MEDICAL RECORDS ANALYSIS

# 416 - 68

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COMMUNITY SYSTEMS FOUNDATION
TO:         Mr. T. G. Whedbee, Jr., Director
FROM:       Vernon MacLeod, Managing Director
SUBJECT:    Medical Records Study

In June of 1965 a study of the Medical Records Department was initiated. The basic purpose of this study was to analyze the present workflow and methods used in the department and make recommendations which would improve the same. This has been done, and the recommendations in this report should lead to a more productive Medical Records Department.

Mr. Hewitt and I would like to thank Mrs. Doline and her staff for their cooperation and participation in the study. We also appreciated the assistance and cooperation we received from all other administrative personnel in the hospital.

October 20, 1965
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I SUMMARY

Several recommendations are made in this report which will improve and simplify the workflow in Medical Records. All of these recommendations are listed briefly below. They will be described in detail later in the report.

A. Rearrange internal layout of the Medical Records Department to improve workflow and working conditions.

B. Discontinue the "Blue Cross Book" and inaugurate the use of a diagnosis slip.

C. Discontinue the typing of the patient's master record card in Medical Records. This should become a third part copy of the admission history form.

D. Revise the present system of "5 x 8 cards" and "outcards" as means of locating charts in process in the Record Room.

E. Revise the present system of assigning chart or history numbers to each patient's chart.

F. Change the present design of the "Church Home and Hospital Daily Census" and the "Progressive Patient Care Census" statistics forms.

G. The "short form" for dictation of medical discharge summaries should be implemented if at all possible. The short form is now being used for gyn and surgical patients.

H. Revise present procedure of assigning charts to interns for dictation.

I. New administrative policies should be established and implemented to improve workflow into the Medical Records Department and reduce the amount of work in process in the Medical Records Department.
J. Implement a system of remote dictating throughout the hospital. This is now being planned for in the O.R. Department. Once this is implemented and the system is found to be satisfactory, it should be extended to the whole hospital. When this is done it will improve the workflow tremendously in Medical Records.

K. A solid program for training interns in the proper use of the dictaphone and the proper dictation of discharge summaries should be undertaken.

L. The microfilming of medical records should be handled in one of two ways. Either the whole job should be placed on bid to outside concerns or the preparation of the records to be microfilmed should be done by the hospital and the microfilming operation be placed on bid to outside concerns. Purchasing microfilming equipment and doing the complete job internally is not recommended.

M. As a follow up to the above recommendations an analysis of the use of PAS in the Medical Records Department should be made. It is felt that a recommendation to utilize PAS at this time would be uneconomical and would further complicate the workflow in the department. However, once all the above recommendations have been implemented and are working smoothly the addition of PAS may be feasible and economical. At such a time the chief advantages of PAS will be in the form of statistics, simplified coding of diseases and operations, and more available information for the Medical Staff.
II PRESENT MEDICAL RECORDS PROCEDURES

The following pages describe the present flow of work in the Medical Records Department. The flow of work is broken down into seven basic functions which are: 1. Patient Chart Processing; 2. Discharge Summaries; 3. Operative Notes; 4. Admissions, Transfers, and Discharges; 5. Abstracts; 6. Locating Charts; 7. Statistics.

1. Patient Chart Processing

a. Charts for discharged patients are picked up each day except for Saturday and Sunday from the Business Office. The present number of discharges a year is about 8,706 which is an average of 33.5 charts per work day. This is based on 260 work days a year for Medical Records personnel.

b. The charts are initially placed in order by admission date. When this is accomplished the charts are assigned their respective history number in the following manner. The "patient register" which was filled out upon admission of the patient and has the patient's name, doctor's name, and patient's history number is obtained. From this register the patient's history number is assigned.

c. Charts are now placed in groups according to the discharge date and then are placed in alphabetical order by the patient's names.

d. At this time the chart is checked for such things as: all permits and reports being signed, all data pertains to the same patient, the number of days of stay being correct, etc. Also at this time the names of any consultants are entered on the front sheet and the diagnosis and operation, if performed, are typed on the front sheet.

e. At this time the "Blue Cross Book" is filled out. This is a three-copy form which contains the following information:

