

Role of Medical Record Department in Hospital Management

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Abstract: *The Medical Record Department plays a multifarious role in the overall operation of the hospital and is an essential part of hospital management. Its primary duties are the careful monitoring of patient records, which includes the compilation, arrangement, and upkeep of thorough medical histories. The department helps medical practitioners provide prompt, well-informed patient care by guaranteeing the accessibility and quality of these records. In addition to its direct clinical influence, the department is essential to legal and regulatory compliance; it maintains HIPAA and other privacy standards and helps the institution meet accreditation requirements. In terms of finances, the department supports revenue cycle management by offering accurate coding for billing needs.*

Additionally, the Medical Record Department supports clinical improvements and provides data for studies, making it a priceless resource for research and teaching. The department's responsibility for crisis management includes catastrophe recovery and continuity planning, which guarantees the durability and accessibility of patient records. To put it simply, the Medical Record Department is a crucial aspect of hospital administration because it connects the dots between effective patient care, legal compliance, financial stability, and continuous quality improvement in healthcare.

Keywords: Medical record, Hospital, Management, Patients

I. INTRODUCTION

To ensure patient safety, X-rays, specimens, medication records, and patient registrations need to be properly managed. Similar to this, maintaining organized and easily accessible storage spaces for unnecessary data allows them to be moved or destroyed on a regular basis, and expediting the process of finding important information can save time and money. The medical record serves as the patient's only source of accomplishment history, a gauge of the quality of care provided by the medical and nursing personnel, a chronicle of the patient's progress, and a repository of information for numerous other uses. This study presents a methodical discussion of the concept, meaning, and limitations of medical records in general, while accounting for their benefits.

The goal of healthcare is to promote, preserve, and restore physical health through a complex web of organizations, individuals, institutions, and actors. Healthcare decision-making is difficult due to its complexity, but it is crucial due to the high stakes: hospital administrators must provide quality care with limited resources while producing sustainable revenues, and physicians must act swiftly when their patients' lives are in jeopardy. Developing policies that impact the whole healthcare system requires policymakers to manage competition for limited resources, adhere to current laws, and comprehend opposing priorities.

Medical records are the methodical recording of a patient's social and personal information, medical history, clinical findings, investigations, diagnosis, prescribed therapy, follow-up notes, and results. The hospital administrator's eyes and ears are provided by the medical records that are used to create hospital statistics. The hospital needs medical records to assess its services and provide better patient care. They also provide a foundation for clinical research and are a resource for medical professionals' education and training. Scientifically documented observations that are represented in the medical record are necessary for research to be effective. Furthermore, it is commonly known how important medical records are in terms of legal matters.

II. MEDICAL RECORD

The "who, what, why, where, when, and how of the patient care during hospitalization" is recorded in a medical record. A patient's medical record is their only source of achievement history, a gauge of the care they received from medical and nursing professionals, a record of their development, and a source of information for a variety of health-related needs. When combined and organized, medical records serve as a tool for the hospital to measure the effectiveness of its services as well as the areas that still require work. They also provide statistics for improvements in the quality of healthcare delivery. Medical records offer the data required to create, implement, and evaluate organizational policies; choose between options with knowledge; establish accessibility and accountability; safeguard individual rights; and uphold legal requirements.

A distinct, well-stocked medical records department is maintained by every reputable hospital and health facility. Medical professionals will undoubtedly be unable to provide the best care and may even misdiagnose a patient, leading to unanticipated health effects, in the absence of accurate, thorough, current, and accessible medical records. The efficient operation of a hospital's administration is ensured by good medical records management. In order to maintain clear and accessible storage locations and to ensure that important data are readily located to conserve time and resources, it is important to transfer or destroy unnecessary records on a regular basis. Medical records are sensitive and important, which presents a number of issues for administrators of healthcare facilities. The most frequent problems are with access, storage, security, and safety of recordings. Hospitals with mostly manual medical record systems frequently experience storage issues. Conflicts about who owns and has access to a patient's record might occasionally arise as a result of access to medical records. In the realm of electronic healthcare, electronic tools including emails, digital imaging, telemedicine, and the Internet are becoming essential for business transactions. Electronic medical records, or EHRs, reduce clinical error rates while also enhancing information access and healthcare quality.

III. ROLE OF MEDICAL RECORDS IN HOSPITALS

As the keeper of patient health records, the medical record department is essential to the efficient operation of the hospital. Its principal duty is the painstaking compilation, arrangement, and upkeep of thorough medical records for every patient. The department helps medical professionals provide the best possible care for their patients by guaranteeing the accessibility and quality of these records. In addition, the Medical Record Department is essential to legal and regulatory compliance because it helps with accreditation standards and complies with privacy laws like HIPAA. The department provides correct coding and billing support, which positively impacts the hospital's financial health. It supports quality improvement programs and improves patient outcomes through data analysis and audits.

The department also offers important data for studies and clinical trials, supporting both research and instruction. Its responsibilities also include continuity and disaster recovery planning, as well as emergency patient record protection. To put it simply, the medical record department plays a critical role in hospital administration by guaranteeing patient data confidentiality, accessibility, and integrity while also improving overall productivity and standard of care.

