c. Personal management

d. Inter-departmental coordination

e. Public relations

f. Government relations

g. Community activities

h. Research and developmental activities.

Manager/Administrator's job: Planning, organization, directing, controlling. He has to understand and interpret medical, financial, economic, functional, logistic matters and possess excellent personnel management.

Manager is an expert in the act of getting things done after assimilating, reconciling and synthesizing all the things. He may have to follow expediency rather than example many times.

Suggestion schemes, house journals, news letters, informal get-togethers, keeping the communication open and help in coordination, management and administration. Change must be planned and coordinated.

An effective manager has to cultivate: Positive attitude, effective communication, creative orientation, high motivation and commitment.

Hospital may mean different things to different groups of people at different times. To the hospital manager or administrator it is an organization requiring management of people and services.

To summarize, one can see that evolution of hospital as a public facility has many connotations. At the moment also different types of hospitals, care to different needs of patients. However, an unwelcome change that troubles both doctor and patient are an unwitting transformation of patient into a consumer and the medical messiah into a business executive.

With the authoritative stamping of the Supreme Court, paid medical services come under purview of the servicing of public grievances redressal. While on the one hand sophisticating equipment and modernization provides better facilities to the patients on the other the corporate transformations are changing the scenario of the present medical services from patient oriented care to technically and corporation-oriented and expensive medical practice.

Governmental agencies have come up with medical insurance scheme followed by many private operators. The medical services in India are rapidly undergoing changes similar to what happened in USA many decades ago.

Whether this change helps in bringing up better medical care or not, time only can decide. American experience appears to be not that buoying.

KEY LEARNING POINTS

- Hospital was aimed at the care of the poor and the destitute.
- Hospital is an open system.
- Hospital is different from other institutions as it is directly exposed to public.
- In 17C (1664) at Chennai—the East India Co. started its first hospital. First medical college started in 1835 in Calcutta.
- Prevention and control of locally endemic diseases.
- OPD clinics can have integrated screening or filter clinics which can dispose cases that do not require specialist attention.
- Problem can be solved to a great extent by improved organization, delegation, task allocation, communication, motivation and discipline.
- Hospital may mean different things to different groups of people at different times.

6. Census reports
7. Medicolegal cases

IV. Ward maintenance register
1. Equipment
2. Sanitary
3. Ward maintenance
4. Pantry, etc.

V. Attendance registers of working staff in the ward.

VI. Nurse treatment register (day and night report of the condition of patient)

Nurse treatment register

Nurse treatment register includes day and night reports where special instructions regarding treatment to patients are noted to serve as a guide for doing duty. To improve the patient care in the wards:

a. By providing ward secretary to work on par with the nursing staff
b. Paramedical departments like pharmacy, dietary, linen, CSSD, laundry, medical records, laboratories, X-ray department, etc. should take the recording work from the nursing staff by maintaining the ward registers by the individual department.
c. Doctors, technicians and other staff on duty should be available at a moment's notice in times of emergency calls.
d. By supplying minor items essential for day to day work
e. By increasing nursing staff according to types of hospital/ward and bed strength if the work of the ward is to be done only by nursing staff
f. Doctors and nurses are expected to see that the paramedical and nonmedical departments function effectively and work on par with the nursing staff round the clock throughout the year.

Mental health records

Mental health records have to meet in the long-term because of its unique characteristic nature of care and treatment. The mental health record is also a basic source of information for study and evaluation of the care rendered. The mental health record should contain pertinent clinical information, which at a minimum should consist of:

1. Identification data
2. Source of referral
3. Reason for referral
4. Admitting psychiatric diagnosis
5. Psychiatric history
6. Record of the complete assessment including the complaints of others regarding the patient as well as the patient's comments
7. All appropriate consents for admission, treatment, evaluation and after care
8. Patient's legal status
9. Provisional diagnose based upon assessment which includes intercurrent diseases as well as the psychiatric diagnoses.
10. Written individualized treatment plan
11. Medical history, report of physical examination and record of all medication prescribed
12. Documentation of the course of treatment and all evaluations and examinations
13. Multidisciplinary progress notes related to the goals and objectives outlined in the treatment plan
14. Information on any unusual occurrences such as treatment, complications, accidents, or injuries to the patient, morbidity, death of patient procedures that place the patient at risk or cause unusual pain
15. Discharge or termination summary
16. Individual aftercare or post-treatment plan
17. Plan for follow-up care and documentation of its implementation.

Assessment

a. Physical assessment: It should includes medical, alcohol, and drug history and an appropriate laboratory work-up. In inpatient programs, a physical examination must be completed within 24 hours of admission

b. Emotional assessment and behavioral assessment: These are history previous emotional behavioral and substance abuse problems and treatment. Patient's current emotional and behavioral functions are assessed.

c. Social assessment: It should include information related to the patient environment and home, religion, childhood history, occupational history, financial status, social, peer group, and environmental setting from which the patient comes, and the patient's family circumstances including the family constellation and current living situation.

d. Legal assessment: It is unusual but documented when the legal situation affects the patient care.

e. Nutritional assessment: Patients being treated for eating disorders or patients having physical conditions which require special diets should have a nutritional assessment.