<table>
<thead>
<tr>
<th>Date of Admission</th>
<th>Number of Consultants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>Doctor</td>
<td>Operative Procedures</td>
</tr>
<tr>
<td>Age</td>
<td>Anesthetist</td>
</tr>
<tr>
<td>Race</td>
<td>Daily Analysis Category</td>
</tr>
<tr>
<td>Rendered Days of Care</td>
<td>Chart Number</td>
</tr>
</tbody>
</table>
The main purpose of this form or book as it is called is to get information up to the Business Office for Blue Cross billing.

f. The charts are posted to the Physicians Index. This involves arranging the charts by doctor and entering into the respective doctor's card:

<table>
<thead>
<tr>
<th>Chart Number</th>
<th>Consultation By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Date Admitted</td>
</tr>
<tr>
<td>Result</td>
<td>Date Discharged</td>
</tr>
<tr>
<td>Operated</td>
<td>Age</td>
</tr>
<tr>
<td>Infection</td>
<td></td>
</tr>
</tbody>
</table>

A cross reference is made if the patient had any consulting doctors.

g. Using the Standard Nomenclature, an employee codes the diseases and operations of each chart. After coding a number of charts, she enters the following information onto the designated card:

<table>
<thead>
<tr>
<th>Chart Number</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>Operated On</td>
</tr>
<tr>
<td>Sex</td>
<td>Age</td>
</tr>
<tr>
<td>Discharged Date</td>
<td></td>
</tr>
</tbody>
</table>

h. This step is the process of getting the residents' and interns' signatures on the chart and joining the chart with its corresponding discharge summary. The numbered steps below refer to the flow chart shown on the next page.

1. Charts are placed in the resident's file to be assigned for dictation.

2. Resident assigns chart to intern and places assigned charts in a designated stack.

3. Charts in stack are sorted according to intern's names, the intern's name is marked on the out-card, and then the charts are placed in the intern's bins.

4. Intern dictates the discharge summary.

5. Chart is returned to the Record Room and is marked off on the out-card as being returned.
(6) Chart is placed in a "to be clamped" file where it awaits the discharge summary.

(7&8) Upon completion of the summary, the chart and corresponding summary are joined together. At this time the chart is checked for completeness, placed in proper chart order, and a check-off list noting anything the chart is lacking is placed on the chart.

(9) Chart is placed in private physician's or resident's file for final signature.

(10) Chart is completed by doctor filling in required signatures.

(11) Chart is picked up by Medical Records and given a final check.

(12) Charts are put in order by admission date and checked off in the patient register as being filed in the chart room. Charts are then placed in terminal digit order and filed away.
2. Present System of Handling Discharge Summaries

a. A copy of each day's discharges is typed on a 5 x 8 card to include all surgical, gynecology, and medical patients.

b. Intern dictates discharge summary, from chart placed in his bin, and the chart goes to the Record Room and the disc to the transcription pool. See steps 4 and 13 on flow chart.

c. An employee listens to the disc to find out the patient's name and the dictating intern's name. She then puts the intern's name and disc number next to the patient's name on the 5 x 8 card. See step 14 on flow chart.

d. The discs are transcribed in order, unless an employee has an extremely difficult summary to transcribe. If the dictation is difficult to understand, the employee will get the chart from the "to be clamped" section to use as a guide in transcribing the summary. Several copies, as many as four, may be made of the summary for requesting physicians, but the original and one carbon copy are used for the chart. See step 15 on flow chart.

e. The original is placed in the intern's bin for signature. See step 16 on flow chart. One carbon is filed, and the remaining ones are mailed out to those who requested them.

f. The summary is signed by the intern. See step 17 on flow chart.

g. After signature, the original is sent back to the transcription pool where it is matched with its carbon copy. This enables the group leader to keep track of the outstanding unsigned summaries. The patient's name is marked off the 5 x 8 card. See steps 18 and 19 on flow chart.

h. The original and its carbon copy are placed on top of the "to be clamped" section to be matched with their respective chart. See step 7 on flow chart.
3. Present System of Handling Operative Notes

a. The following are picked up from the Operating Room daily:
   - Discs that have been dictated.
   - Operative Log Sheet.
   - "T & A" Sheets.
   - Operative permits on the outpatient.

b. The log sheet information is copied into the operations book and the sheet is returned to the Operating Room. The information copied is as follows:
   - Date of Operation.
   - Patient's Name.
   - Surgeon.
   - Anesthetist.
   - Operative Procedure.
   - Assistant.
   - Room Number.
   - Age of Patients.
   - Chart Number.

