REPORTS AND RETURNS BY THE RECORD DEPARTMENT

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Hospital Information System (HIS) is dependent upon the well-established reporting system of medical record department.

The reports are required for the following purposes:

1) For evaluating the quality of medical care
2) For identification of deficiency in care
3) Increase the effectiveness of hospital administration.
4) Prevention and control of disease
5) Surveillance of diseases by the public health authorities as hospital serves as sentinel surveillance entrées for many diseases
6) Collection, recording and reporting of vital statistics
7) Provide morbidity, mortality data to public health authorities
8) Assess the utilization of hospital facilities
9) Planning of hospital, and health care delivery systems to the community
10) Prioritization of health problems.
11) Monitoring and evaluation of health care

Reports

Following types of reports are prepared by the medical records department:

Reports relating to work load:

1) Total number of out patient
2) Total no. of new cases
3) Total no. of follow up cases statistics.
4) Total no. of operations
5) Total X-rays done
6) Total investigations done
7) Department-wise work load breakup

Report relating to hospital care:

1) Postoperative Infection rate
2) Postoperative complication rate
3) Caesarean section rate
4) Consultation rate
5) Autopsy rate
6) Rate of normal tissue removed
7) Rate of disagreement between final diagnosis and pathological diagnosis
8) Result of treatment

Report relating to Admission of patient:

1) Daily admission
2) Unit wise daily admission
3) Total admission during the period
4) Distribution of patients by Age, Sex, race, geographical area

Report relating to Hospital beds:

1) Daily census of hospital
2) Maximum patient on any day
3) Minimum patients on any day
4) Average daily attendance
5) Bed Occupancy Rate (BOR)
6) Total patients days care
7) Bed turn over interval

Reports relating to discharges:

1) Daily discharges
2) Total patients discharged over a period
3) Days of care to patient discharged
4) Average Length of Stay (ALS)

Reports relating to Deaths:

1) Daily number of death
2) Total deaths over a period
3) Total deaths under 48 hours
4) Total death over 48 hours
5) Net death rate
6) Gross death rate
7) Faetal death rate
8) Maternal death rate
9) Infant death rate
10) Postoperative death rate

ICD

Introduction

- It is the international "standard diagnostic tool for epidemiology, health management and clinical purposes
- It is maintained by WHO.
- Published by WHO. Used worldwide for morbidity and mortality statistics, reimbursement system and automated decision support in health care.

Objective

- This system is designed to promote international comparibility in the collection, processing, classification and presentation of these (morbidity and mortality)statistics.

HISTORY

- In 1860, first model of systemic collection of hospital data was proposed.
- In 1893, Jacques Bertillon introduced bertillon classification of causes of death.
- In 1898, APHA (American Public Health Association) adopted this classification.
- It was recommended to revise this system every 10 years.

- As a result, first international conference to revise international classification of causes of death took place in 1900.
- Thereafter revisions occur every 10 years.
- With the 6th revision classification system expanded to two volumes.
- WHO proposed eighth edition in 1968.
- Later it became clear that 10 year interval is too short.

Why the Need for ICD-10

- ICD-9 does not facilitate the continued need for greater coding detail and cannot continue to accommodate the addition of necessary diagnostic codes.
- HIT (Health Information Technology) brings with it the need to enhance the diagnostic code set to meet the international standards for which ICD was created.
- The ICD-10 code set will allow for greater measurement and tracking of quality outcomes.

ADVANTAGES of ICD-10

- Monitor the incidence and prevalence of diseases and other health problems.
- It helps classify the diseases and other health problems recorded on many types of health and vital records.
- Enable the storage and retrieval of diagnostic information for clinical, epidemiological and quality purposes.
- It is used for reimbursement and resource allocation decision making by countries.

WHY is the ICD important?

- Because it provides a common language for reporting and monitoring diseases.
- It allows the world to compare and share data in a consistent and standard way-between hospitals, regions and countries and over periods of time.
- It facilitates the collection and storage of data for analysis and evidence-based decision- making.

Why is the ICD being revised?

The ICD is being revised to better reflect progress in health sciences and medical practice. In line with advances in information technology, ICD-11 will be used with electronic health applications and information systems.

THANK YOU