- Anesthesia record
- Operation report form
- Investigation request and report forms
- Blood transfusion request form
- ECG form
- EEG request and report form
- Paramedical services record
- Nurses notes form
- TPR chart
- Fluid balance chart
- Medical record folder
- Laboratory mount sheet
- X-ray mount sheet | and discharge summary form

Rights and Responsibilities of a Patient

Patient's Rights

- Considerate and respectful treatment from all staff in the hospital and to receive safe care at all times
- Complete, current information concerning his diagnosis, treatment and prognosis in terms that the patient can reasonably understand
- Information for informed consent from his/her physician prior to start of any procedure or treatment
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of his/her action
- Privacy concerning his/her own medical care program
- All communications and records pertaining to his/her care confidential
- To accept his/her willingness to be transferred to another hospital
- To be advised if the hospital. Proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects
- Reasonable continuity of care. He/she has the right to know the advance the names and professional status of the people treating him/her and the physician responsible for his/her care
- The patient has the right to complain to appropriate authorities if complications arise in his/her care
- Examination in privacy and to have a person of the same sex present when being examined or treated by someone of the opposite sex
- To obtain assistance in communicating with people treating him or her in another language.

Patient's Responsibilities

- Give correct and full identification information, full name, age (date of birth), occupation, father's/husband's name, nationality, and complete address including telephone number.
- Regarding his/her previous visits to hospitals and to furnish information regarding present complaints, past illnesses hospitalization and medications.
- Keep the appointment card safely and to produce this card whenever he or she visits the hospital or health clinic.
- Inform the hospital authorities about the loss of a hospital number card so as to retain the correct hospital number.
- Visit the hospital at the day and time of appointment and to avoid going to hospital without prior appointment except in the case of an emergency. If the patient is given a follow-up appointment for future visits, he or she should register and obtain a date and time for the next visit before leaving the hospital.
- Report only to authorized staff in the hospital for his/her appointments.
- Observe the rules and regulations and strictly follow instructions of the hospital and never remove hospital record except the patient appointment card and specific documents given to the patient.
  - Avoid making wrongful alterations in his/her records, to avoid giving wrong information or producing wrong documents such as bringing records of other patients when seeking personal care.
  - Be respectful of the rights of other patients and of the hospital staff by assisting in the control of noise, and by limiting the number of visitors, wherever necessary.

Legal Aspects of Medical Records

Each medical record reveals information always centered around a patient who may be a man or woman or a child. The patient is the recipient of the medical care, which is offered to him by a team which usually consists of doctor, the nurse and the paramedical worker. This care is offered by the team to the recipient in a particular location, this being the hospital. All activities by the team in this location are for the benefit of the patient and this is recorded, thus making the existence of the hospital medical record possible. This necessitates keeping a chronological record of the care and treatment rendered by the personnel. Medical record must be safely guarded from unauthorized persons. This is used either as personal or impersonal document.

Duplicate file

- Receive the duplicate file for patients whose file is missing
- Make an entry on the list regarding the duplicate file and observe the same procedures as those adopted for other types of cases.
- Separate the duplicate record note from the file after the patient has been seen by the physician.
- Refer the duplicate record note to the medical record officer personally.

Casualty Number Control

- Allocate block of 2000 casualty numbers at a time to the casualty registration section.
- Enter the name of the employee who received the numbers and obtain his/her signature for having received the numbers.
- Verify periodically the casualty register and pre-numbered casualty treatment forms to ensure that the allocated numbers are properly used.
- Allot new blocks of casualty numbers two days prior to exhausting the numbers.

Admission of Patient

- *New cases*: Send the admission request form along with the casualty treatment form to central registration for verification and issuance of a new patient file.
- *Established cases*: Send the written request slip for retrieval of the file to the medical record library if the patient file is not available in the casualty service.
- Obtain new or old files, as the case may be, to verify whether the files actually belong to the same patient.
- Send the files with a porter to the admissions office (ask the patient or relatives to accompany the porter) for completion of the admitting formalities.
- Make a note of the admission in the casualty treatment record and in the casualty register.
- During off hours and on public holidays especially in small hospitals the functions of central registration and the admissions office are performed by the casualty registration section. The procedures prescribed for registering and established cases must be observed.

Patient's death in the casualty service.

Ensure that the casualty treatment form of the patient's unit is completed with all required details of the death.

Obtain the death notification forms duly filled in and signed by the authorized physician.

Medicolegal Cases

Ensure that all prescribed medicolegal forms are used for all the medicolegal cases

Ensure that all medicolegal cases are registered in the central medicolegal register.

Ensure that all MLC stamps are affixed on the file.

Inform the police by sending them the necessary information in prescribed form.

Collect and file separately the medicolegal form.

Observe the procedures as prescribed for medicolegal cases.

Basic Admission form Set

- Admission and discharge sheet
- Consent to operation and investigations
- History and physical examination form
- Progress notes form
- Physician's orders
- Nurses notes
- TPR chart
- Discharge summary form

Direct Admission

Admission from the casualty
Waiting list of admissions
Admission of livebom cases
Admission of medicolegal cases

- Enter a notation of MLC in the admission register corresponding with the name of the medicolegal case admitted,
- Inform the treating physician if the case is suspected to be medicolegal, but is not registered as a medicolegal case in the hospital.

Submission of Admission List

- Enter all the admission of the day on the admission list,
- Prepare five copies of the admission list and distribute to the following:
  - Medical record library
  - Hospital central inquiry
  - Statistical section
  - Computer section
  - Accounting section

Discharges

Receive the patient's file from the ward and verify the file with patient or relative to ensure that the record belongs to the same patient.