c. The operative note is then transcribed. The note, upon completion, is taken to the floor, and marked off as so in the operations book. The note will either be signed before discharge of the patient or upon final approval of the chart by the physician.
4. Present System of Handling Admissions, Transfers, and Discharges

**Admissions**

a. Admission history cards are received daily from the Admitting Office.

b. The cards are placed in alphabetical order to check for previous admission in the master file.

c. Re-admissions are assigned the same history number and designated so by the use of black ink in the patient register. New admissions are designated by the use of red ink and are assigned a new history number.

d. A 3" x 5" patient master card is typed with the following information obtained from the admission history card:

   Name
   Address
   History Number
   Telephone Number
   Admission Date and Time
   Age
   Floor and Room Number
   Race
   Nearest Relative
   Address
   Physician
   Family Physician

e. The 3" x 5" card is filed in the active file which is reserved for those patients currently in the hospital and the admission history card is returned to the Business Office.

**Transfers**

a. Transfer cards are picked up from the Admitting Office daily.

b. Upon verification, the necessary changes on the patient master card regarding physician, service, and room number are made.

**Discharges**

a. Discharge cards are picked up from the Admitting Office daily.
b. The patient master card is pulled from the active file.
c. The discharge date is typed on the master card.
d. The cards are filed in the patient master file.
5. Present System of Doing Abstracts

a. Record Room receives an authorized request for information regarding a particular patient's chart.

b. The discharge date is looked up in the master card file by means of the patient's name.

c. Using the discharge date, the employee is able to find the location of the chart.

d. If the chart is incomplete it is given priority in being completed and then the information requested is typed and sent to the requesting party. An example of a common request made by Blue Cross is for the following information:

   Discharge Summary
   Doctor's Order Sheet
   Admission History
   Final Diagnosis
   Operative Notes
6. Present System of Locating a Chart

a. Initially the Record Room is notified that a chart or information from a chart is needed.

b. Step 1 is for the employee to go to the master card file and obtain the admission and discharge date of the patient. If the discharge date is not recent, the employee will go directly to the file room. For recent discharges the process is a great deal different. Four aids are used to determine the chart's location and these aids are listed below.

1. Patient Register - tells whether or not the chart has been permanently filed.

2. Charge-Out File - denotes that a chart is out of the Record Room.

3. Out-Card - denotes possible in process locations of the chart.

4. 5" x 8" Card - denotes possible in process locations of the discharge summary.
7. Statistics

Listed below are eleven categories of statistics now being kept by Medical Records.

a. Progressive Patient Care Census for House patients.

b. Progressive Patient Care Census for all patients.

c. Daily census for House patients.

d. Daily census for all patients.

e. Mortality Book.

f. Post-Operative Infection Book.

g. Alcoholic Cases Book.

h. Daily Analysis of Hospital Service.

i. Statistics for Daily Admissions

j. Short-Term Stay Book.

k. Blue Cross Book.
II PROPOSED SYSTEM

This section closely parallels the first section but gives the methods and procedures that will be used if all recommendations are implemented.

1. Chart Processing

a. Daily except for Saturday and Sunday Medical Records will receive all charts for discharged patients. Each chart at this time also has 3" x 5" cards which have been imprinted with the patient's addressograph plate.

b. The charts are placed in order alphabetically by the patient's name and the following procedures are carried out.

1. The patient's master card is removed from the active file and the discharge date written on the card. The master card is then filed in the permanent file.

2. Each chart is checked to see that all permits and reports are signed, and that all data pertains to the patient.

3. The names of any consultants, the diagnosis, and any operations are typed on the front sheet of the chart.

4. One of the 3" x 5" cards is filled out with the following:

Blue Cross Information and is sent to the Business Office.

Discharge Diagnosis
Operative Procedures
Anesthetist

5. An incomplete form noting any and all information that the chart is lacking is attached to the chart. (See appendix for example of incomplete form.)

c. The charts are posted to the physicians index. The following information is entered onto the respective doctor's card.
<table>
<thead>
<tr>
<th>Chart Number</th>
<th>Infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>Consultation</td>
</tr>
<tr>
<td>Result</td>
<td>Date Admitted</td>
</tr>
<tr>
<td>Operated</td>
<td>Date Discharged</td>
</tr>
</tbody>
</table>

d. Using standard nomenclature the disease and operations of each chart are coded. After coding these are posted.