IV. LITERATURE REVIEW

Isfahani SS, Bahrami S, Torki S. (2013) The relationship between job features and intrinsic motivation in hospital medical record staff was examined in a study article titled "Job characteristic perception and intrinsic motivation in medical record department staff." The importance of human resources in service organizations like hospitals was also discussed in this study. As a result, it's critical to inspire human resources to meet organizational goals.

Al-Jafar E. (2013) Patient satisfaction with the quality of services received before and after the implementation of electronic health records (EHRs) at Primary Health Care Centers (PHCCs) in Kuwait was examined in the study titled "Exploring patient satisfaction before and after electronic health record (EHR) implementation: the Kuwait experience." According to this survey, prior to the use of EHRs, more than thirty percent of respondents disagreed about the care with which a doctor conducted an examination, how they used medical terminology, why they gave a patient medication, and how much time they spent with them. After the adoption of the EHR, disagreement increased on the remaining items concerning the patient-physician interaction (from 25% to 39%).

Nahid Tavakoli, Sakineh Saghainnejad, Mohammad Reza Habibi (2012) According to the findings of "A comparative study of laws and procedures pertaining to the medical records retention in selected countries," hospitals in

Iran are confused by the absence of a comprehensive, clear, and up-to-date medical record retention schedule. *Bali Amit, Bali Deepika, Iyer Nageshwar and Iyer Meenakshi (2011)* The many facets of record maintenance were described in the paper "Management of Medical Records: Facts and Figures for Surgeons." One of the most crucial factors that determines whether a medico-legal case is won or lost is medical records. Correctly drafted notes will help the physician argue that the course of therapy is appropriate. Even though people in India are aware of how important it is to maintain accurate records, the practice is still relatively new.

Thomas Joseph (2009) numerous approaches to record keeping were mentioned in his research work on "Medical records and issues in negligence stated about various methods." Most hospitals in India still maintain their data manually, using books and paper. This is the conventional approach. Manual record keeping has significant drawbacks, such as the requirement for sizable storage spaces and challenges with record retrieval. However, because it is impossible to tamper with the records without being discovered, it is more legally acceptable as documented proof.

Mestri Shashidhar (2009) Medical records are an institution's index, and the medical records department is the foundation of the health information system, according to C in his research "Legal and Ethical Aspects of Medical Records - An Indian Perspective." Medical records include a wealth of information regarding hospital history, current and past statistical analysis, patterns in hospital admissions, etc. Medical records serve as an expanding repository of scientific and medical knowledge and assist the government in budgetary planning and distribution for the nation's healthcare system. It is imperative that medical records be stored uniformly in accordance with numerous Acts.

Praveen Kumar A, Gomes L.A. (2006) The current situation in India is that the majority of the medical records department is partially computerized, according to their study, "a study of the hospital information system (his) in the medical records department of a tertiary teaching hospital." The hospital's survey indicates how important it is for departments to share information with one another. The computerization of medical paperwork and records has led to effective data management and user information distribution. The investigation also came to the conclusion that a contemporary, computerized information system is not too far off.

Chattoraj, S. Satpathy, R.K. Sarma (2005) Patient care comprises a chronological record of care and treatment, specifically medical records, according to the paper "Standardizing Medical Records Forms: A Study at a Tertiary Super Specialty Hospital." Hospital-developed printed performs are frequently utilized to establish consistency and regularity in the documentation and display of data. Medical record keeping requires a steady stream of well-designed forms, which must be provided smoothly. This study showed that the number, color, content, and size of forms are not uniform. Numbers are only present in fundamental forms. There are too many sizes in use. When one uses the same color in excess, it can become difficult to distinguish them, which was the original intent of color coding.

Organizations rarely prioritize record management procedures, and staff members with little expertise or training in this area typically handle records. Hospitals must employ records staff with the necessary abilities to handle the records generated during business operations if they are to maintain patient records effectively and efficiently. Issues with record keeping in healthcare facilities have included inadequate staff training, inept record keepers, and a low priority of record keeping compared to other departments (*Afolabi, 2004; Egwunyenga, 2009*).

4.1 OBJECTIVES OF THE STUDY

- To study the role of medical record department in hospital management.
- To understand the functioning of medical record department in hospital management
- To understand the importance of medical record in hospital management.

V. RESEARCH METHODOLOGY

The Research has been based on conceptual research work. A depth study was carried out. This paper discusses the role of medical record department in hospital management to understand the depth of the concept of medical record department in hospital management, the values that medical records holds and to understand the importance of medical record department in hospital management.

Secondary data has been used and studies from the previous researchers to identify various aspects related to the topic. Literature review and introduction has been preparing with the help of research paper publications, article, and other internet sources.

VI. FINDINGS AND CONCLUSION OF THE STUDY

It is impossible to overestimate the critical role the Medical Record Department plays in hospital administration. This division acts as the custodian of patient data, making certain that correct and easily accessible medical records are created, arranged, and maintained. Its influence extends beyond the therapeutic domain and touches on important fields including quality improvement, financial management, and legal compliance. The department builds a foundation of trust and responsibility by adhering to privacy legislation and supporting accreditation requirements.

