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**INDO AMERICAN JOURNAL OF
PHARMACEUTICAL SCIENCES**<http://doi.org/10.5281/zenodo.3819110>Available online at: <http://www.iajps.com>**Research Article****DIFFERENT MANAGEMENT MODE OF CLINICS AND
PATIENT'S SATISFACTION IN HOSPITALS OF PAKISTAN****Dr. Areeba Maryam¹, Dr. Syed Muhammad Arslan¹, Dr. Mariam Fatima¹**¹Bahawal Victoria Hospital, Bahawalpur**Article Received:** March 2020**Accepted:** April 2020**Published:** May 2020**Abstract:**

Background and objectives: Nowadays department of clinics is formulated in all major hospitals where specialists usually provide outpatient care to Medical, Surgical and Pediatric patients and occasionally to inpatient queries as well. The objective of this study was to determine the management mode of clinics in general hospitals of Bahawalpur. **Material and methods:** This cross-sectional study was conducted in Bahawal Victoria Hospital, Bahawalpur during July 2019 to December 2019. For these 5 hospitals were selected for the determination of clinical mode. All hospitals were visited one by one and collect the data for the determination of mode of clinics. Number of patients and number of doctors were also counted. **Results:** The Stat software is currently performing a very significant role in the individualization and optimization of drugs intended for patients and, subsequently, all patients in general hospitals. **Conclusion:** The research system is as follows: Using available parameters the patient's age, clinical condition, genetic makeup, and other variables the software creates a treatment dosage "proposal." Positive and negative changes in drug effects related to dosage and concentration are monitored. Research includes the dosage program, patient individualization, and drug effects for extracorporeal blood circulation.

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INTRODUCTION:

General Hospital is a place where you find remedy to all your health-related issues under one roof. Hospitals deal with the life and health of their patients and best medical care depends on highly trained doctors and nurses and on out class services and equipment. Proper and excellent medical care also depends upon proper record maintenance. Governance and leadership are generally considered the most difficult and hence the most important functions of government in relation to the health system¹.

According to IRMT, 1999 (International Records Management Trust), in some hospitals out-patient case notes are patient-based (case notes given to the patients for safe keeping) while in-patient case notes are hospital-based (case notes retained by the hospital in its own records registry or storage areas). Risks correlated with patient care can never be completely eradicated so for this reason management of clinical issues offers a vital role in facilitating hospitals to improve patient safety². Accomplishment of disease management programmes for chronic conditions could reduce hospital admissions, out-of-hours services and emergency department attendance³.

The consequence of this is a wide range of opportunities for enhanced healthcare, but on the other hand also increases the risk factor of adverse measures and patient damage. Involvement of patient in making decisions related to healthcare is increasingly and internationally renowned as important for matching care to patient preferences and for improving the safety and quality of care⁴. Risks concerned with patient healthcare can never be completely eliminated so clinical management plays a critical role in facilitating hospitals to improve safety of the patient. Management of clinics is a specific form of RM (risk management) mainly focusing on all clinical procedures directly and indirectly connected to the patient. Therefore, clinical management is defined as all procedures, activities and instruments that facilitate hospital employees to recognize, examine, hold and manage threats while providing clinical treatment and patient care⁵.

Clinical information is one of the most important reserves that a hospital holds. Information can be characterized only by its function and consists of

knowledge about how to accomplish a goal and data⁶.

Objectives of the study

The objective of this study was to determine the management mode of clinics in general hospitals of Bahawalpur.

MATERIAL AND METHODS:

This cross-sectional study was conducted in Bahawal Victoria Hospital, Bahawalpur during July 2019 to December 2019. For these 5 hospitals were selected for the determination of clinical mode. All hospitals were visited one by one and collect the data for the determination of mode of clinics. Number of patients and number of doctors were also counted.

Collection of variables

A questionnaire had given to all consultants for the determination of clinics mode. The questions included type of clinic, organization, types of patients seen, reasons for establishing the clinic, and the specialists' opinions. Same questionnaire was also given to up to three general practitioners using each clinic, covering details of the clinic and general practitioners' opinions. General record keeping standards and hospital safety scores were also collected

Statistical Analysis

The Stat software is currently performing a very significant role in the individualization and optimization of drugs intended for patients and, subsequently, all patients in general hospitals. This test controlled for age, sex, severity of underlying disease, medical service, and mortality. Adjustment for the severity of disease was accomplished with use of hospital safety scores and compliance with RCP medical record keeping standards.

RESULTS:

Analysis of results was performed by comparing the data of hospitals with international standards. Patient case notes were checked for compliance with RCP 12 point generic medical record keeping standards on 5 point scale to stratify the level of compliance. Hospitals where case notes fulfilled all the 12 standards were placed at point 5. Hospital safety scores were measured on 4 point scale and different hospitals were categorized according to grades A, B, C, D and F. Different hospitals were also checked for the provision of services like use of electronic health record system, ambulatory services, transport facility for the staff, child immunization facilities and family planning consultancy and services in each hospital.

Table 01: Hospital Safety Scores

Grade	Safety Criteria	Score	Count of Hospitals	Percentage of Hospitals
A	≥ 3.133		23	46%
B	≥ 2.964		11	22%
C	≥ 2.476		8	16%
D	≥ 2.047		5	10%
F			3	6%
Totals			50	

A 5-point scale was developed to stratify the level of compliance (Figure1). Hospitals where case notes fulfilled all the 12 standards were placed at point 5.