e. The charts are now placed in the respective resident's bins according to service, either medical, surgical, obstetrical, or gynecology. At this time the remaining 3" x 5" card has the resident's name typed on it, and it is placed in a chart location file. (See the flow chart on the next page.)

f. After the resident has assigned the charts to the interns, the charts are placed in the intern's bins for dictation and the 3" x 5" controlled card is marked with the intern's name.

g. After the intern has dictated the discharge summary, the charts and discs are collected by the transcription pool. The summary is transcribed and the chart and summary are returned to the intern for signature.

h. After the intern has placed his signature on the summary the charts are collected and reassigned to the private physician or resident for their signature. This is noted on the 3" x 5" control card.

i. After the physician or resident has signed the chart it is given a final check, the incomplete form is detached, the 3" x 5" control card is destroyed, and the chart is permanently filed in the file room. A check is also made on the master card noting that the chart has been permanently filed away.
PROPOSED SYSTEM

Control File  |  Record Room  |  Dictaphone Room  |  Transcription Pool

Card  \(\rightarrow\) To Resident  \(\rightarrow\) Chart  \(\rightarrow\) Chart

Card  \(\rightarrow\) To Intern

Chart  \(\rightarrow\) Dictated By Intern

Chart and Disc  \(\rightarrow\) To Pool

Chart and Summary  \(\rightarrow\) To Pool

Chart and Summary  \(\rightarrow\) Intern Sig

Chart and Summary  \(\rightarrow\) Doctor Sig

Card  \(\rightarrow\) Destroy

Chart and Summary  \(\rightarrow\) To Records

Chart and Summary  \(\rightarrow\) Check and File

Chart and Summary
2. Admitting Office Procedures

a. When a patient is admitted to Church Home and Hospital the Admitting Office will type a three-part admission form. This form is made up of the following:

Admission History Form - to accompany patient to floor.
Admission Form - to go to Business Office.
Patient Master Card - to go to Medical Records and be filed in active file.

b. Admitting is to assign the patient's chart number upon admission and record the same in a patient register. Terminal digit numbers are to be assigned as follows.

(1) If the patient has never been at Church Home before a new number is assigned to the patient. About 66% of the admissions fall into this group.

(2) About 34% of the patients are re-admissions and will have their previous number assigned to them. This will be done as follows:

For patients admitted who have also filled out a pre-admission form (about 54% of all re-admitted patients) - In this case the number should be obtained from Medical Records in advance of the actual admission.

For patients that are admitted Monday through Friday between 8:00 a.m. and 4:30 p.m. (about 31% of all re-admission patients) - In this case a call to Medical Records should be made to obtain the number.

For the remaining 15% of re-admitted patients who are admitted on Saturday or Sunday or between 4:30 p.m. and 8:00 a.m. the number will have to be obtained from Medical Records at the earliest possible time that the Record Room is staffed.
3. Locating Charts

Upon request for information from a patient's chart, the following steps should be taken:

a. Go to the master card file and locate the patient's master card. If the card is checked as being filed, go to the file room and obtain chart.

b. If the master card has no check on it, go to the 3" x 5" control card file. This then designates where the chart is in the Record Room.
4. Statistics

The following list of information sources is to be used by Medical Records for future statistical purposes.

a. Admission Cards - These cards are typed up daily by Admitting and sent to Medical Records.

b. Transfer Cards - These cards are typed up daily by Admitting and sent to Medical Records.

c. Discharge Cards - These are typed up daily by Admitting and sent to Medical Records.

d. The Patient's Chart.

From the above sources, the following statistics are to be kept.

a. Mortality Book - This involves no change from the present procedure.

b. Post Operative Infection Book - No change from present procedure.

c. Daily Analysis of Hospital Service - No change except the information required is obtained directly from the chart.

d. Short Term Stay Book - No change from present procedure.

e. Combined Progressive Patient Care and Daily Census - This is a new form and is described in detail in the recommendation section of this report.

It is also noted at this time that the transfer cards are to be used for making corrections or additions to the patient's master card.
5. Procedures Not Changed

The present procedures for handling abstract requests and transcribing operative notes have not been changed. The procedure for transcribing discharge summaries has only been changed in that the chart and summary are kept together at all times and the 5 x 8 control card has been eliminated.
III RECOMMENDATIONS

This section of the report elaborates on the recommendations made in Medical Records and gives the reasons why the recommendations were made. However, it is felt that some of the recommendations made in the summary section of this report do not need further explanation and will not be elaborated upon here.
A. Layout Improvements

Several changes are recommended to improve the physical layout and equipment location in the Medical Records Department. The recommendations below will do the following: improve work flow, reduce transportation steps, improve traffic flow, increase supervisor’s visibility of employees, and give the transcription pool a quieter work area.