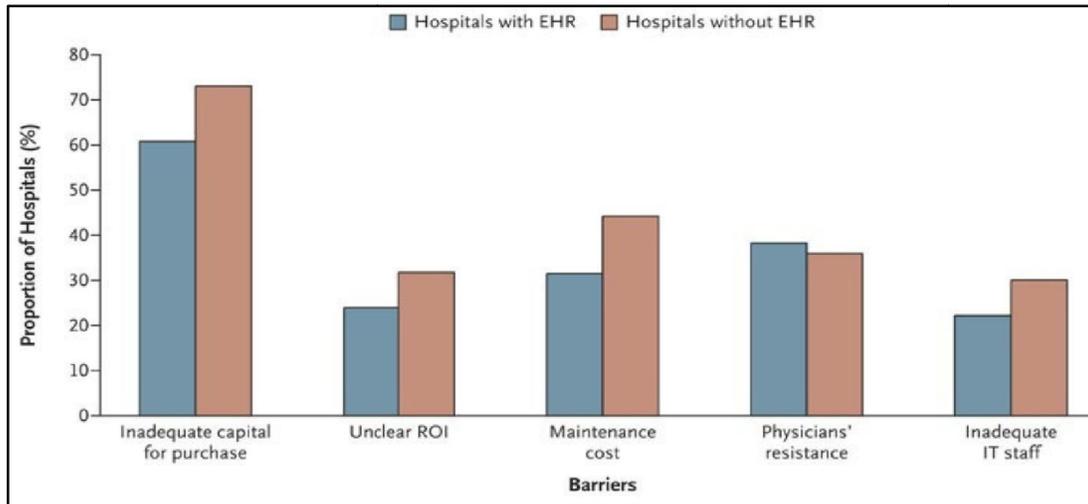


Figure: Major Perceived Barriers to Adoption of Electronic Health Records (EHRs) among Hospitals with Electronic-Records Systems as Compared with Hospitals without Systems.

Source: <https://www.nejm.org/doi/full/10.1056/nejmsa0900592>

Hospitals that have electronic record systems include those that have a simple system that only has features for nursing assessments and physician notes, as well as those that have a full system. All comparisons had $P < 0.01$, with the exception of physicians' reluctance ($P = 0.20$). ROI stands for return on investment, and IT stands for information technology.

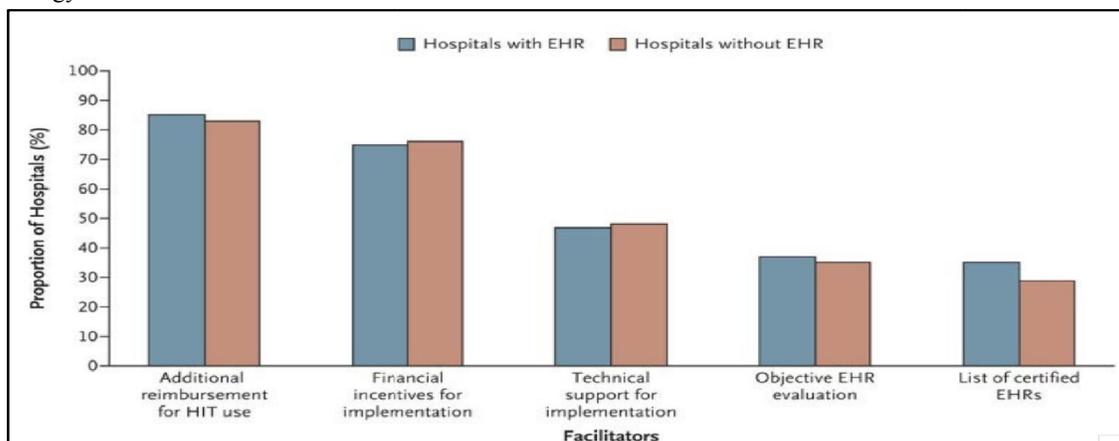


Figure: Perceived Facilitators of Adoption of Electronic-Records Systems among Hospitals with Systems as Compared with Hospitals without Systems.

Source: <https://www.nejm.org/doi/full/10.1056/nejmsa0900592>

Hospitals with electronic record systems can be classified as either comprehensive or basic, with basic systems having features like nursing assessments and physician notes. $P > 0.10$ in all comparison. HIT stands for health information technology, and EHR stands for electronic health record.

Its contribution to the billing and coding procedures financially sustains the hospital's profitability. By doing ongoing data analysis and audits, it turns into a proactive collaborator in the quest for improved health outcomes. Furthermore, the department is at the forefront of medical breakthroughs due to its role in research and education. Its careful catastrophe recovery and continuity planning emphasizes its dedication to the safety and availability of patient records during emergencies. The Medical Record Department is essentially a vital component of the overall hospital management structure, tying together financial stability, efficiency, compliance, and the constant quest of quality in healthcare delivery.

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