MRD/01/PR
Radiology Register (IP) -	FHL-A-MRD/02/RR
Cath lab Register (IP)-	FHL-A-MRD/03/CR
Outgoing Register-	FHL-A-MRD/04/OUTR
Death Register-	FHL-A-MRD/05/DR
OT Register-	FHL-A-MRD/06/OR
Birth Register-	FHL-A-MRD/07/BR
Birth Intimation Register-	FHL-A-MRD/08/BIR
Death Intimation Register-	FHL-A-MRD/09/DIR
DAMA Register-	FHL-A-MRD/10/DAR
Document Handover Register-	FHL-A-MRD/11/DHR
MRD Entry Register-	FHL-A-MRD/12/MER
Oncology Register-	FHL-A-MRD/13/ONCO
Oncology Intimation Register-	FHL-A-MRD/14/OIR
Daily Census Register-	FHL-A-MRD/15/DCR

DATA COLLECTION

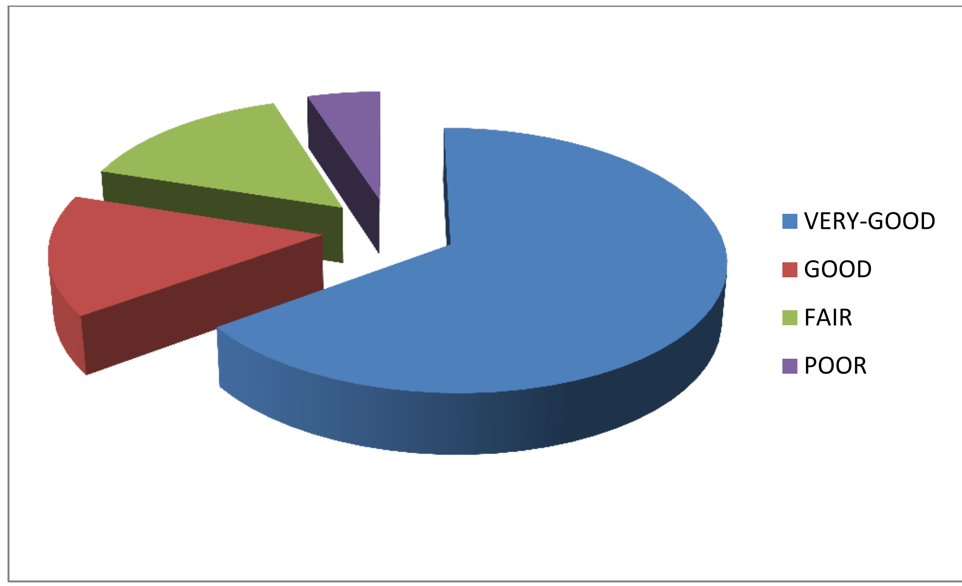
PERFORMANCE OF MEDICAL RECORDS DEPARTMENT OF ANANDPUR BRANCH : -

VERY-GOOD	GOOD	FAIR	POOR
55	25	15	5



2. QUALITY OF SERVICE RENDERED WITHIN TIME BY MEDICAL RECORDS DEPARTMENT :

VERY-GOOD	GOOD	FAIR	POOR
65	15	15	5



PROBLEMS AND RECOMMENDATION:-

- Not recording negative findings
- Not recording substance of discussions about the risks and benefits of proposed treatments
- Not recording the results of investigations and tests
- Illegible entries
- Not reading the notes when seeing a patient
- Wrong patient/wrong notes.
- Out-patient records not linked with in-patient records to be preserved for 5 years.
- Out-patient records linked with in-patient records to be preserved for 10 years.
- In-patient records to be preserved for 25 years.
- All medico-legal cases to be preserved for posterity.
- All medical records other than those mentioned above to be disposed off on a regular basis.
- All old X-rays relevant to the out-patient files that are being disposed off to be destroyed.

CONCLUSION:

After a training of 90 days in Fortis Hospital, Anandapur. I have observed & learnt that running a hospital is not that easy. Some of the best Hospitals in Kolkata are now considered as among the best in the world. These hospitals have reached this stage due to their highly dedicated medical staff and their zeal to deliver the best treatment to their patients. Apart from that, there are some other reasons due to which a significant number of patients, from all over the world, visit these hospitals to get treated.

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THANK
YOU