Layout Changes

1. Remove partitions around Mrs. Doline’s office.

2. Construct partition at location shown on layout. This partition should be about 6 feet in height and be constructed of glass from the height of 2½ feet to 6 feet.

3. Relocate Medical Records staff in the area designated on the layout and rearrange the equipment as shown.

4. Relocate transcription pool in the area designated on the layout and rearrange the equipment as shown.

5. Construct 4 dictation booths in the doctors’ dictation room as shown and rearrange furnishings as shown. Make no changes in this room if a system of remote dictation is going to be implemented in the hospital.

6. A new system of telephone connections should be installed as follows: The department in total should have three telephones. One phone would be in the transcription pool room at the transcription pool leader’s desk. Another phone would be located at the Medical Record Librarian’s desk. The third phone should be located in the Record Room at the employee’s desk nearest the patient master card file.

The directory should list one phone number for Medical Records. Any calls for the librarian or the transcription pool should be transferred internally in the department.
B. New Admitting Office Procedures

Through the use of a new three-part admitting form shown schematically in the appendix and by having the Admitting Office assign patient history numbers, the following advantages will be realized.

1. The need for Medical Records to type a master card will be eliminated.

2. It will not be necessary for admitting to send a copy of the admitting form to Medical Records.

3. The patient's history number can be put on the addressing plate. This is not presently possible.

4. The additional time required of Admitting Office personnel to keep a patient register will be less than 20 minutes a day.

5. The above will save Medical Records personnel better than 120 minutes a day.

6. Duplicate typing of information is eliminated.

The procedure which admitting will use to assign history numbers has already been described in section III of this report.
C. Statistics

Many changes regarding the present statistics that Medical Records keeps have been made in this report. The main reason for making the changes is to greatly reduce the amount of time spent on this work and at the same time simplify and improve the quality of the statistical records that will still be kept by Medical Records.

It is recommended that the following statistics no longer be kept by Medical Records.

1. Alcoholic Cases Book
2. Statistics for Daily Admissions

It is further recommended that a new form called the "Combined Progressive Patient Care and Daily Census" be used in place of the present "Daily Census Form" and the "Progressive Patient Care Form". The new form is shorter and easier to use and gives the same information as the other two forms. The only difference is that the computations for average length of stay by service become accurate estimates rather than the actual figures that can now be obtained. A schematic drawing of this form and the instructions for its use are shown in the appendix.

It is also noted at this time that the admission, transfer, and discharge cards that will be used in making entries on the "Combined Progressive Patient Care and Daily Census Form" must have the patient's service, (OB, Gyn, Med., Surg.) designated on the card.

It is recommended that the "Blue Cross Book" also be eliminated and a 3" x 5" card pre-stamped with the patient's addressograph plate be used to record Blue Cross information for the Business Office. This procedure will eliminate duplication of information and save time in Medical Records.
D. Administrative Policies

It would be a great benefit to the Medical Records Department if all
external influences on the department's operation could be systematically
controlled and coordinated with Medical Records. While this is not com-
pletely realistic or possible at Church Home or any other hospital,
certain recommendations are made here that should help the present situation
tremendously. If these policies are made and followed, the quality in
Medical Records will increase and the time spent on records will decrease.

1. More effort should be made by the Laboratory in getting patient's
lab slips on the charts. Presently too many of these slips are coming
down to Medical Records to be posted on the chart. This is presently
taking about 18 hours a week of Medical Record time. A suggested
remedy for this problem is to have the Laboratory daily take completed
lab slips back to the nursing units. Either Nursing or Laboratory
could paste the slips on the chart. I would recommend Nursing do
this job. I also recommend that every lab slip be stamped with the
patient's addressograph plate.

2. The backlog of charts awaiting doctors signatures is way out of hand.
The present policy gives a doctor up to one month to sign a chart
before action is taken. Again I feel it would be a benefit to
Medical Records, the hospital, the doctor, and the patient if this
rule were tightened up. One week to sign the chart and suspended
privileges at two weeks would be my recommendation. This will again
expedite the processing of charts.