Compliance with RCP Generic Medical Record Keeping Standards Rating on a 5 point Scale

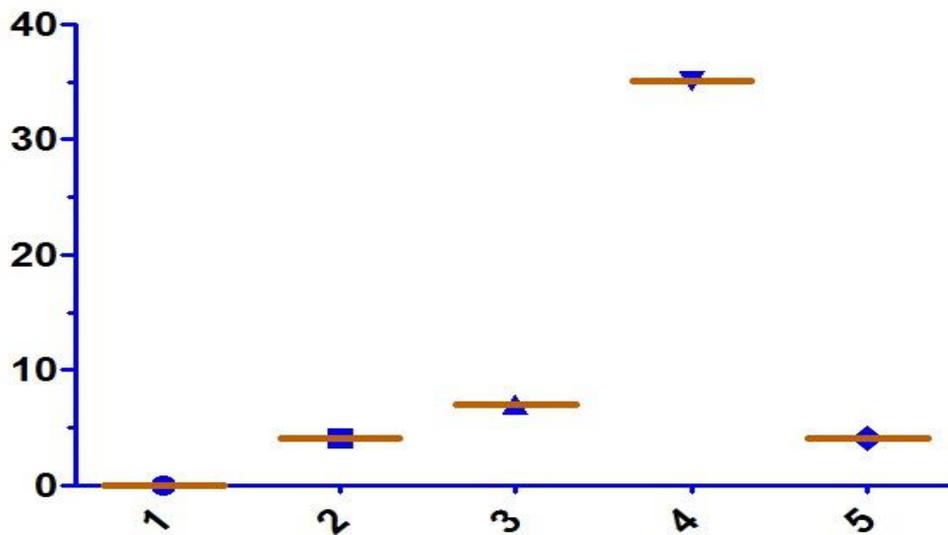
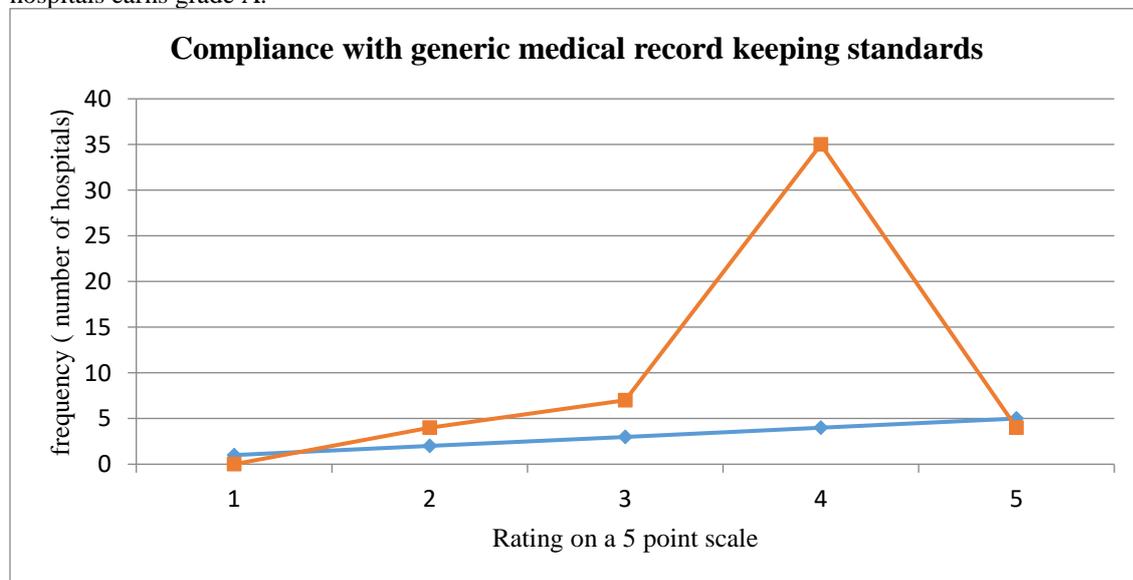


Figure 01: Showing RCP generic medical record

Using 26 national measures of safety, a numerical safety score for all eligible hospitals were calculated. According to our data none of the hospital earns hospital safety score of 4, but 23 hospitals has safety score of 3.5, hence 23 hospitals earns grade A.



DISCUSSION:

Generic medical record keeping standards were developed by the Health Informatics Unit of the Royal College of Physicians⁷. The purpose of these standards is to, maximize patient safety and quality of care and support professional best practice, Assist compliance with Information Governance standards⁸. The standards were reviewed and revised based on received comments and were approved at the RCP's Clinical Standards Board in March 2007⁹. Our data includes number of hospitals fitting into these record keeping standards. The standard description is as follows:

1. During patient's stay in hospital their entire medical record should be accessible to patients and medical people as well.
2. The medical record keeping booklet should include the name of the patient, recognition number and locality in the hospital.
3. The Documents related to medical record should imitate the patient care variety and should be sighted in sequential order.
4. The medical record must have a uniform arrangement and design.
5. Each new entry in the medical record must have mentioned with date, time (24 hour clock), should be comprehensive and marked by the person who makes that entry.
6. The consistent and standardized Performa should be used for the information documented or corresponded on admission and discharge¹⁰.

CONCLUSION:

Medical record keeping is the organized method of recording the essential data and other related papers so that it becomes easily available at the time of its requirement. That type of medical records contains patient name, sex, age, mailing address, profession, illness and types of analysis. This would be helpful for patients to attain the right and suitable treatment and it would also be helpful for the specialist who is checking the patient. Results showed that in both inpatient and outpatient mode different methods were deployed by all those 5 hospitals

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