3. It is also recommended that the use of the short form for dictation of
medical discharge summaries be reopened for discussion. The short
form saves a good deal of transcription time. The use of this form
could save approximately 300 hours annually for the transcription pool.
4. With a large number of foreign interns it is also felt that the existing program for demonstrating and teaching the proper use of the dictaphone be expanded with added support from the resident staff. Poor or inaudible dictation slows down the initial transcription, mistakes are made which must be corrected, and quality of record content sometimes suffers. If the importance of clear and precise dictation can be demonstrated to both the interns and residents, their cooperation should be achieved. One way to do this would be to have one intern try to interpret another intern's dictation. Here again, if a stronger program is instituted, the long-range savings to Medical Records in transcribing time should pay for itself.
E. Chart Locating

The present system of "5 x 8 cards" and "outcards" is too complicated and time consuming. To save time and simplify the process of locating charts in the Record Room a new system using only one 3" x 5" control card is recommended. The use of this card was described in section III of the report.
F. Remote Dictating System

It is recommended that a system of remote dictating be installed in Church Home and Hospital. Such a system, if properly utilized, would lead to the following advantages.

1. The number of steps required to get a discharge summary dictated and transcribed will be reduced. The following steps shown on the flow chart on page 15a will be eliminated.
   a. Charts being placed in residents bins.
   b. Residents assigning charts to interns for dictation.
   c. Transcription pool having to pick up charts and discs from the dictation room.

2. Discharge summaries must be dictated at or before the actual time of discharge. Presently they are being done several days after discharge.

3. The system should encourage more private physicians to dictate their own discharge summaries.

4. Work in process and delays now caused by discharge summaries would be reduced in the Medical Records Department.

5. Time saved in Medical Records would be about 450 hours a year. The annual cost of the new system based on a 10 year life is estimated at $400. This cost estimate is based on information obtained from Mr. Cook of the Graymar Company.
G. Microfilming

Through past studies and reports that have been made on microfilming, plus an initial estimate of the volume of microfilming at Church Home, the feasibility of purchasing microfilming equipment and doing the total job internally is not economically sound. However, it is also not recommended that the whole job be bid outside. The following recommendation is made. Bids should be obtained from a minimum of two outside concerns. The work to be microfilmed should be bid in two ways.
1. Bid the whole job outside.
2. Bid only the microfilming itself outside and do the preparation inside.

At this time it is estimated that number 2. above will be the best method economically and from a quality standpoint.
V CONCLUSIONS

Once all recommendations in this report are implemented the total time now being spent by Record Room personnel will be reduced by 2,500 to 3,500 hours annually. This time savings should be utilized initially to expedite training of employees for the new procedures and eventually reducing the Record Room personnel by two full-time positions and hiring one part-time position.

However, if the remote dictating system is implemented the time saved will be increased by an additional 450 man-hours a year. This could then lead to an overall savings of two full-time positions. Estimates of the time savings are based on actual observation of the work being done in Medical Records. Calculated estimates were used where no observations were possible.

Besides the time and dollar savings, the quality and speed of chart processing will also be improved. The number of charts and other work in process should also be greatly reduced.
VI APPENDIX
INSTRUCTIONS FOR PERFORMING STATISTICAL COMPUTATIONS

The following tabulation and computation instructions are for use with the new daily statistics form. The instructions are given in step form.

Step 1  Total columns (2 through 58)
Step 2  Compute average daily census.
        Divide the totals of columns (6, 11, 16, 21, 26, 31, 36, 41, 46, 47, 52, 53, and 58)
                by the number of days in the month.
Step 3  Compute average length of stay.

<table>
<thead>
<tr>
<th>Service</th>
<th>Computation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Self</td>
<td>6 divided by 4 + 5</td>
</tr>
<tr>
<td>Medical Intermediate</td>
<td>11 divided by 9 + 10</td>
</tr>
<tr>
<td>Medical Special</td>
<td>16 divided by 14 + 15</td>
</tr>
<tr>
<td>Surgical Self</td>
<td>21 &quot; 19 + 20</td>
</tr>
<tr>
<td>Surgical Intermediate</td>
<td>26 &quot; 24 + 25</td>
</tr>
<tr>
<td>Surgical Special</td>
<td>31 &quot; 29 + 30</td>
</tr>
<tr>
<td>Gyn. Self</td>
<td>36 &quot; 34 + 35</td>
</tr>
<tr>
<td>Gyn. Intermediate</td>
<td>41 &quot; 39 + 40</td>
</tr>
<tr>
<td>Gyn. Special</td>
<td>46 &quot; 44 + 45</td>
</tr>
<tr>
<td>All Excluding OB</td>
<td>47 &quot; (4 + 9 + 14) + (19 + 24 + 29) + (34 + 39 + 44)</td>
</tr>
<tr>
<td>OB</td>
<td>52 &quot; 50</td>
</tr>
<tr>
<td>All Including OB</td>
<td>53 &quot; 55</td>
</tr>
<tr>
<td>New Born</td>
<td>58 &quot; 57</td>
</tr>
<tr>
<td>All Medical (Approx.)</td>
<td>6 + 11 + 16 &quot; 4 + 9 + 14</td>
</tr>
<tr>
<td>All Surgical (Approx.)</td>
<td>21 + 26 + 31 &quot; 19 + 24 + 29</td>
</tr>
<tr>
<td>All Gyn.</td>
<td>36 + 41 + 46 &quot; 34 + 39 + 44</td>
</tr>
<tr>
<td>All Self</td>
<td>6 + 21 + 36 &quot; (4 + 5) + (19 + 20) + (34 + 35)</td>
</tr>
</tbody>
</table>
All Intermediate | $11 + 26 + 41$ divided by $(9 + 10) + (24 + 25) + (39 + 40)$

All Special | $16 + 31 + 46$ divided by $(14 + 15) + (29 + 30) + (44 + 45)$

Step 4 Checks for accuracy and correct data.

A. $3 + 8 + 13 + 18 + 23 + 28 + 33 + 38 + 43 + 49 = 5 + 10 + 15 + 20 + 25 + 30 + 35 + 40 + 45 + 51$

B. Total of column 53 should equal
$6 + 11 + 16 + 21 + 26 + 31 + 36 + 41 + 46 + 52$

C. Total of column 54 should equal
$2 + 7 + 12 + 17 + 22 + 27 + 32 + 37 + 42 + 48$

D. Total of column 55 should equal
$4 + 9 + 14 + 19 + 24 + 29 + 34 + 39 + 44 + 50$
This record lacks the parts not checked:

Dr. ______________________________ Date ______________________________

1. ___ Visiting Physician's signature and date on front of chart
2. ___ Signature on History
3. ___ Signature on Physical Exam
4. ___ Signature on Discharge Summary
5. ___ Signature on Operative Note
6. ___ Progress Notes
7. ___ Consultation Note
8. ___ Physician's Note
9. ___ Surgeon's Note - If patient is not submitted to Surgery
10. ___ Check final diagnosis
11. ___ Condition on discharge
12. ___ See positive Laboratory findings (Circled in Red)
13. ___ Pathological report not in accord with final diagnosis
14. ___ Posted to Physician's Index
15. ___ Disease coded and posted
16. ___ Operation coded and posted
17. ___ Operative Note to be dictated
18. ___ Discharge Summary to be dictated
19. ___ Cystoscopic Note to be dictated
20. ___ Operative procedure not recorded on front of chart
<table>
<thead>
<tr>
<th><strong>Admission History</strong></th>
<th><strong>Church Home and Hospital</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Information</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>Chart No.</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td><strong>Date Admitted</strong></td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td><strong>Time Admitted</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td><strong>Blood Type</strong></td>
</tr>
<tr>
<td><strong>Next of Kin (Husband, Wife, Parent, Guardian)</strong></td>
<td><strong>OCCUPATION (Former or Active)</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td><strong>Occupation</strong></td>
</tr>
<tr>
<td><strong>Relative or Friend</strong></td>
<td><strong>Length of Residence</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>IN MVI</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td><strong>IN MVI INJURY</strong></td>
</tr>
<tr>
<td><strong>Father's Name</strong></td>
<td><strong>DOB</strong></td>
</tr>
<tr>
<td><strong>Mother's Name</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Your Last Admission to This Hospital</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>INSURANCE- COMPANY</strong></td>
<td><strong>Policy No.</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>Address</strong></td>
</tr>
<tr>
<td><strong>Employee</strong></td>
<td><strong>Insurance Company</strong></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>Phone No.</strong></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td><strong>Policy No.</strong></td>
</tr>
<tr>
<td><strong>Send Bills To</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Name</strong></td>
<td><strong>Compensation No.</strong></td>
</tr>
</tbody>
</table>

*No change in this part of form*